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REVIEW ARTICLE

Comparative Review of the CCIM and NCISM Postgraduate Panchakarma Curricula and Their Implications for Ayurvedic Education

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Abstract

Background: The National Commission for Indian System of Medicine (NCISM) introduced a competency-based postgraduate Panchakarma curriculum, replacing the earlier Central Council of Indian Medicine (CCIM) syllabus from the 2024-25 admission batch. **Objective:** To compare the NCISM and CCIM MD Panchakarma curricula, highlighting structural changes, educational merits and implications for stakeholders. **Methods:** A structured qualitative document analysis compared the official NCISM Semester II (AYPG-AB-PK) and Semesters III-VI (AYPG-PK) curricula with the archived CCIM postgraduate syllabus. Programme structure, learning outcomes, credits, training hours, assessments and examination patterns were evaluated. Curriculum provisions were cross-checked against the 2024 NCISM postgraduate regulations, and examination-blueprint counts were independently recalculated. **Results:** Compared with the earlier topic-based syllabus, the NCISM curriculum specifies competency-oriented outcomes, modular assessment and structured clinical training. It comprises 80 credits and 2,400 notional learning hours. The 1,920-hour AYPG-PK component includes 320 teaching, 640 practical, 832 experiential and 128 assessment hours. Formative assessment totals 2,000 marks, while Panchakarma-related university examinations account for 1,100 marks. The examination blueprint contains 118 units across four papers. Additional emphasis includes medication review, patient safety, emergency management and contemporary clinical approaches. **Conclusion:** The NCISM curriculum provides a more structured framework for postgraduate Panchakarma education, emphasising practical and experiential learning. However, anticipated improvements in clinical competence and patient safety remain unproven. Educational outcomes depend on faculty preparedness, clinical exposure, infrastructure and consistent assessment practices, warranting empirical evaluation.

Keywords: Ayurveda education, CCIM, curriculum evaluation, NCISM, Panchakarma, postgraduate medical education

Introduction

Panchakarma comprises the five principal *Shodhana* procedures (*Vamana*, *Virechana*, *Basti*, *Nasya* & *Raktamokshana*) together with preparatory (*Purvakarma*) and post-procedural (*Paschat Karma*) care. It is applied in preventive, promotive and curative care, and public interest in it has grown in lifestyle disorders, chronic disease and wellness practice. Postgraduate training in this subject therefore carries unusual responsibility: scholars must master classical procedures safely, judge patient suitability, manage complications and increasingly participate in research and institutional management. For several decades, the MD Panchakarma curriculum followed the CCIM postgraduate

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syllabus. It organised the subject into a first-year (preliminary) Panchakarma paper and four final-year papers, defined mainly by lists of topics, with reference books and a practical requirement. In recent years, the NCISM introduced a new MD/MS Ayurveda curriculum built on learning outcomes, credits, notional learning hours, defined teaching-learning methods and continuous modular assessment, in line with the National Education Policy and global trends in competency-based medical education. [1,2]

As this change affects every Panchakarma scholar and teacher, a clear comparison of the two schemes and a reasoned assessment of the new design are useful. This review presents that comparison and discusses the merits of the new syllabus and how it benefits different stakeholders.[3]

Aim and Objectives

Aim: To review the NCISM MD Panchakarma curriculum in comparison with the earlier CCIM scheme.

Objectives:

1. To compare the structure, content and teaching-learning design of the two schemes.
2. To compare practical training and assessment, including examination patterns.
3. To identify the merits of the new curriculum and its benefits for stakeholders.
4. To critically appraise the new curriculum, noting implementation challenges and gaps, and to make recommendations.

Materials and Methods

This review used qualitative document analysis of official curriculum and regulatory documents. The document set was selected purposively because it represents the superseded CCIM postgraduate Panchakarma framework and the NCISM framework applicable to the 2024–25 batch. The following primary documents were examined:

- **New scheme:** NCISM Curriculum for MD/MS Ayurveda, Semester II, *Applied Basics of Panchakarma* (*Procedural and Management*), code AYPG-AB-PK, 90 pages, applicable from the 2024-25 batch.
- **New scheme:** NCISM Curriculum for MD/MS Ayurveda, Semesters III to VI, *Panchakarma* (*Procedural Management*), code AYPG-PK, 442 pages, applicable to the 2024-25 batch from the academic year 2025-26.
- **Historical comparator:** the CCIM postgraduate Ayurveda syllabus for Panchakarma, including the preliminary Panchakarma paper and final-year Papers I-IV, retrieved from the archived postgraduate syllabus section of the NCISM website. The archive does not provide a stable publication date or complete bibliographic metadata for the historical syllabus; this limitation is stated rather than assigning an unverified year.

