Document Type	Policy on the Development of Policies and Guidelines
Date Approved	May 17, 2023
Approved By	Postgraduate Medical Education Committee
Effective Date	May 17, 2023
Review to Commence	May 17, 2026
Responsible Portfolio/Unit/Committee	Postgraduate Medical Education Committee
Responsible Officer(s)	Associate Dean, Postgraduate Medical Education

Purpose

The purpose of this policy is to ensure Queen's postgraduate medical education (PGME) policies and guidelines are developed in a consistent and transparent manner, aligned with Queen's University and Queen's Health Sciences, with input from relevant subject matter experts, and in accordance with the General Standards of Accreditation for Institutions with Residency Programs. This policy was created in accordance with element 2.1 of the General Standards of Accreditation for Institutions with Residency Programs, "There are effective policies and processes to govern residency education". This policy will be used by the PGME office to create, amend, and revoke policies and guidelines as needed.

Further, the purpose of this policy is to ensure that PGME policies and guidelines align with the Faculty of Health Sciences principles of equity, diversity, Indigeneity, inclusion, and accessibility (EDIIA). See appendix: "Department of Family Medicine, Policy Development and Review Checklist—Equity Focused", for further guidance.

This policy will assist in promoting accountability, inclusivity, mitigating risk, and establishing policies that are aligned with Queen's PGME's mission, vision, and values.

Definitions

CFPC: The College of Family Physicians of Canada (CFPC) is the professional organization that represents more than 42,000 members across the country. The College establishes the standards for and accredits postgraduate family medicine training in Canada's 17 medical schools. It reviews and certifies continuing professional development programs and materials that enable family physicians to meet certification and licensing requirements. The CFPC provides high-quality services, supports family medicine teaching and research,

and advocates on behalf of the specialty of family medicine, family physicians, and the patients they serve.

CPSO: College of Physicians and Surgeons of Ontario (CPSO) regulates the practice of medicine in Ontario. Physicians are required to be members to practice medicine in Ontario. The role of CPSO and its authority and powers are set out in the Regulated Health Professions Act (RHPA), the Health Professions Procedural Code under the RHPA and the Medicine Act.

PARO: The Professional Association of Residents of Ontario (PARO) is the official representative voice for Ontario's doctors in training. PARO's priority is to advocate on behalf of its members, addressing professional and educational concerns in order to optimize the training and working experience of Ontario's newest doctors thus ensuring that patients receive the best possible medical care. Members of PARO are, by definition, post-graduate medical residents training in accredited programs which lead to certification by either the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of family Physicians of Canada (CFPC), in one of their recognized specialty or subspecialty programs.

PGME: Postgraduate Medical Education (PGME) Office is responsible for overseeing the training and education of medical trainees. The Office provides support to residency programs and ensures that the programs meet the requirements set out by the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. Queen's PGME ensures that residents receive high-quality training and education that meets the standards set by these regulatory bodies. This includes providing oversight of the curriculum, assessment methods, and faculty development programs for each residency program. The department also ensures that the residents receive appropriate clinical experiences and that their training is in line with the latest developments and best practices in medicine.

PGMEC: The Postgraduate Medical Education Committee (PGMEC) supports the Associate Dean, Postgraduate Medical Education at Queen's University in planning, organizing, and evaluating all aspects of residency education. The Committee is responsible for: developing appropriate policies and processes to oversee residency education; advocating for resources to facilitate and enhance residency education; and addressing social accountability within residency programs ensuring the needs of the population are served. The Committee will include all program directors and representation from residents, learning sites, postgraduate administrative personnel, and key community stakeholders.

RCPSC: The Royal College sets the highest standards for specialty medical education in Canada. The Royal College is responsible for accreditation of the residency programs at the

17 universities across Canada and ensures that physicians meet all the requirements necessary for Royal College certification. They also administer the national certification exams, and the Maintenance of Certification Program, a continuing professional development program to meet the lifelong learning needs of Royal College Fellows.

