



Northern Ontario
School of Medicine
École de médecine
du Nord de l'Ontario
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NORTHERN ONTARIO SCHOOL OF MEDICINE

Academic Principles			
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Introduction

NOSM's Academic programs, in both research and education, support NOSM's vision, mission and values and uphold the School's social accountability mandate through the delivery of programs that respond to the health needs of the communities that NOSM serves.

In keeping with its vision to provide Innovative Education and Research for a Healthier North, Distributed Community Engaged Learning (DCEL) continues as NOSM's distinct model of education and research. The Academic Principles create a framework for the development, delivery and evaluation of the School's academic programs.

Academic Principles

Interprofessionalism

The term interprofessionalism includes the key features of participation, collaboration and collegial decision-making processes to improve learning, patient care and research activities.

In the NOSM context, interprofessionalism can be applied to the way in which learners in all of NOSM's programs learn with, from and about each other as developing and practicing health care professionals. In addition, it can be applied to the way in which care is provided by health services, to elements of research, and to the way in which continuing health professional education is provided and undertaken. The Interprofessional Care Strategic Implementation Planning Committee of the MOHLTC of Ontario accepted the definition of "interprofessional care" as: "The provision of comprehensive health services to patients by multiple health caregivers, who work collaboratively to deliver quality care within and across settings."

According to The World Health Organization (WHO)¹, Interprofessional education is “the process by which a group of students or workers from the health-related occupations with different backgrounds learn together during certain periods of their education, with interaction as the important goal, to collaborate in providing promotive, preventive, curative, rehabilitative, and other health-related services.”

Integration

Integration is the combination and interaction of individuals, groups and programs around common purposes to create meaningful experiences and address life-long learning and the continuum of education of health professionals.

The Oxford Canadian Dictionary² defines “integrate” as “combined into a whole, united and undivided, uniting several components previously regarded as separate”. From an organizational perspective, integration implies collaboration and the creation of opportunities for the inclusion of individuals and organizations that may not have been part of organizational thinking and planning in more traditional medical school models. From an educational perspective, the application of this principle at NOSM involves the development of opportunities within the curriculum whereby learners are guided to make connections between different domains of knowledge, examine problems from different viewpoints, and begin to construct the basis of their own future decision making and expertise. It also involves a whole school and community approach in implementing and evaluating these opportunities through a variety of learning tools and through the development of curriculum and programs that link within and across disciplines.

Community Engagement

Community engagement is the conceptual and pragmatic understanding of the dynamics of communities in Northern Ontario (geographical, social, cultural, linguistic and communities of practice) and the creation of meaningful, enduring partnerships involving all Northern Ontario communities and NOSM, the hallmark of which is integrated networks of education and research.

According to Benner et al³ community involves both physical and conceptual components, thus the term “community based” in our view is too narrow because it implies only the physical component. Clearly, one cornerstone of community based medical education is a network of facilities that are learning locations in communities across the geographical region which is Northern Ontario. In this context these facilities may be clinics, hospitals, medical practices,

¹ The World Health Organization (WHO), *Report: Learning together to work together for health*, Web. 1988.

² "integrate." Def. 1. *The Oxford Canadian Dictionary*. Canadian ed. 2004.

³ Benner et al, in *New directions for medical education* (1989). Chapter 4. New York: Springer-Verlag

rehabilitation facilities, extended care facilities and a variety of institutions that provide care to individuals in one way or another.

However, of equal importance is the conceptual component of community which is characterized by an understanding of the structure of communities, the dynamic of communities, the epidemiological and social aspects of communities and an understanding of how these components interact. It is further evident in the commitment of NOSM research endeavors focused on northern community needs, and perhaps most evident in the social accountability mandate which forms the basis for NOSM's creation. Community engagement occurs through interdependent partnerships between the NOSM and Northern Ontario communities and organizations for mutual benefit, always focused on improving people's health.

Distributed learning and research is the hallmark of community engagement. Distributed community engaged learning acknowledges that both learners and faculty members are distributed across Northern Ontario. This focus on human resources as learners and teachers is concomitant with the availability of learning resources in a distributed fashion across the north.

Inclusivity

NOSM embraces the social, cultural, linguistic and geographic diversity and richness of the Peoples of Northern Ontario and strives to be inclusive of and reflect that richness.

The social accountability mandate of NOSM speaks directly to the importance of the need to serve the socially, culturally, linguistically and geographically diverse populations of Northern Ontario. This implies the need to include experiences for learners, faculty and staff that contribute to a deeper understanding of the people and cultures of Northern Ontario, which enrich the fabric of life in the North. Inclusivity also demands the recruitment of faculty, staff and learners that represent the identified populations and cultures of Canada. Inclusiveness demands flexibility in creating a curriculum, a body of learners, and working and learning environments that address our social accountability mandate.

Generalism

Generalism is a broad, holistic and integrated view and approach to activities, values and knowledge in educational, organizational and patient care activities.

“Generalism is a professional philosophy of practice, distinguished by a commitment to a holistic, integrated, person-centred care, the broadest scope of practice within each discipline and collaboration with the larger health care team in order to respond to patient and community needs. It involves:

1. Seeing the person as a whole and in the context of his or her family and wider social environment.
2. Using this perspective as part of one's clinical method and therapeutic approach to all clinical encounters.