The documents were compared using a structured extraction matrix covering course structure, subject content, learning outcomes, credit and hour framework, teaching-learning methods, practical and experiential training, formative assessment, summative assessment and examination pattern. For the examination blueprint, each unit in Table 6F was counted once and coded independently for ABQ, SAQ and LAQ eligibility; totals were then checked against the paper-wise module structure and the paper-setting rules in Table 6G. Hours and marks were recalculated from the curriculum tables. Regulatory interpretations were checked against the final NCISM Minimum Essential Standards and Minimum Standards for Postgraduate Education in Ayurveda Regulations, 2024, rather than relying on the earlier draft regulation. The official NCISM documents were accessed on 12 November 2026. The archived CCIM webpage was accessed on the same date. No primary data from students or teachers were collected; conclusions about educational outcomes are therefore analytical expectations rather than measured effects.[1-5]

Observations

The old (CCIM) scheme

First year (Preliminary)

One Panchakarma paper (Paper II, 100 marks, two parts of 50 marks). Part A covered the principles of *Chikitsa, Kriyakala, Shadvidha* and *Dvividha Upakrama,* and applied anatomy, physiology and clinical examination of the nervous, locomotor, cardiovascular, respiratory, integumentary and gastro-intestinal systems. Part B covered the definition of *Karma, Trividha Karma,* importance of Panchakarma, *Koshtha* and *Agni, Purvakarma* and *Paschat Karma, Samsarjana Krama, Aushadha* and *Ahara Kalpana*, areas of research, instruments and their possible modifications, NABH quality standards and eco-friendly Panchakarma theatre management including biomedical waste.

First-year practical (100 marks)

Duty in the Panchakarma ward and theatre; performance of five cases each of *Snehana, Svedana, Vamana, Virechana, Basti* and *Nasya* with detailed records; and detailed records of 25 patients treated with Panchakarma. Marks were distributed as case records (20), long *Karma* (20), short *Karma* (10), Panchakarma procedures (15), instruments and spotting (15) and viva voce (20).

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Final year:

Four papers.

- Paper I: *Purvakarma* (*Snehana* and *Svedana*).
- Paper II: *Vamana* and *Virechana*.
- Paper III: *Basti Karma* (*Niruha*, *Anuvasana*, *Uttara Basti*) and *Nasya Karma*.
- Paper IV: *Raktamokshana* (33 marks), clinical physical medicine (33 marks) and disease-wise Panchakarma (34 marks).

The archived CCIM syllabus is presented mainly as a topic-based framework. In the versions available for this review, it does not specify a credit-based structure, notional learning hours, session-level learning objectives or a mapped competency framework comparable with the NCISM documents. This comparison is restricted to the content and assessment information visible in the archived syllabus.

The new (NCISM) scheme

Framework

The programme in Panchakarma comprises Semester II (AYPG-AB-PK) and Semesters III to VI (AYPG-PK). Together they carry 80 credits and 2,400 notional learning hours.[1,2]

Component	Semester II (AYPG-AB-PK)	Semesters III-VI (AYPG-PK)
Modules	6	32
Credits	16	64 (16 per semester)
Notional learning hours	480	1,920
Formative assessment marks	400	1,600
University examination	100 theory + 200 practical = 300	400 theory + 400 practical = 800
Examination held	End of Semester II	End of Semester VI

Table 1: Credit and assessment framework of the NCISM Panchakarma curriculum

Each credit in AYPG-PK represents 30 learner-engagement hours: 5 hours of teaching, 10 hours of practical training, 13 hours of experiential learning and 2 hours of modular assessment (25 marks per credit). Across Semesters III-VI, this equals 320 teaching hours, 640 practical-training hours, 832 experiential-learning hours and 128 modular-assessment hours. Thus, practical and experiential learning together account for 1,472 of 1,920 hours (76.7%); teaching accounts for 16.7% and modular assessment for 6.7%. The percentages total 100% after rounding (16.7 + 33.3 + 43.3 + 6.7).[2]

Course outcomes. The AYPG-PK curriculum defines eight course outcomes mapped to programme outcomes. In summary, the scholar should be able to: apply the principles of Panchakarma and *Upakarma*; customise standard operating procedures; perform procedures and prepare formulations; design protocol-based interventions; identify and manage emergencies; communicate and lead ethically; integrate recent advances and evidence; and blend traditional knowledge with technology for global outreach.