Scope

This policy applies to all PGME policies and guidelines relating to the governance and administration of postgraduate medical education at Queen's University.

Principles

The underlying principles of Queen's PGME policy and guideline development are as follows:

Accountability: Establish clear lines of accountability for policy/guideline development, review, and approval.

Flexibility: Policies and guidelines should be flexible enough to accommodate changes in the clinical learning environment, accreditation standards, and other related legislation and standards.

Inclusivity: Ensure that policies and guidelines are inclusive and considerate of diverse perspectives and needs, and considers equity, diversity, Indigeneity, inclusion, and accessibility (EDIIA). See appendix.

Review and Evaluation: Establish a process for regular review and evaluation of policies and guidelines to ensure they remain relevant, effective, and current.

Transparency: Policies and guidelines will be transparent and include feedback and consultation with relevant PGME constituents and subject matter experts.

Compliance: Ensure that policies and guidelines are compliant with applicable laws, regulations, University and Faculty polices, clinical and educational standards, including the CanERA General Standards of Accreditation for Institutions with Residency Programs.

Process

New and amended policies and guidelines

1. Determining the need for new policy/guidelines, policy/guideline amendments, renewal or elimination of a policy/guideline occurs through the Postgraduate

Medical Education Committee (PGMEC). PGMEC meetings include "Policy Review" as a standing agenda item. This provides PGMEC the opportunity to discuss and identify any changes in their practice, accreditation, and legislation as well as consider feedback from programs and residents that may warrant a policy review.

2. PGME will ensure that any existing policies and guidelines up for review are included as an agenda item under "Policy Review" and distributed in advance of the meeting. The PGME office is responsible for drafting new policies/guidelines and amendments, which are subsequently presented to the Postgraduate Medical Education Committee (PGMEC) for review and ratification. This may include consultation with University Legal Counsel or other key departments at Queen's (e.g., Environmental Health and Safety) in order to be aligned with university policies and procedures. Some policies or guidelines may not be the purview of the PGMEC (e.g., Queen's Harassment and Discrimination policy) but specific procedures for the training environment may need to be developed.
3. Depending on the complexity of the policy or guideline, PGMEC may form a policy sub-committee for additional scrutiny.
4. The Policy Development and Review Checklist—Equity Focused (see Appendix) must be consulted while drafting policies and guidelines, and before formal implementation.
5. Final drafts are distributed to PGMEC members with the instruction that each member will consult their own program constituents for feedback. The policy or guideline will remain as a standing item until PGMEC and the Associate Dean, PGME, agrees it is in its final form and appropriate for implementation.
6. The PGMEC Chair will motion to approve the policy/guideline at a subsequent PGMEC meeting where quorum is met.
7. PGME will ensure that programs, trainees, and the faculty are informed of new policies/guidelines or amendments to an existing policy via email and via posting on the PGME website.

Process for Policy and Guideline Revocation

A policy or guideline may be rescinded if it is determined by PGMEC that it is no longer required. Additionally, a policy or guideline may be revoked if a similar exists in another regulatory body such as the CPSO or PARO and would result in policy/guideline duplication and/or confusion. A motion to revoke a policy or guideline is to be brought forward at PGMEC under agenda item, "Policy Review". PGME will document justification for the revocation in meeting minutes, will remove the related policy/guideline from the website, and notify relevant stakeholders via email.

Roles and Responsibilities

Authority for Policy Approval

Authority for policy approval sits at different levels within Queen's (e.g. program, PGME, SOMAC, Faculty Board, Queen's Senate). Approved policies must funnel up to their appropriate final level of approval.

Postgraduate Medical Education Office (PGME)

PGME is accountable for coordinating the process from the first draft through to the approval of the policy or guideline. This includes coordinating reviews with Queen's Health Sciences decanal office as needed and consulting with Queen's University Legal Counsel. It includes forwarding policies for final approval to the relevant body as needed.

