Correspondence

Competency-based curriculum: Mirage or reality

Beginning with the new batch of medical students, the Medical Council of India (MCI) has introduced a month-long foundation course followed by an Attitude, Ethics and Communication (AETCOM) module[1] along with the competency-based core subjects namely, anatomy, physiology, biochemistry and community medicine.[2]

To know whether the course is working with the same objectives and goals as envisaged by the MCI, in all institutes, is difficult, as getting the curriculum operational in about 500 medical colleges in one go is not an easy task. No country till date seems to have organized such a major curricular change. Faculty training workshops have been organized since 2015, to prepare institutes for the final launch of 'VISION 2015' of the MCI from the batch of 2019–2020.[3]

I do support this initiative, as a faculty, because I felt a need for a foundation programme, so that students get acclimatized to the institutional setting and comprehend the extent of the medical course.

The change is big and so would be the challenges. I would like to highlight some of the dimensions of this new competency-based curriculum (CBC).

Each subject and every topic in the programme has well-stated competencies. Departments have to prepare objectives (general and specific) with the liberty to explain the competency/ies in one or two sessions, using teaching–learning approaches of their choice.[4] Topic delivery has to be in an aligned and integrated manner. Although the previous curriculum did focus on the integrated approach, but the integration was not mandatory.[5] Medical education cannot be confined merely to books and lectures. The aligned and integrated approach would allow students to assimilate the basic content at their level for clinical practice and probably yield better outcomes for the medical education system.

The curriculum proposes at least 60% of sessions to be small-group teaching (SGT), tutorials or practical demonstration,[4] allowing interaction between students and faculties. However, it is peculiar that for a batch of 150 students, the number of minimum faculty recommended by the MCI is seven.[6] Mathematically, with seven real faculty (not considering ghost faculties), the SGT size would be 21 students, implying the presence of every faculty for each session. Is this practically possible? Furthermore, some of the institutes have allied courses going on in parallel with the medical programme, for which the same faculty is engaged and the council has no specific rules to tackle this issue.

Sufficient time has been allocated to self-directed learning and early clinical exposure (ECE).[4] This may look like an easy task, with less burden. However, it is not true. Its pre-preparation is a great task, starting from objectives and assessing students with questions, discussions or reflective writing, to identify the attainment of outcome, followed by summarization. A major question that has to be answered is, how will ECE work? Are all the faculties open to this new scheme or are they just going with the flow?

A well-structured, 36-hours, AETCOM module,[1] focusing on the affective domain, is appealing. My concern, is whether we are adequately trained to conduct it? Gandhiji had said that he liked to undertake a task only after he had acquired confidence in carrying it out. In the same way, the faculty needs to be confident that it can carry out this onerous task. We would have to work hard to acquire this confidence and also accept and carry out this change in curriculum.

The assessment technique, for the integrated topics, is challenging. To ease this, a module has been published by the MCI on its website, which includes the format of the structured long- and short-answer questions and multiple-choice questions (MCQs).[7]

Another question bothering me is the progress of undergraduates towards the postgraduate (PG) programme. The present PG selection test, i.e. the National Eligibility Cum Entrance Test for PGs (NEET-PG), is still MCQ-oriented,[5] based on 'knows' and 'know-how' aspect of Bloom's taxonomy[8] and does not match the undergraduate assessment pattern. Thus, it compels undergraduate students and interns to join coaching institutes, spending extra money for their education. If the medical programme is a continuous process, taught within the medical institutes, then why is there a need for coaching institutes or portals? Aren't our medical institutes preparing graduates adequately, or are the requirements and prerequisites for the selection process somewhat different from what we are preparing them for? Many more questions are yet unanswered, but I am sure we will be able to find an answer for each as we move ahead.

Feedback from faculty members, administrative authorities and students (private and government) on the new curriculum, while they are going through it and even after its completion, will help the MCI evaluate the programme in a better way and make necessary corrections. The opinion of stakeholders, countrywide, will provide a clear idea of the programme implementation and may provide suggestions to make it better and effective.

I believe that, in due course, evidence would be gathered, for and against, the competency-based curriculum within India and would allow authorities to modify the same for better outcomes. The choice lies in our hands; whether we mine and cut diamonds, or simply dig out more stones.

Conflicts of interest. None declared

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