Module	Credits	Hours	Marks
M1 Panchakarma *Siddhanta*, equipment and instruments, Panchakarma for health and wellbeing	3	90	75
M2 Surface and applied anatomy and physiology, integrated with Panchakarma *Siddhanta*	3	90	75
M3 Clinical examination	3	90	75
M4 Identification and modification of concomitant medications during Panchakarma	2	60	50
M5 Panchakarma *Aushadha Kalpana* and *Ahara Kalpana*	2	60	50
M6 Administration and regulatory framework related to Panchakarma	3	90	75
Total	**16**	**480**	**400**

Table 2: Semester II modules (Applied Basics of Panchakarma)

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Paper	Theme	Modules (semester)
1. *Upakalpaniya Siddhi*	Preparatory and supportive therapies	M1-M2 *Snehana*, *Abhyantara Sneha* (III); M3-M4 *Sneha* application, *Bahya Snehana* (IV); M5-M6 *Sagni* and *Niragni Sweda*, *Swedana* modalities (V); M7-M8 *Marma Chikitsa*, physiotherapy with Panchakarma (VI)
2. *Shodhana Siddhi*	Core *Shodhana* procedures	M9-M10 *Vamana* (III); M11-M12 *Virechana* (IV); M13-M14 *Nasya* (V); M15-M16 *Raktamokshana* (VI)
3. *Basti Siddhi*	*Basti* in depth	M17-M18 applied anatomy, classification, screening, dose schedule (III); M19-M20 pharmacokinetics and pharmacodynamics, methodology of *Niruha, Anuvasana* and *Uttara Basti* (IV); M21-M22 contents, formulations (V); M23-M24 emergencies, recent advances (VI)
4. *Naimittika Panchakarma Siddhi*	Disease-wise application	M25-M26 respiratory, mental, gastro-intestinal disorders (III); M27-M28 *Raktadushti, Sthaulya, Karshya, Prameha, Hridroga* (IV); M29-M30 *Vatavyadhi, Mutrakrichra, Mutraghata* (V); M31-M32 *Shotha, Amavata*, supportive management (VI)

Table 3: Semesters III to VI: four papers of 16 credits each

Teaching-learning design. Each module is broken into units and sessions with a session learning objective, competency domain, level of competency (for example, the "does" level for experiential skills), notional hours and a named teaching method (such as case-based and inquiry-based learning). Separate tables list practical training activities and experiential learning activities, so that what a scholar does in clinical time is itself specified.

Comparison of the schemes

Aspect	Old (CCIM) scheme	New (NCISM) scheme
Design	Topic-based syllabus	Competency-based, outcome-mapped, module-based
Panchakarma papers	1 in first year + 4 in final year	Sem II foundation course + 4 papers over Sem III-VI
Time frame	Not defined in the syllabus text	80 credits, 2,400 notional hours, split into teaching, practical, experiential, assessment
First-year foundation	One theory paper mixing anatomy, examination, *Kalpana*, research, NABH	Six dedicated modules in Sem II incl. clinical examination, drug interactions, regulatory framework
Snehana and *Svedana*	Final-year Paper I	Paper 1, with *Marma Chikitsa* and physiotherapy added
Vamana, Virechana	Paper II	Paper 2 (*Shodhana Siddhi*), now with *Nasya* and *Raktamokshana*
Basti	Paper III with *Nasya*	Paper 3 (*Basti Siddhi*) with pharmacology, emergencies, recent advances
Raktamokshana	Paper IV (33 marks)	Paper 2, modules M15-M16
Physical medicine	Paper IV (33 marks)	Paper 1, M8 (physiotherapy with Panchakarma)
Disease-wise Panchakarma	Paper IV (34 marks), long list of diseases and modern conditions	Paper 4, eight modules grouped by body system
Recent advances, mode of action	Listed under some topics	Built into each procedure's modules
Emergencies	Not a distinct component	M23, *Basti Siddhi* paper
Wellness, quality, regulation	NABH and theatre management only	Regulatory framework, wellness spa governance, medical tourism and AYUSH visa (stated in the course preface and Sem II)

