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Medical Education In Bangladesh: Some Thoughts

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THERE are today eight medical colleges in Bangladesh run by Government with an annual production of around 1400 doctors. Besides, there are two private medical institutions which are four and three years old respectively. These are Bangladesh Medical College (BMC) in Dhaka and the Institute of Applied Health Sciences (IAHS) in Chittagong. There are limited number of seats for students in each of these which are yet to produce doctors.

The total number of qualified doctors registered by Medical and Dental Council is around 21,000. The doctor-population ratio, therefore, is approximately 1:5,200. If the distribution is critically analysed, a dismal picture of maldistribution is noticed. Almost 80% of the doctors live in urban areas which contain 15-20% of the population while the remaining 20% live in rural areas where 85-90% of the population live. Virtually, therefore the doctor-population ratio in the rural areas is 1:20,000. With the rate of production of doctors as stated above one can easily visualise that it will take decades if not ages to produce sufficient number of qualified doctors to serve the entire nation.

There are several reasons for uneven and maldistribution of qualified manpower. The first and foremost contributory factor is medical education. Fortunately this has undergone revolutionary changes for the last few decades. It is no more confined to the four walls of the institutes. Community Based Medical Education (CBME) is, now a recognised concept. According to WHO there are six reasons to justify need for CBME. These are:

i. Development of a sense of social responsibility among the trainees through understanding of the local problems, needs and requirements.

ii. Trainees can discover during the course the relationship between theoretical knowledge and practical training. Exposure to the community prepares them for future life and field of activity.

iii. It helps breaking down the barrier between the professionals and the layman and establishes closer relationship between the institute to which they are attached and the community they serve.

iv. Problem-based learning prompts students to learn more and become uptodate.

v. Enables students to develop competence for providing health care with limited facilities in the community.

vi. The system improves the quality of community health care through the participation of teachers and students.

Development of upazila (thana) health complexes and rural health centres with provisions for consultants is no doubt a move towards peripheral health care in Bangladesh. The programme has unfortunately failed to come up to the expectation. A surprise visit to an Upazila health complex brings to light the real situation prevailing there. Many of those posted here are almost invariably absent. Some of them perhaps visited the place only for a few hours for joining report then at the end of the month only to draw salary. This sordid affair is the inevitable outcome of inefficient administration and the unrealistic western system of medical education which had never been community-oriented.

Bangladesh Medical and Dental Councils have recommended CBME from the beginning of medical curriculum. If a sincere effort is made to implement the programme community health care will have a brighter future with the participation of the teachers and students. In this system the students will receive training in this field of future activities and the community shall get the benefit of improved health care.

The consultants of an Upazila health complex today are in fact the neglected group of unutilised postgraduates who have qualified themselves through several challenging tests. If the medical students are placed at various Upazila health complex for training and the consultants are designated as teachers this shall benefit the health complex, the consultants, the students and the population in the area. Administratively this is advantageous in that the presence of students demands regularity of attendance by the consultants.

While discussing changes in medical education, it goes without saying that the quality and standard must as well improve. Appointments on adhoc basis strikes at the very root of quality assessment. Examples are not rare where candidates rejected by PSC have been appointed in the same posts on adhoc basis which continue for years. This has greatly contributed towards deterioration in the quality of teachers. If by any means one is appointed as a Professor, he faces no further assessment or challenge. The sincerest teacher with all his contribution as a teacher, researcher and health provider not uncommonly fails to procure a suitable placement where he can effectively contribute. An institute which may be most suitable for a man of his calibre may prove to be a dream for him while someone who stands no comparison occupies the position through unholy alliance. Lack of defined principles regarding placement and posting, opens up opportunities for the unscrupulous and deprives the honest and the bright ones. This on the one hand impedes progress and destroys the potential for development in research. Publications in recognised journals once a requirement for appointment of professor is now almost nonexistent. It will not be difficult to find out some teachers who have never contributed an article to even an occasional publication. Nothing can be more dangerous than be backdated with abandoned ideas in the field of teaching and yet this is a phenomenon which has not yet been out of existence. This is reflected in our prescriptions which are often criticized abroad a common experience of our people going abroad for treatment.

