

## Indian Academy of Pediatrics Releases Uniform Learning Objectives for Competency Based Curriculum in Undergraduate Pediatric Education

The Medical Council of India (MCI) has introduced competency based medical education curriculum [1] with effect from the admission year 2019. They have come out with a list of competencies expected in a medical student at the end of undergraduate training. These competencies cover a wide range of areas, with inclusion of knowledge, attitudes, skills and communication. Suggestions on teaching methods and assessment have also been provided [1].

At the operational level, the competencies must be translated into specific learning objectives (SLOs), which allow the teachers to use them as a framework for teaching and assessment. The task of converting competencies into objectives has been left to the teachers/departments/institutions. While this allows flexibility in teaching and assessment, it is also likely to bring a lot of variability across medical institution and universities across the country, with more than 500 medical colleges trying to carry this task independently.

Professional associations can play an important role in ensuring uniformity of teaching throughout the country. With this background, the Indian Academy of Pediatrics undertook the task of developing SLOs out of competencies listed in the MCI document. Under the leadership of the IAP President-2019, a task force comprising of two experts was created. A total of 20 teachers at various levels from across the country were enlisted. One of them was designated to collect and compile the suggestions. An orientation and training session for the task force members and contributors was organized at Delhi on 6 July, 2019. The methodology was discussed, and topics were allotted to individual members for framing the SLOs.

The members created SLOs as per standard methodology. These were shared within the group and comments were invited and discussed. Modifications, where appropriate, were made and the first draft was circulated at the National Conference of Pediatric

Education at Jodhpur in October, 2019. The draft was further revised in the light of the comments which were received. This draft was then circulated to around 100 Departmental heads of pediatric departments in various colleges in India for comments/ modifications and suggestions. The final version was released during the National Conference of IAP in January, 2020 at Indore. The document is available at the Indian Academy of Pediatrics website ([www.iapindia.org/iap-recommendations-on-competency/](http://www.iapindia.org/iap-recommendations-on-competency/)), and is in the public domain. All medical colleges in India are encouraged to use it as the base document for implementation of teaching of pediatrics in the new competency based MBBS curriculum. We believe that this unique initiative by IAP, the first of its kind by any professional society in India, will go a long way in setting the standards and serve as an example for others to follow.

The next phase of this activity will be to train teachers into using appropriate teaching learning methods and assessment, with emphasis on direct observation and feedback. Maintaining the logbook and assessment of competencies will also be included in the plan.

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### Annexure I

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#Could not attend the consultation meeting.

## Protocol Driven Extubation in Neonates- A Quality Improvement Initiative

We read with interest the study on a quality improvement (QI) initiative for extubation in newborns [1]. Failed extubation is a common problem faced by healthcare workers across all neonatal intensive care units [2,3] and a QI initiative designed to improve this is a welcome step. We have two observations regarding this reasonably well-conducted study.

Authors have stated that ethical approval was not obtained as this study was a quality improvement initiative. Multiple articles have questioned this approach of not obtaining ethics approval for QI studies [4,5]. We feel ethics committee approval should be sought for all QI studies when it directly impacts patient care.

Secondly, authors have not specified if they have calculated sample size, as primary objective was to reduce extubation failure rates by 25% from baseline.

In Table I of the article, extubation failure in PDCA-1 is mentioned as 23.8% (5/21) while in figure 2 it is mentioned as 10/21. The other two categories *ie*, baseline and PDCA-2 figures are appropriate.

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### AUTHOR'S REPLY

We thank the readers for their queries - their concern is justifiable. Quality improvement (QI) projects are being widely used to improve quality of care in patient management. In fact several government-supported QI projects are underway *eg*, LaQshya program. These projects do not need any ethical approval as they intend to implement already established evidence-based recommendations in clinical practice. We also implemented evidence-based practices and recommendations modified to our needs and available resources in this project. As long as no new intervention of questionable efficacy is introduced, QI projects do not need any ethical approval. Taking ethical approval in such cases would just hamper rapid progress in delivering quality care.

We did not calculate sample size for the study. The targets in QI projects are usually not based on sample size. There are many ways to set targets *eg*, benchmarks, percentiles, best achieved elsewhere etc. In our project, there is no benchmark or we can say that there should be theoretically zero extubation failures. Setting zero extubation failures as target would be unrealistic. So, a realistic target is set depending on our current performance and feasibility.

We did not find any discrepancy in Fig. 2 and table I of the article.

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