Table 4: Comparison of the old (CCIM) and new (NCISM) schemes

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Practical training and assessment

Aspect	Old scheme	New scheme
Formative assessment	Not described in the syllabus text	Module-wise, with Modular Grade Points (MGP) and Semester Grade Point Average (SGPA); at least 60% SGPA needed to sit the summative examination
Summative theory	100 marks per paper (first-year paper in two parts of 50)	Sem VI: four papers of 100 marks each, 3 hours
Theory paper pattern	Not given in the syllabus pages reviewed	1 application-based question (20) + 8 short answers (5 each = 40) + 4 analytical long answers (10 each = 40)
Practical (first year)	100 marks: case records 20, long *Karma* 20, short *Karma* 10, procedures 15, instruments and spotting 15, viva voce 20	Sem II: 200 marks
Practical (final)	Final-year practical scheme not covered in the pages reviewed	Sem VI: 400 marks, see below
Dissertation	Not covered in the pages reviewed	Dissertation viva voce included (40 marks)

Table 5: Assessment in the old and new schemes

New Sem VI practical heads (400 marks)

Long case or major procedure (100); short case or minor procedure (50); spotters (50); viva with four examiners (80); dissertation viva (40); assessment of teaching ability (20); presentation skills (20); logbook (20); practical or clinical record (20). The structure shows that skills, communication, teaching ability and research are all examined, not only knowledge and procedure. The following critical appraisal examines how effectively this intent is reflected in the examination blueprint.

Discussion

Merits of the new curriculum

Clarity of purpose through learning outcomes.

Each course outcome is mapped to programme outcomes, and each session has its own objective. A scholar knows what must be achieved, and a teacher knows what to teach and test. In the older text, a long list of topics left depth, sequence and expected performance to the individual institution.

Logical sequencing and a proper foundation.

Semester II front-loads clinical examination, applied anatomy and physiology, instruments, *Kalpana*, concomitant medication and regulation before the scholar enters procedure-intensive semesters. In the earlier scheme the same foundation had to be absorbed in a single first-year paper. The staged order of *Snehana* and *Svedana*, then *Vamana, Virechana, Basti, Nasya* and *Raktamokshana*, follows the order of clinical use.

Procedure-wise depth with standard operating procedures.

Each major procedure has paired modules: one on principles, drugs, indications and applied anatomy, and one on the standard operating procedure, assessment, mode of action and recent advances. This encourages uniform, safe practice across colleges and links classical description to modern evidence.

Skill-centred time allocation.

Practical training and experiential learning together account for 1,472 of 1,920 notional hours (76.7%) in AYPG-PK. This is a substantial allocation of time to clinical and applied learning. The curriculum specifies practical and experiential activities within modules; however, the proportion of time allocated does not itself establish the quality of supervision, the number or diversity of patients encountered, or the level of competence ultimately achieved.

Continuous and structured assessment.

Module-wise formative assessment, Modular Grade Points (MGP) and Semester Grade Point Average (SGPA) provide a mechanism for feedback and progression monitoring. Under the 2024 PG Regulations, a minimum SGPA of 60% is required for eligibility for the relevant summative assessment, while the regulations separately prescribe an 80% attendance requirement across academic activities. The MGP formula incorporates both attendance and modular-assessment performance. These arrangements create a structured assessment pathway, although the reliability of feedback and grading depends on clear criteria and consistent implementation.[2,5]

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Patient safety and clinical judgement.
The curriculum explicitly includes concomitant medication review, patient screening, dose schedules, procedure-related complications and emergency management. These curricular elements are intended to strengthen risk recognition and clinical decision-making. They should not, in the absence of cohort-level outcome data, be described as demonstrated improvements in patient safety or clinical performance.

Integration of recent advances and evidence.
Recent advances and mode of action feature in the *Vamana, Nasya, Basti* and *Raktamokshana* modules, and research is a stated outcome. Experiential tasks such as searching *Samhita* and journal sources, interpreting indications and choosing a formula from published work train scholars to read evidence critically.