3. Being able to deal with undifferentiated illness and the widest range of unselected patients and conditions.
4. Taking continuity of responsibility for people's care across many disease episodes and over time.
5. Coordinating care as needed across organizations, within and between health and social care."⁴

Generalism as it is used and represented in the NOSM curricula as well as in multiple of educational forums such as plenaries, workshops and conferences, suggests a broad scope of skills, attitudes and knowledge regardless of whether or not the health care practice is community based care or institution based care. Furthermore, generalism implies that role modeling of the breadth of this expertise is an important component of the medical education program at all levels to meet the community needs.

This notion applies therefore to the curriculum which students learn as well as the sites for education and the clinical faculty who serve as educators. Generalism, while wholly applicable to all stages of MD education can also be applied to other programs under the Academic Council.

Continuity

Continuity encompasses an approach to educational experiences from undergraduate through to continuing health professional development, as well as research that recognizes transitions between professional educational stages in a synergistic way.

According to "Continuity as an Organizing Principle for Clinical Education Reform" published in *NEJM* in 2007, Hirsh et al.,⁵ describes the principle of continuity applicable to educational experiences, the curriculum as a whole and to the experience of supervision as faculty as follows:

Rooted in the principles of modern learning theory, the notion of educational continuity reflects the progressive professional and personal development required of physicians in training. A spirit of "ownership" of the entire curriculum, rather than one discipline-specific portion of the curriculum, is a prerequisite for educational continuity. As applied to the core clerkship year, educational continuity subsumes two interrelated integrating forces: horizontal integration (enhancing the development of general competency by linking learning experiences between and across clinical specialties) and vertical integration (enhancing evidence-based practice by linking advances in the biomedical and clinical sciences to clinical problem solving).

Continuity of the learning environment fosters both patient-centeredness and learner-centeredness by establishing more opportunities for connections with patients ("continuity of care"); by integrating important educational themes across clinical specialties, focusing on the developmentally appropriate attainment and assessment of core clinical

⁴ PGME Collaborative Governance Council

⁵ David A. Hirsh, M.D., Barbara Ogur, M.D., George E. Thibault, M.D., and Malcolm Cox, M.D. *New England Journal of Medicine NEJM*, 2007; 356:858-866 [February 22, 2007](#)

competencies, and promoting the connection between science and clinical medicine (“continuity of curriculum”); and by enhancing supervision, role modeling, and mentoring (“continuity of supervision”)....

...Continuity of curriculum creates space for self-reflective practice, conceptual integration, and critical thinking, without which learning becomes task-based and heuristic. ...continuity of supervision support students' ability to know all they can about their patients and their conditions, from the basic science underlying the pathophysiology to the family and community in which the patient lives. Continuity of supervision also provides the luxury of intergenerational, iterative dialogue grounded in practice about values, professionalism, and lifelong learning. In this way, the entire learning community nurtures and maintains a spirit of idealism — idealism that will surely be translated into enhanced learning, greater patient satisfaction, and more efficient and effective medical care.

The notion of continuity then applies in the NOSM context to the way that curriculum is delivered and the way that patient care in the learner context may be provided across the NOSM academic programs.

Dedication to Inquiry

The process of inquiry is central to the role and identity of the School as it defines our commitment to the creation, augmentation and validation of knowledge.

Inquiry is about exploring the world, creating, augmenting and validating knowledge, solving problems, challenging suppositions and resolving debates. Not only is this central to the work of academics and physicians, it is a core value for any learning organization, particularly one that espouses evidence-based practice. Learners are intrinsically involved in a process of inquiry, as are researchers and those developing and evaluating educational programs. For the School to be truly socially accountable it must pursue deliberate and evidence-based practice, which in turn must be approached in the spirit of inquiry.

Professional Identity Formation

“Each individual’s journey from layperson to skilled professional is unique and is affected by “who they are” at the beginning and “who they wish to become.” Identity formation is a dynamic process achieved through socialization; it results in individuals joining the medical [health professional] community of practice.”⁶

⁶ Cruess et al ; A Schematic Representation of the Professional Identity Formation and Socialization of Medical Students and Residents: A Guide for Medical Educators Acad Med. 2015;90:718–725.

“Health Professional education is as much about the development of a professional identity as it is about knowledge learning.The ways in which [learners] develop their professional identity and subsequently conceptualise their multiple identities has important implications for their own well-being, as well as for the relationships they form with fellow workers and patients/clients.”⁷

Guided by social accountability, professional identity formation is focused on responding to the health needs of the people and community they have the privilege to serve. There is a consequent recognition that the health professional role is a privilege granted by society coupled with an obligation to serve. Faculty members across Northern Ontario refine and develop their professional identities as teachers and researchers as well as clinicians. Effective attention to and support of professional identity formation for faculty and learners is essential to the academic mission of NOSM.

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Version	Date	Authors/Comments/Stakeholders Consulted
1	May 18, 2006	Original presentation approved by Academic Council
2	June 9, 2011	Governance Review/Review and revisions to principles Approved revisions by Academic Council
3	June 15, 2017	Extensive Review by Academic Council and Standing Committees Additional principle/formatting and other changes.

⁷ Monrouxe L, Identity, identification and medical education: why should we care? Medical Education 2010; 44: 40–49