The history of undergraduate medical education in Sri Lanka dates back to 1870, when the Colombo Medical School was founded. In 1942, the University of Ceylon was established, and the medical school acquired university status as the Faculty of Medicine. Subsequently, in 1978, the university act was changed and the campuses of the University of Ceylon became regional universities. Thus, the Faculty of Medicine became part of the University of Colombo. Over time, more faculties of medicine were established; at present, there are six medical faculties in Sri Lanka, i.e. the medical faculties of the Universities of Colombo, Peradeniya, Jaffna, Galle, Delaney, and Sri Jayewardenepura. The curricula of all the medical faculties were based on the British system of medical education. This year, a new faculty of medicine was established in the eastern province of Sri Lanka, with an integrated curriculum based on the needs of the community.

In the mid-1980s, the Colombo Medical Faculty felt the need to change its traditional curriculum. Some of the main reasons for this need to change were the awareness of newer trends in medical education, pressure created by the general public for better healthcare, emerging new public health problems, and awareness of the need to emphasise ethics in medical practice. However, the medical curriculum did not undergo a major revision until 1995, although many small-scale changes were made in keeping with international trends in medical education.

In 1995, the traditional discipline-based curriculum was changed to a more integrated and student-centered curriculum. The contents for the core curriculum were classified into four main areas; namely basic sciences knowledge, clinical competencies, generic competencies, and professional values which include ethical issues and commitment to continuing medical education. The main features of the new curriculum are the integration of subject content, the introduction of a system-based module system, early exposure of students to clinical and community learning environments, and the introduction of a behavioral sciences stream.

The teaching/learning methods have shifted from traditional lecture-based didactic teaching activities towards methods involving greater student participation. These include small group discussions (SGD), problem-based learning tutorials (PBL), student seminars, staff seminars, dramas, debates, poster sessions, and field-based teaching. Students are assessed by stream examinations and module examinations, with continuous assessment components and end-of-stream assessments. In addition to these summative assessments, there are formative assessments as well. A number of assessment tools are used befitting the knowledge attitude and skills being tested at the...
stream examinations. These include written tests such as structured essay questions (SEQ) and multiple choice questions (MCQ), as well as practical and clinical exams such as objective structured practical and clinical exams (OSPE and OSCE).

The change from the traditional to the new curricular format was based on the needs of the community, and the decision for the early introduction to clinical and community learning environments was directly due to the changing health needs and the disease pattern of the Sri Lankan community. The single most important innovative feature of the new curriculum is the emphasis on behavioral sciences. This was brought about as a direct result of community perception of poor doctor-patient communication skills of the medical graduates. The new stream, which is one of the five main streams of the curriculum, focuses on areas such as communication skills, professionalism, and ethics.

In late 2004, the long-established traditional curriculum of the medical faculty in the University of Peradeniya was changed into a more integrated curriculum, with the objectives of reducing information overload, improving generic skills, and imparting skills necessary to deliver better primary healthcare. Communication skills and research skills are cultivated, while community-based training and electives give students a broader vision. The new curriculum is based on integrated modules arranged in a sequential order, and the content matter is continually revised and strengthened.

The Faculty of Medicine, Kelaniya, was established in the mid-1980s. Following the Colombo example, the curriculum of the Faculty of Medicine, Kelaniya, was changed from a traditional discipline-based one to an integrated organ system-based one in early 2004. Students learn about the normal structure and function of the human body through self-contained, organ system-based modules during Phase 1. In the next phase, in addition to the acquisition of clinical skills, they revisit the same organ systems around which Phase 1 is organized, as in a spiral curriculum. Learning behavioral sciences, mental health and ethics, and community health takes place parallel to these. Problem-based learning sessions have been added to the traditional lectures and tutorials, while students are assessed via continuous assessments and traditional bar examinations.

The University of Ruhuna still adheres to a traditional curriculum, but is in the process of changing to a system-based integrated curriculum to produce socially responsible and competent medical graduates. This would include having learning inputs from nonmedical disciplines such as sociology and anthropology in a foundation module; introducing a behavioral science stream; developing a multidisciplinary module in rural health (including a clinical attachment); and improving the learning skills, language skills, group skills, IT skills, and time management skills of the students.

The Faculty of Medical Sciences, University of Sri Jayewardenepura, commenced in 1993. Presently, it follows a predominantly conventional subject-centered curriculum, with minimal horizontal and vertical integration between the preclinical, paraclinical, and clinical disciplines. However, it has decided to embark on a predominantly organ system-based curriculum with both horizontal and vertical integration, and has introduced Community Health and Behavioral Sciences as two concurrent streams. Students will learn the fundamental concepts and principles of each subject in introductory modules, in addition to developing language skills, computer skills, and social consciousness. Laboratory and clinical skills learning, problem-based learning, and electives are some of the proposed teaching/learning methods.

The main feature of the proposed Eastern University curriculum plan is integration
achieved through an organ-system approach and problem-based learning. The students will learn medical knowledge, effective communication, and professional ethics and behavior via complementary comodules and generic courses. The evaluation will be through continuous modular and terminal assessments, where emphasis is placed on feedback and counseling.

Most of the abovementioned curricula have greater emphasis on effective communication as well as professional ethics and behaviour.

All of the above curricular changes have taken place in a very conservative background with medical schools of long-established traditions. The main reason behind the successful implementation of curricular changes in Sri Lanka was the fact that they were based on the needs of the community. This highlights the fact that if curricular changes and innovations in medical education are to be successful, they should be based on the needs of the community.

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