Broadened scope of *Marma*, physiotherapy and supportive care.
Marma Chikitsa, physiotherapy with Panchakarma and supportive management of disease are now formal modules, aligning Panchakarma with rehabilitation and chronic-disease practice. The detailed physical-medicine heading of the old Paper IV is reorganised in a more integrated way.

Systematic disease-wise application.
The *Naimittika* Panchakarma paper groups diseases by body system across eight modules, giving a coherent route from a clinical condition to the choice and sequence of procedures, instead of a single long list.

Professional, ethical and managerial competencies.
Communication, leadership, ethics, teaching ability and presentation skills are course outcomes and are examined. Modules and the course preface on regulation, quality assurance, wellness centre governance and medical tourism prepare scholars for roles beyond bedside practice.

Alignment with national quality frameworks. A credit system, defined notional hours and grade points make the programme comparable with other disciplines, support academic mobility and are consistent with the direction of national education policy.

How the new syllabus benefits different stakeholders

Stakeholder	Expected benefits
PG scholars	Defined outcomes; early foundation; more hands-on time; frequent feedback; recognised credit for participation; skills in teaching, research and management
Teachers and guides	Ready session-level objectives, methods and activities; common reference for planning; shared language for assessment; room for innovation in teaching
Institutions and hospitals	Uniform standards for audit and accreditation; clearer needs for infrastructure, equipment and patient flow; better preparation of future faculty
Patients	Potential for improved procedural safety and consistency through standard operating procedures, patient screening, medication review and emergency preparedness, subject to empirical evaluation.
Researchers	Habit of evidence searching, protocol design and dissertation viva; recent-advance modules identify gaps and research questions
Regulators and councils	Measurable outcomes and records (logbook, MGP, SGPA) that support monitoring and comparison between colleges
UG programme (BAMS)	Potential for improved preparation of future PG teachers; clearer progression from BAMS Panchakarma to PG competencies
Wellness industry and medical tourism	Graduates familiar with regulation, quality standards and communication with international patients
Society and the wider health system	Credible, evidence-linked Panchakarma services; better integration with preventive, rehabilitative and chronic care

Table 6: Expected benefits of the NCISM curriculum for different stakeholders

Critical appraisal of the new curriculum

The merits above describe the intended educational contribution of the design. This section examines the curriculum and its examination blueprint (Tables 6C-6H of AYPG-PK), with regulatory interpretation checked against the final 2024 PG Regulations. Unit counts were re-tabulated from Table 6F: each listed unit was counted once, and ABQ, SAQ and LAQ eligibility were recorded separately. The count is a measure of the number of listed units, not of their relative breadth or instructional depth.[2,5]

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Equal weight, unequal coverage

Every paper carries 16 credits, 80 lecture hours and 100 theory marks, whatever the breadth of its subject matter. The blueprint lists a very different number of units under each paper (Table 7).

Paper	Credits	Lecture hours (5 per credit)	Theory marks	Modules	Units in blueprint	Units open to the 20-mark application question	Units open to long answer questions
1. *Upakalpaniya Siddhi*	16	80	100	8	34	32	34
2. *Shodhana Siddhi*	16	80	100	8	43	39	43
3. *Basti Siddhi*	16	80	100	8	14	12	8
4. *Naimittika* Panchakarma *Siddhi*	16	80	100	8	27	4	25

Table 7: Paper-wise weight and coverage in AYPG-PK (units counted from Table 6F)

The unit count should therefore be interpreted cautiously. Units differ substantially in scope: a single unit may encompass multiple procedures or a broad clinical process, whereas another may address a narrower topic. Counts identify the distribution of listed examinable units but cannot measure content volume, complexity or teaching depth. The comparison supports a question about blueprint balance; it does not establish that a paper with more units receives proportionately greater instructional coverage.

The blueprint may undermine the application focus

The re-tabulation confirms 27 listed units in Paper 4 (*Naimittika* Panchakarma *Siddhi*), of which four units in module M29 are marked eligible for the 20-mark ABQ. Thus, ABQ eligibility is concentrated in one of the paper's eight modules. The paper-setting instruction further states that no other question should be drawn from the module selected for the ABQ. Consequently, when M29 is selected for the ABQ, the remaining M29 units are excluded from SAQ and LAQ selection for that paper. This restriction may reduce the breadth of disease-wise content represented in an individual examination and may encourage strategic rather than comprehensive preparation. The concern is about the blueprint's permitted distribution, not evidence that every university paper has in fact been set in this way.[2]

The blueprint also marks all three units of M24 (Recent Advances in *Basti*) and the unit of M23 (Handling Emergencies in Panchakarma) as not eligible for LAQs, although they remain eligible for ABQs and SAQs. This limits the formats through which these topics can be assessed. Whether this is educationally appropriate is a matter for review by NCISM and universities, particularly for safety-critical content.

