Curricular reforms have been the hot selling story of this era. To achieve these the need for the integration of basic with clinical sciences is also becoming increasingly important. Achieving the goals of integration the terms of outcome based, theme based, problem based, competency based and case based are in discussion among the medical educationists. The most popular approach claimed is the competency based approach. Knowledge, skills and attitude are incorporated together to achieve the dream of competent physician. The competency based curriculum may be spiral based which is dividing the curriculum of five years into three spirals Year one and two make first spiral, year three the second spiral and year four and five the third spiral. Competencies are usually formulated for a particular module or a particular spiral of the year. These competencies are actually more important than we often think these are. This seems a very simple task. But the actual task is matching the competencies of each module with the exit competencies of the medical graduates at the end of five years. To achieve this vertical integration we need to define proper learning strategies. What actually is happening at present is that these competencies are designed with keeping the content of each discipline and what happens in the classrooms is totally a different story from what the graduate is going to deal in the community. We claim to make a product glorified with the pearls of ethics and professionalism, problem solving, effective communication, using basic science in the practice of medicine; diagnosis, management, and prevention, basic clinical skills and critical thinking. This seems a very simple task. But the actual task is matching the competencies of each module with the exit competencies of the medical graduates at the end of five years. To achieve this vertical integration we need to define proper learning strategies. What actually is happening at present is that these competencies are designed with keeping the content of each discipline and what happens in the classrooms is totally a different story from what the graduate is going to deal in the community. We claim to make a product glorified with the pearls of ethics and professionalism, problem solving, effective communication, using basic science in the practice of medicine; diagnosis, management, and prevention, basic clinical skills and critical thinking. But what happening in the classrooms is covering the content of disciplines. The last nail in the tomb is our assessment methodology. It is based only on the content of the disciplines and competencies mentioned above are nowhere part of the assessment. We never try to unrevel the abilities of young doctors to perform in complex situations or in real life. Unfortunately we are following the concepts of syllabus by giving a road map of whole year in order to cover the content of each discipline. This situation is not only in our country but this concept is confused in many parts of the world including Australia and US. In Australia when competency based curriculum was adopted it was rejected because people thought it was conceptually flawed and difficult to implement. In UK it was criticized at the level of faculty because transformation of their role from knowledge transmitter to facilitator was distressing. In Canada frustration developed in faculty because basic sciences was totally ignored at the expense of achieving clinical outcomes. It was labelled as top down approach which aimed at changing the whole environment of medical schools. Some educationists like Donnelly advocates a 'discipline-based approach' and criticises outcome based curriculum for undermine the worth of disciplines. It seems difficult to maintain coherence between the exit competencies and the succeeding levels of competencies for each year and achievement of some competencies like professionalism seem non-existent from the boundary wall of medical schools. A medical college holds the responsibility of equipping a student what he has to do for diagnosis and management of patient outside the medical college doors. The beauty of this curriculum lies in translation of broad statements into specific achievable and measurable learning activities. The teacher must transform from information storehouse to a promotor of lifelong learning. Assessment should be a continuous process based on evaluation of skills along with knowledge and attitude. Multiple formative assessments should be designed to dig out the building process of competencies. The level then raises from recall to problem solving thus raising the level according to Millers pyramid. This type of curriculum makes one to learn by doing, developing an attitude of problem solving and at the same time developing interpersonal skills. The principles for this type for designing his type of curriculum can be:

- Clear vision and pinpoint focus on future doctor as community healer rather than memorizer of factual knowledge
- Top down approach starting from broad exit competencies to specifies classroom outcomes
- Criterion based standards to promote high level achievers as the medical graduates

Efforts should be done to implement the competency based curriculum in our country because our community needs good general physicians to satisfy the needs of our community.

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