In the Supreme Court of Bangladesh while I was sitting in the office of a leading lawyer, there were half a dozen senior lawyers around. I was there for a personal reason. It was a recess period. One lawyer sitting next to me wittily asked me as a busy practitioner how could I compare myself with a busy lawyer. I said a busy lawyer faces the judges and the defence counsel. There is therefore double protection. A busy practitioner on the other hand can very well go unchallenged. The patients accept whatever is advised in writing as a prescription and something in addition verbally. Even if the prescription is wrong resulting in delay in recovery, non-recovery, complications and even fatality, he is not answerable. There is no legal challenge and the people accept these as their fate. Here lies the difference. This has resulted in gradual deterioration of standard of health care, teaching as well as research.

A system of periodic assessment of teachers exists even in some developing countries. Even the students have the opportunity of assessing the quality of teachers through ballot. The selection committee makes an assessment from academic performance of a particular teacher by way of research publication during the previous years. In many western countries the teachers are required either to publish or perish. There are instances where professors have been demoted as consultants because they could not prove their worth though academic performance.

In our country curiously enough, a professor or a teacher can go unchallenged even if he has shown no academic activity after obtaining postgraduate qualification and securing a job.

Question arises how easy it is for the Government to assess academic activities. How the Ministry of Health can shoulder such a country-wide activity. The problem is not as difficult as one is tempted to think.

I suggest that some procedure be adopted in all medical colleges and other teaching institutions. Institutions should bring out annual publications which will contain report of their academic activities including research and publications.

By this the picture will become clear not only about the organisation but also about the individual teacher. The publication shall also serve as a permanent document on academic activities and research findings.

Finance involved in such work is not a problem. A token grant from the ministry may be enough as additional amount may be collected through advertisements. It is our common experience that several souvenirs are published by teachers and students during various college functions. These occasional publications are like perishable items. They are never retained in the libraries and also do not have much academic value. The publication so proposed shall be of great value in our effort to assess the quality of an institute as well as its teaching staff. On the basis of these we can define appropriate line of action for promotion, transfer, reward and so on. Besides, these shall be useful addition to our libraries for future reference.

It is often said that we do not have facilities for research. This is far from true. Fundamental research may be difficult but for some basic and clinical research we have abundant materials and sufficient facilities. Finance is also not a problem. A well-planned protocol is all that necessary. Both national and international agencies like Bangladesh Medical Research Council (BMRC), WHO and many others are eager to provide fund. In fact we are guilty of underutilisation of these resources in Bangladesh.

It is worthwhile discussing here on the latest development in the field of medical education at home. Soon after liberation Bangladesh was beset with many problems as a natural consequence. Enthusiastic among politicians and the labourers led to serious miscalculation in some sectors. Nationalisation of several industries was one such dangerous step. The idea that prompted the leaders were lofty and the sentiment behind was an unmixed love for people. Over the subsequent few years we had to pay heavily for this. Many industries were destroyed. Some are till today too sick to recover.

Behind this dark cloud there is a silver lining. We are today convinced that the nationalisation can be destructive where social responsibility is thin and personal interest prevails over the national goal. Lack of competition is detrimental to progress and job security begets indifference towards personal responsibility. A look at the government and private enterprises displays the differences between the two sectors too prominently to go unnoticed. Nationalised industries are now being gradually disinvested with the hope of establishing competitive efforts to contribute towards national economy.

In the field of education there is another example where private institutions are flourishing maintaining well quality and standard. This ranges from primary and secondary education to health care centres. The last four years have experienced a new development in the field of medical education. Two institutions viz. Bangladesh Medical College in Dhaka and Institute of Applied Health Sciences (IAHS) in Chittagong have been developed entirely with private efforts. There has been enthusiastic response and the competition for admission has been no less than that in the government medical colleges. In some instances there has been in fact greater learning towards the private ones because of the quality of teaching and the commitment of teachers. Notwithstanding the advantages of these private institutions in selecting quality teachers with attractive pay the students cannot avoid session-jam because of its academic link with the existing universities along with other medical colleges.

The latest move by the government for establishment of private universities will undoubtedly solve this problem. Breaking the chain of administrative obstacles and odd influences and giving the institutions academic freedom, performances by these private universitites through regularity and quality will naturally bring to light how well education can be conducted, if this is freed from administrative bottlenecks and political influences.

(To be continued)