Time allocation and mark allocation do not match

Across Semesters III–VI, teaching accounts for 320 of 1,920 hours (16.7%), practical training for 640 (33.3%), experiential learning for 832 (43.3%) and modular assessment for 128 (6.7%). Theory carries 400 of the 800 summative marks (50%) in the Semester VI AYPG-PK examination. The difference between time allocation and examination marks is not, by itself, evidence of a defect: theory examinations may assess the knowledge underpinning clinical practice. It does, however, raise a legitimate question about whether the summative assessment sufficiently samples the practical and experiential competencies emphasised by the curriculum.[2]

Lecture time is also very small for the amount of content. A three-credit module such as M18 (classification of *Basti*, screening and dose schedule) has 15 lecture hours in the credit framework. The design relies on flipped, self-directed and experiential methods to cover the rest. That depends on scholars having time, mentors and resources outside the lecture hall, which will not be equal in all institutions.

Formative assessment, SGPA eligibility and passing rules

The Panchakarma curriculum assigns 400 formative-assessment marks in Semester II and 1,600 across Semesters III-VI, giving 2,000 formative marks in total. The Panchakarma-specific university examinations carry 300 marks in Semester II and 800 marks in Semester VI (1,100 marks in total). These figures describe separate assessment components and should not be interpreted as a combined final-mark total. The AYPG-PK curriculum uses modular assessment to calculate MGP and SGPA. The final NCISM PG Regulations, 2024 specify a

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minimum 60% SGPA for eligibility for the first, second and third summative assessments, with the third assessment based on the average SGPA of Semesters III-VI. Students who do not meet the required SGPA become eligible only after completing the prescribed teaching and training again, with programme duration extended proportionally. The regulations also prescribe passing criteria: at least 50% separately in theory and practical/clinical components in the first and second summative examinations; for the third summative examination, at least 50% aggregate across papers, at least 40% in each theory paper and at least 50% in practical/clinical including viva voce. A student failing a component must reappear in all components of the examination. The regulations do not state that the formative marks are simply added to the university summative marks; their stated role in this framework is modular grading and SGPA-based eligibility.[2,5]

The MGP formula is the product of the proportion of notional learning hours attended and the proportion of marks obtained in the module, multiplied by 100. For example, 80% attendance combined with 75% of the available modular-assessment marks yields an MGP of 60. The regulations separately require attendance of at least 80% of total academic activities for university-examination eligibility; the SGPA threshold is an additional requirement, not a substitute for attendance. Since SGPA is calculated as the average of the module grade points in the semester, the example illustrates the effect of the formula when the same attendance and performance proportions apply across modules; it does not mean that every module must independently achieve 60%. The multiplicative formula gives attendance a direct influence on MGP, which may be educationally defensible as an engagement measure but also makes transparent rubrics and monitoring of actual participation important.[4]

Single high-stakes examination at the end of two years

The Semester VI AYPG-PK examination is the third summative assessment and covers the specialty-specific curriculum taught across Semesters III-VI. It comprises four theory papers (400 marks) and practical/clinical assessment including viva voce (400 marks). This cumulative assessment places a substantial recall and integration demand on scholars. The regulations provide for summative assessments in the first, second and sixth semesters; the extent to which modular formative assessment reduces the cumulative burden depends on how effectively departments use feedback and how universities structure their examination preparation.[2,5]

Practical requirements for ambitious activities, modest floors

The practical and experiential activities are educationally ambitious and include patient assessment, procedural demonstrations, supervised practice, case documentation and evidence searching. The curriculum differentiates levels of performance through competency domains and labels such as “knows”, “knows how”, “shows how” and “does”. These labels describe intended levels of competency; they should not be treated as interchangeable evidence that a scholar has independently performed a procedure safely.[2]

The minimum recorded practical/clinical work and logbook requirements should be interpreted in the context of the full module activity tables, rather than as a direct measure of independent competence. Some modules focus on regulation, recent advances or emergency response and do not map neatly to a procedure count. The earlier CCIM requirement for five cases each of selected procedures and 25 detailed patient records is not directly comparable with the NCISM module-based activity design because the categories, supervision expectations and documentation rules differ.

