Schulich
MEDICINE & DENTISTRY

STATEMENT 3.0.0 – Curricular Integration

Approved by:	**Curriculum Committee**
Date of original approval:	**November 15, 2013**
Date of last review:	
Date of next scheduled review:	**October 11, 2016.**

I. BACKGROUND

The accreditation standard that describes the primary roles and responsibilities of curricular management is ED-33:

> *"There must be integrated institutional responsibility in a medical education program for the overall design, management, and evaluation of a coherent and coordinated curriculum."*

Evidence of a "coherent and coordinated curriculum" includes, in part:

> *"content that is coordinated and integrated within and across the academic periods of study (i.e., horizontal and vertical integration)."*

II. WHERE ARE WE?

Curricular integration is multi-faceted and complex including: logical sequencing, scaffolding and framing of curricular content; interdisciplinary teaching; interdisciplinary faculty collaboration; curricular linkages and methods of teaching and assessment that are appropriate for the achievement of the overall curriculum goals.

Our Doctor of Medicine program already has strong areas of integration in our curriculum so that our students:

- Learn content in a logical sequence
- Learn the basic science underpinnings of clinical medicine thereby promoting conceptual, contextual and authentic understanding
- Connect skills and knowledge from multiple sources and experiences
- Apply skills and knowledge in various settings
- Are exposed to diverse interpretations and points of view.

III. SCOPE OF INTEGRATION

In order to have a more fully "coherent and coordinated curriculum" we need to ensure that all curricular material will be presented in a manner that builds on early curricular foundations, shows logical linkage to other course teaching and is firmly focused on the goals and competencies of the Doctor of Medicine Program (hereafter "Program") at the Schulich School of Medicine & Dentistry.

The word "integration" arises in several contexts including:

Horizontal Integration: connecting the learning of concepts across different content areas or parallel disciplines in

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Vertical Integration: connecting the teaching of different disciplines or bodies of knowledge that are traditionally taught in different phases of the curriculum[1,2];

Longitudinal Integration: connecting and integrating Program instruction and learning for the entire curriculum.[1,2]

IV. MOVING FORWARD

In order to fully integrate our curriculum and achieve our Program's Vision:

> *"Our program will graduate competent, reflective, caring physicians educated with a broad general training. Our students are committed to the practice of medicine as professionals devoted to patient and family centered care, with a commitment to excellence through lifelong learning."*

We will need to commit and achieve the following:

1. Courses and teaching faculty working towards ensuring that objectives, content and assessments demonstrate horizontal integration within the course and across the year or stage of study.

2. Courses and faculty being aware of and committing to a process that will support vertical integration with other relevant curriculum teaching across all four years of the Program. It should be clear to our students how each course / module links with or adds to other instruction in the Program.

3. Courses annually reviewing their course / module / rotation objectives and assessments and searching our curriculum for other similar content in other courses with a view towards improving student learning of like or linked material. Linkages should be clearly documented for students within course material.

4. For pre-clerkship courses, improving horizontal integration by annually collaborating with representatives of courses in the same curriculum phase through semester groups or individual sessions and documenting and reporting such meetings to PIC.

5. Having an annual meeting of CEC and PIC in order to create and implement plans for improved vertical integration of pre-clerkship courses, clerkship rotations and ICE in a documented session reported to the Curriculum Committee.

6. Agreeing that all new course or curricular content should be created with a view towards building on / integrating with similar learning across the Program curriculum.

7. Modeling collaborative practices in our courses and sharing course content for the benefit of students and the curriculum. All materials used should be attributed to the original author and / or the literature from which it was derived.

8. Committing to course review and improvements using the advice of the Instructional Design Committee and to the monitoring of teaching, curricular mapping and integration by the Quality Committee with reports to the Curriculum Committee.

(See Appendix 1 for Suggested Strategies)

References:

1. Kulasegeram KM, Martimianakis MA, Mylopoulos M, Whitehead CR and Woods NN. *Cognition Before Curriculum: Rethinking the Integration of Basic Science and Clinical Learning*. Acad Med 2013;88:1578-1585.
2. Malik AS, Malik RH. *Twelve Tips for developing an integrated curriculum.* Medical Teacher 2011;33: 99-104.

Suggested Strategies to Improve Integration

1. For Course and Rotation Committees

Post Course: Review material for redundancy and content not linked

Pre- course: Map new or revised material to other areas of the curriculum.

Membership: All meetings must include Windsor or DME lead

Ad Hoc invitation to other course or learning modality leads

2. For Faculty

Encouraged to search and map content using one45 for curricular competencies and MCC Objectives

3. For Semester Clusters

Semester clusters: Institute twice-yearly facilitated sessions between courses in the same semester in to horizontally integrate content

Integrated Assessments: Create integrated assessments using the integration of course content with case-based MCC-type questions

Learning Modality to be invited to attend all sessions