The PGME Office is responsible for communicating PGME policies and guidelines to:

- Program Directors
- Program Administrators
- Learners
- PGMEC members
- SOMAC
- Faculty Board
- Queen's Senate.
- Others as required

Postgraduate Medical Education Committee (PGMEC)

PGMEC is accountable for supporting the Associate Dean, PGME, in planning, identifying, developing, reviewing, evaluating, and approving. PGMEC members are also required to inform the Associate Dean, PGME of any issues with new or existing policies or guidelines that may require immediate revisions as soon as possible if urgent, or, at the subsequent PGMEC meeting.

Program Directors (PD)

PDs are responsible for the dissemination of all new policies/guidelines and policy/guideline amendments to their respective trainees, program administrators and program faculty. PDs are responsible for ensuring all trainees and faculty are aware of the new/amended/revoked policies and guidelines and that they are implementing them as intended. PDs must also ensure that when developing program-specific policies and guidelines, they consult with the Policy Development and Review Checklist, "Items to Consider", in the Appendix.

APPENDIX

Department of Family Medicine, Queen's University

POLICY DEVELOPMENT AND REVIEW CHECKLIST – EQUITY FOCUSED

PURPOSE

This checklist is designed to assist the Department of Family Medicine at Queen's University in developing and reviewing their policies and procedures. A special focus has been placed on EDII. The intention of the checklist is to provide considerations rather than requirements for policy development and review.

ITEMS TO CONSIDER

Policy Initiation or Revision

A) Is a policy required or is the issue better resolved through other means, such as improved communication or an educational campaign?

B) Is there an existing policy with the same or similar intent?

C) Have policies from similar institutions been examined for comparison?

D) Have plans been made on how the policy will be implemented and who is responsible for implementation?

E) Have plans been made on how the policy will be communicated?

Consultations

A) Have experts in the subject area been consulted if appropriate?

B) Have all stakeholders who may be impacted by the terms of the draft policy been identified?

C) Have stakeholders (including end users and those who have lived experience) been consulted?

Reviewing a Draft Policy

A) Have related departmental policies and procedures and other governing documents (e.g., Strategic Plan) been reviewed to ensure the draft policy aligns with existing documents?

B) Is the need or purpose of the policy clearly articulated? Are health equity considerations and social disparities considered in the policy's justification and development?

C) Is it clear to whom and what the policy applies? Is discrimination and/or barriers experienced by particular groups addressed?

D) Does the policy accurately reflect current practice? Does the policy explicitly account for the different circumstances of particular equity deserving groups?

E) Are social disparities discussed in the policy's targeted outcomes?

F) Is the policy written in a manner that can be understood by a wide audience? Does the document employ gender neutral and inclusive language?

G) Does the policy change over time to address any documented exclusionary practices or barriers to participation?

Policy Implementation

A) Does the policy serve the total eligible population with special attention being paid to equity deserving groups?

B) Are resources allocated to target outreach to groups facing potential barriers to participation?

C) Do implementation practices differentially affect administrative burden for certain groups (e.g., language barriers, document requirements)?

D) Are outcome assessments and monitoring standards appropriate for different equity deserving groups (e.g., language, test settings)?

E) Does the policy/program include a collaborative aspect (i.e., across departments, levels of government, sectors) in order to address social disparities more effectively?