The practical examination includes assessment of teaching ability, presentation skills, viva voce, logbook and practical/clinical records. The curriculum specifies assessment heads and marks but does not provide detailed common analytic rubrics for every head. In addition, the training activities distinguish observation of faculty demonstration, assisting or performing under supervision, and learner performance at the “does” level. Observation demonstrates exposure; supervised performance demonstrates a skill with guidance; independent competence requires repeated, directly observed performance against defined criteria, including appropriate judgement and safe management of deviations. The curriculum’s competency labels indicate intended outcomes, but actual independent competence must be established through documented assessment rather than inferred from attendance or participation alone.[2]

Institutional implementation may vary despite a common national curriculum. Differences in faculty familiarity with competency-based education, the availability of trained supervisors, patient numbers and case mix, procedure-room capacity, equipment, inpatient occupancy and access to investigations can affect opportunities for observation and supervised practice. The 2024 PG Regulations prescribe minimum faculty and hospital standards, but formal compliance does not guarantee equivalent day-to-day clinical exposure or equivalent teaching quality across

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institutions. Faculty development, transparent logbooks, inter-institutional calibration and monitoring of actual case exposure are therefore necessary.[5]

Evaluating competency-based medical education requires systematic assessment of curriculum implementation, educational outcomes and the effectiveness of assessment practices, rather than relying solely on prescribed competencies and training hours.[6]

Coverage of what is gained and what is thinly stated

The NCISM curriculum explicitly includes concomitant medication review, interpretation of investigations, adverse-drug-reaction reporting, medicolegal aspects, emergency management and recent advances. The Semester III-VI curriculum also contains activities involving informed explanation and written consent in practical training. Therefore, informed consent is not wholly absent from the curriculum text, although its placement within activity instructions rather than as a clearly mapped standalone competency may warrant more explicit curricular emphasis.

Some topics present in the historical CCIM syllabus, such as aromatherapy and occupational therapy, were not identified as clearly named standalone topics in the two NCISM Panchakarma curriculum files reviewed. This finding should be read as an absence of an explicit standalone heading in the reviewed documents, not proof that the concepts are entirely absent from all teaching activities. Institutional delivery of wellness, quality assurance and global-outreach content may also vary according to faculty expertise, local partnerships and available facilities.

Evidence and editorial quality

The reference lists in the NCISM curriculum contain repeated entries and editorial inconsistencies. In addition, the curriculum's stated preference that the Master Scheme of Examination be treated as authoritative in case of discrepancy makes careful cross-checking important. This review therefore treats the official curriculum and final Gazette regulations as distinct sources: curriculum documents support descriptions of course content and assessment design, while the 2024 Regulations govern attendance, SGPA eligibility and passing requirements.

A general caution on competency-based models

A competency-based curriculum can create substantial documentation demands and may encourage checklist-driven teaching if assessment records become an end in themselves. The NCISM design therefore requires faculty development, calibration of assessors and a balance between documentation and authentic clinical learning. The extent of this risk has not been measured in the present document analysis.

Summary of the critical appraisal

Aspect	Points
Strengths	Outcome-mapped design; staged Semester II foundation; paired principle and SOP modules for each procedure; high share of practical and experiential time; inclusion of safety, drug interaction, emergency and research content; assessment of teaching and presentation skills
Weaknesses	Equal paper weight with unequal coverage; ABQ confined to one module in Paper 4; Need for clearer guidance on formative assessment implementation, SGPA calculations and standardised assessment rubrics; attendance-heavy MGP formula; modest practical floor of 40 records; no rubrics for viva, teaching and presentation heads; duplicated references and editorial slips
Opportunities	Standardised training across colleges; comparable data for research on education; a base for national benchmarking; stronger link between classical knowledge and modern evidence; better preparation for wellness and international roles
Threats	Unequal infrastructure and patient load; faculty not trained in competency-based methods; assessment fatigue and inconsistent marking; predictable theory papers; scholars concentrating on the final examination despite the continuous model

