

Advancing Medical Education in Bangladesh through Integration and Group Discussion

Bangladesh has made great progress in recent years in modernizing its medical school system to meet international standards and generate skilled and kind medical professionals. The implementation of integrated medical education and the use of group discussions as a teaching technique are crucial components of this change. These strategies have enormous potential to support medical students' clinical competency, teamwork, and critical thinking while meeting Bangladesh's changing healthcare delivery needs. This editorial examines the value of group discussions and integrated medical education in Bangladesh, emphasizing their contributions to the development of qualified medical professionals.

The Case for Integrated Medical Education

Integrated medical education moves away from traditional, discipline-based teaching, where subjects like anatomy, physiology, and pharmacology are taught in isolation. Instead, it emphasizes a holistic curriculum that interweaves basic sciences with clinical practice from the early years of medical training. In Bangladesh, studies have shown that students and faculty view integrated teaching favorably, with a 2021 cross-sectional study reporting a mean score of 3.47 (out of 4) for adopting integrated curricula in MBBS programs, compared to 1.2 for the existing curriculum.¹ This shift is crucial for preparing students to address complex clinical scenarios that require synthesizing knowledge across disciplines.

The benefits of integration are manifold. It promotes contextual learning, enhances retention of knowledge, and prepares students for real-world challenges where patients present with multifaceted conditions. For instance, pharmacology, a core preclinical science, can be integrated across all phases of medical education to improve prescribing competency, a critical skill for future physicians.² In Bangladesh, where the healthcare system faces challenges such as resource constraints and a high patient load, an integrated curriculum ensures that graduates are better equipped to make informed, logical decisions in clinical practice.

However, implementing integrated curricula is not without challenges. Faculty training, curriculum

redesign, and resource allocation are significant hurdles, particularly in private medical colleges where infrastructure may lag. The government's initiatives, such as the Further Improvement of Medical Colleges (FIMC) Project and the establishment of the Centre for Medical Education (CME), have laid a foundation for reform, but sustained investment and stakeholder collaboration are essential to scale these efforts.³

The Role of Group Discussion in Medical Education

Complementing integrated education, **group discussion** is a powerful active learning strategy that fosters critical thinking, communication skills, and teamwork—essential for modern medical practice. In Bangladesh, where medical students often rely on rote memorization due to large class sizes and exam-oriented teaching, group discussions offer a dynamic platform for peer-to-peer learning and problem-solving. A 2019 survey revealed that 90% of medical students preferred using social media platforms like Facebook and WhatsApp for collaborative study, indicating a natural inclination toward group-based learning.⁴ Formalizing group discussions within the curriculum can harness this enthusiasm while addressing gaps in critical academic skills.

Group discussions, particularly in the form of problem-based learning (PBL) or case-based discussions, encourage students to engage with clinical scenarios, question assumptions, and develop evidence-based reasoning. For example, discussing a patient case involving diabetes can integrate knowledge of biochemistry, pathology, and clinical management while promoting teamwork and communication. These skills are vital in Bangladesh's healthcare context, where physicians often work in multidisciplinary teams under time and resource constraints.

Moreover, group discussions can address the lack of adequate clinical exposure, a concern highlighted in a study of Bangladeshi medical colleges, where private institutions reported fewer functioning clinical units than required.⁵ By simulating clinical scenarios in a classroom setting, group discussions can bridge this gap, ensuring students develop practical skills even when hands-on opportunities are limited.

Challenges and Opportunities

Despite their promise, integrating these approaches faces logistical and cultural barriers. Faculty resistance to change, limited training in active learning methodologies, and a lack of standardized assessment tools for group-based learning are significant obstacles. Additionally, the integration of Information and Communication Technology (ICT), which could enhance group discussions through virtual platforms, remains inadequate in many medical colleges. The 2019 survey noted that 74% of students felt the current syllabus lacked sufficient ICT integration, hindering their professional skills development.⁴

Yet, opportunities abound. The growing recognition among stakeholders of the need for curriculum reform, coupled with a “critical mass” of trained medical educators, provides a strong foundation for change. The Association for Medical Education (AME) and the Bangladesh Medical and Dental Council (BM&DC) can play pivotal roles in standardizing integrated curricula and promoting active learning strategies. Additionally, leveraging digital platforms, as demonstrated by students’ preference for social media collaboration, can make group discussions more accessible and scalable, even in resource-constrained settings.

A Path Forward

To realize the full potential of integrated medical education and group discussion in Bangladesh, a multifaceted approach is needed:

- 1. Curriculum Reform:** Develop a national framework for integrated curricula, drawing on successful models from institutions like King Edward Medical University or Kathmandu Valley medical colleges.⁶ Pilot programs in selected medical colleges can test and refine these curricula before nationwide implementation.
- 2. Faculty Development:** Invest in training programs to equip educators with skills in integrated teaching and facilitation of group discussions. Workshops by organizations like the CME can build capacity among faculty.
- 3. Technology Integration:** Incorporate ICT into the curriculum to support virtual group discussions and access to digital resources like PubMed and Medscape, addressing students’ call for a basic ICT learning program.⁴
- 4. Assessment Innovation:** Develop robust assessment methods to evaluate competencies gained through integrated learning and group discussions, such as peer assessments, reflective essays, and case-based evaluations.
- 5. Stakeholder Collaboration:** Foster partnerships between the government, AME, BM&DC, and international organizations to secure funding and expertise for sustained reform.

Conclusion

The transformation of medical education in Bangladesh through integrated curricula and group discussion is not merely an academic exercise but a necessity to produce physicians who can navigate the complexities of modern healthcare. By fostering a learning environment that emphasizes integration, collaboration, and critical thinking, Bangladesh can ensure that its medical graduates are not only competent but also compassionate and adaptable. As the nation continues its journey toward a robust healthcare system, these educational reforms will serve as a cornerstone for building a healthier future.

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