APPENDIX

Social Determinants of Health, Health Inequities, and Intersectionality

Health is influenced by a broad range of factors [1-2, 5-6, 10-11]. Some factors are genetic or biological [1-2, 5-6]. Biological factors have significantly less impact on an individual's overall health and well-being than one may expect [1-2, 5-6]. Rather, research has shown that factors pertaining to an individual's lifestyle and behaviours and physical and social environments have considerably greater effects on health [1-2, 5-6]. These non-biological factors are commonly referred to as the social determinants of health (SDHs) [1, 5, 10-11]. According to the Government of Canada, the main social determinants of health include [5]:

1) Income and social status
2) Employment and working conditions
3) Education and literacy
4) Childhood experiences
5) Physical environments
6) Social supports and coping skills
7) Healthy behaviours
8) Access to health services
9) Gender
10) Culture
11) Race and racism

Canada is one of the healthiest countries in the world. However, some Canadians are healthier and have more opportunities to lead a healthy life compared to others [5, 12]. These differences in the health status of individuals and groups are called health inequities and can, in large part, be explained by differences in SDHs listed above [12]. In other words, some individuals and groups are at greater risk of negative health outcomes due to their economic and/or social position within society [12]. For example, people living in poverty have higher rates of diseases and die younger than those belonging to higher income groups [12]. Additionally, women often have disadvantaged health outcomes when compared with men and racialized groups in Canada have poorer health outcomes when compared with their white counterparts [12]. These are just a few examples of the influence of SDHs on health.

A related concept to SDHs and health inequities is intersectionality [7, 9, 12-14]. Intersectionality is defined as "a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, SES, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression [12]." In simpler terms, intersectionality is a concept that recognizes that

individuals are multifaceted and dynamic [12, 13]. As such, they cannot be described using only one or two characteristics,
such as gender or race, and hence, their health (or lack thereof) cannot be attributed to a single factor alone [12]. Rather, human beings are complex creatures that come from unique backgrounds and have countless experiences, all of which come together to make them who they are [12]. Consequently, an individual's health lies at the intersection of the many traits, behaviours, and systems that make up their life [12]. As these factors shift and change, an individual's health is also likely to follow suit.

The above illustration is a conceptualization of intersectionality. It helps demonstrate how identities of individuals and social inequalities contribute to health adversities and health-related stigma.

Equity Deserving Populations

Equity deserving populations are defined as those population groups at risk of experiencing socially produced health inequities [9, 14]. An extra effort should be made to address health disparities and inequities faced by equity deserving populations.

There is no universal list of equity deserving populations [9]. In fact, equity deserving populations differ across time, location, and service [9]. Some individuals or groups may require and or receive greater access to health and social services in some

years/geographical areas than others [9]. Certain health and social services may choose to focus on certain equity deserving populations and their subgroups based on their expertise [9]. Consequently, it can be difficult to identify one's equity deserving populations [9, 14]. However, this is a key step in creating socially informed and equitable policies and providing personalized care.

Some equity deserving populations identified by KFL&A Public Health that may be relevant for Queen's DFM are as follows [7]:

1) People living with intellectual and developmental disabilities
2) Low-income families
3) People experiencing homelessness
4) Newcomers
5) Indigenous people
6) People with substance use disorders
7) Francophone families
8) Rural families
9) Military families
10) Single parent families
11) 2SLGBTQ+ populations
12) Women and female-identifying populations
13) People experiencing violence
14) People with complex medical needs
15) Families with loved ones who are incarcerated and/or post-incarceration populations

PLEASE NOTE: This is not an exhaustive list and should be reviewed and modified on a regular basis.

How To Use Policy Checklist to Best Serve Equity Deserving Populations

Recommended Steps:

1) Before policy development and/or review, identify and understand equity deserving population(s) in question:
    a. Who is this policy for (i.e., which equity deserving populations)?
    b. What are some key social determinants of health that impact the identified equity deserving population(s)?
        i. How do these SDHs intersect?
        ii. What are the associated short- and long-term health impacts of these SDHs and their intersection?
    c. How is this policy expected to address these SDHs and their intersection?
    d. What are the expected health outcomes of this policy?
2) Read policy and review using provided checklist
3) Compare Step 1 answers and performance on checklist. The two should align.
4) If Step 1 answers and performance on checklist do not align, make recommendations for revision, or reject policy, as appropriate

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