Table 8: Summary of strengths, weaknesses, opportunities and threats

Overall judgement

On balance, the NCISM curriculum is more explicit in its structure, outcomes, teaching-learning activities and assessment architecture than the earlier topic-list scheme. Its design provides a stronger framework for planned clinical exposure and for teaching safety-related competencies. However, this review cannot establish

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that graduates will be more competent or that patient outcomes will improve. The most defensible conclusion is that the curriculum creates opportunities for more systematic training, provided institutions have adequately prepared faculty, sufficient patient exposure, appropriate facilities and reliable assessment processes. The examination blueprint and assessment rules should be reviewed periodically using feedback and outcome data.

Limitations of this review

This review is based on documentary sources and is limited by the availability and metadata of the archived CCIM syllabus. The CCIM archive does not provide a stable publication date or complete bibliographic record for the historical Panchakarma syllabus. Unit counts were re-tabulated from Table 6F of AYPG-PK and represent listed units rather than weighted measures of content volume. No primary data were collected from scholars, faculty, institutions or patients. The study therefore cannot assess actual faculty preparedness, institutional variation, clinical competence, patient safety outcomes or the impact of the curriculum on graduate performance. The 2024 NCISM PG Regulations were used to verify attendance, SGPA and summative passing rules.[1-5]

Recommendations

1. Clarify in future NCISM guidance whether formative-assessment marks are used only for MGP/SGPA eligibility or also contribute to any university-declared final aggregate, and provide worked examples for SGPA calculation and progression.
2. Review the Paper 4 blueprint so that ABQ eligibility is distributed across more than one module, and consider permitting analytical questions on emergency management and recent advances.
3. Retain transparent attendance requirements while reviewing whether the multiplicative MGP formula adequately distinguishes attendance from demonstrated competence; publish worked examples and clarify how SGPA averages are interpreted.
4. Publish common assessment rubrics for modular assessment, long and short cases, viva voce, dissertation viva, teaching ability and presentation skills, and train examiners in their use.
5. Clarify how practical and experiential activities, including modules without a conventional procedure, should be documented and assessed; distinguish observation, supervised performance and independently demonstrated competence.
6. Provide structured faculty development in competency-based teaching, clinical supervision, formative feedback, assessment design and inter-rater calibration.
7. Ensure that each institution has adequate Panchakarma theatre facilities, instruments, trained support staff and a sufficient and diverse patient flow; consider inter-institutional clinical postings where case exposure is limited.
8. Map wellness, quality assurance, global-outreach, informed-consent and patient-communication competencies to specific teaching sessions and assessment activities across the programme.
9. Issue a corrigendum or updated curriculum edition to correct typographical inconsistencies and duplicated references, and strengthen the bibliography with current peer-reviewed and benchmark sources.
10. Collect longitudinal data from the first NCISM cohorts on competency attainment, examination performance, patient-safety events, clinical exposure and research output before making claims about educational impact.
11. Publish a short comparison guide for scholars and teachers moving between the old and new schemes.

Conclusion

The NCISM curriculum reorganises MD Panchakarma education into a structured programme with defined outcomes, credits, modular learning activities and summative assessment. It explicitly allocates substantial time to practical and experiential learning and includes safety-related content such as patient screening, medication review and emergency management. These provisions represent an intended educational framework, not demonstrated improvements in clinical competence or patient safety. The extent to which the framework achieves its aims will depend on faculty preparation, institutional resources, patient availability, quality of supervision and consistent assessment. Empirical evaluation of the first cohorts is required to establish its educational and clinical effects.

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Conflict of Interest

The authors declare that they have no conflicts of interest.

Author Contributions

A.K.Y.: Conceptualization, methodology, document analysis, interpretation, original draft preparation. G.M.: Supervision, critical review and editing.

Ethics approval

Ethics approval was not required because this study analysed publicly available curriculum and regulatory documents and did not involve human participants or identifiable personal data.

Data availability

No primary dataset was generated. All documents analysed are publicly available from the issuing bodies or identified in the reference list. The reported unit counts were derived from the cited curriculum examination blueprint.

AI Usage Disclosure

AI tools assisted with language editing and structural organization during the revision process. The authors retain full responsibility for the manuscript's accuracy, originality, and adherence to journal policies, and have approved the final submitted version.

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