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Resident-focused trauma-informed medical education policies: an environmental scan of Canadian medical schools and partner organizations

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Abstract

Background: Psychological trauma among resident physicians (residents) is common yet underrecognized, even though it can significantly impact learning, patient care, and well-being. Trauma-informed approaches are one way in which trauma can be mitigated. The purpose of this study was to examine institutional policies related to resident-focused trauma-informed medical education (RF-TIME) at Canadian institutions involved in providing and governing physician training.

Methods: We conducted an environmental scan of publicly available online content related to RF-TIME at Canadian medical schools (*n* = 18) and partner organizations (*n* = 42), initially focusing on policy, and then broadening our scan to include strategic planning, standards, guidelines, reports, educational documents and support resources. Findings were tabulated and synthesized.

Results: We were unable to find RF-TIME-specific policies at any Canadian medical school or partner organization. Thirteen schools briefly mentioned RF-TIME approaches within strategic planning (*n* = 3 schools), policies not focused on trauma (*n* = 9), guidelines (*n* = 1), reports (*n* = 3), educational resources (*n* = 3), and/or support resources (*n* = 8). Seventeen partner organizations included RF-TIME content within strategic planning (*n* = 2 organizations), standards (*n* = 2), guidelines (*n* = 1), reports (*n* = 9), educational resources (*n* = 2), and/or support resources (*n* = 4).

Conclusions: Resident-focused policies around trauma-informed approaches to medical education are absent within Canadian institutions and organizations involved in the training and regulation of physicians. Developing and implementing RF-TIME policies may help establish more supportive learning environments for medical trainees with psychological post-traumatic injury.

Résumé

Résumé français à venir.

Introduction

Many resident physicians (hereafter referred to as residents) experience trauma and carry traumatic injury related to previous and current life circumstances or experiences within the context of residency training.[1] Trauma can mean many things, reflected by its many definitions and understandings.[2] For the purpose of this study, we use the term trauma to represent an event, series of events or set of circumstances that has enduring adverse emotional impact, with downstream effects on mental, physical, social, emotional, and spiritual well-being, development and functioning.[3-6] When those effects are deleterious to the individual, we call this traumatic injury.

Traumatic injury can impact learning, patient care, relationships within and outside of the workplace, as well as mental health and well-being.[7,8] Residents who experience trauma, whether directly or vicariously, often do not receive the support they need to process this trauma and be successful in their residency training.[10] A trauma-informed approach to education could potentially address these challenges. [1]

Trauma-informed medical education (TIME) has been described as education that addresses trauma-related content and contexts, where content pertains to knowledge and skills required for trauma-informed patient care and managing personal trauma, and context relates to a trauma-informed learning environment.[1] To differentiate education about trauma-informed patient care from education specific to trauma within residents (i.e. personal trauma and learning environments), we use the term resident-focused trauma-informed medical education (RF-TIME). Trauma-informed approaches to education in elementary and post-secondary schools have seen limited translation into medical education.[1,9] However, change within medical education in Canada can be slow[10,11] and it is unclear what progress related to RF-TIME has been made. The focus of this paper is on the current state of policy rather than policy development.

Applying a systems-thinking lens, new ways of relating, knowing and framing trauma within medical education require changes at institutional and structural levels, which can be facilitated by policy. [12] Policies make visible the systemic and structural aspects of medical education which inform institutional priorities, influence culture, and guide program development. We use the term 'policy' to refer to statements of principle and associated guidelines formulated and enforced by the governing body of an organization to direct and limit individual actions and institutional operations in pursuit of the organization's long-term goals.[13,14] Policies are often political–they reflect and project the values of those involved in the process of policy development at a given time in history and direct the allocation of resources in a way that may overshadow other priorities.[15]

As far as we were able to tell based on our previous work in this area,[2,8] RF-TIME policies related to residency education have not previously been examined. The purpose of this study therefore was to scan the current landscape of RF-TIME policies at Canadian institutions involved in providing and governing physician training. We also sought to identify gaps in policy as well as exemplar policies within the Canadian context that could be adapted by other institutions to address gaps that exist. Our hope is that, by raising awareness of gaps in RF-TIME policy and exemplars of such policy within medical schools across Canada, this study will help improve learning environments and systems of support for residents with traumatic injury.

Methods

We employed an environmental scanning methodology for data collection, which involved collecting and synthesizing existing information to inform decision-making and responses to policy and service delivery issues and opportunities.[16] Environmental scans are typically designed to raise awareness of gaps and identify opportunities to improve policy and service delivery.[16,17] Modes of scanning depend on assumptions about the environment to be scanned and the approach to obtaining information:[18]

- Undirected viewing: Environment perceived as unanalyzable, passive approach to gathering information
- Enacting: Environment perceived as unanalyzable, active approach to gathering information
- Conditioned viewing: Environment perceived as analyzable, passive approach to gathering information
- Searching: Environment perceived as analyzable, active approach to gathering information

An active approach to scanning involves a comprehensive approach to seeking and generating data (e.g., conducting interviews), which is then used to influence the environment. A passive approach involves using available information and using this to interpret the environment.[18] Given the large number of institutions and the limited

resources available for this study, we applied a conditioned viewing mode of environmental scanning–we sought and reviewed existing sources of information that were publicly accessible as the source of data. We approached this study with the assumption that the dataset would be analyzable, in that policies would be focused, clear, and not changing rapidly.

Data collection involved scanning for policies related to TIME on the websites of the 18 medical schools in Canada (as of December 2024) and websites of partner organizations involved in the regulation and certification of residents and residency programs in Canada (January 2025, with additional organizations reviewed in June 2025). Sources of data included both webpages and formal documents linked from those websites. For medical schools, AR reviewed websites related to both postgraduate and undergraduate medical education anticipating that some policies could be university-wide and may have been linked to undergraduate and not postgraduate medical education websites. Partner organizations were identified through discussion amongst the members of the research team and included those involved in resident certification and/or program accreditation (Association of Faculties of Medicine of Canada [AFMC], the College of Family Physicians of Canada [CFPC], the Royal College of Physicians and Surgeons of Canada [RCPSC], Canadian Excellence in Residency Accreditation [CanERA], and Committee on Accreditation of Canadian Medical Schools [CACMS]), resident-inclusive physician regulatory organizations (Federation of Medical Regulatory Authorities of Canada [FMRAC], the 10 provincial and three territorial colleges, and Canadian Medical Protective Association [CMPA]), and resident-inclusive physician associations (Resident Doctors of Canada (RDoc), Canadian Medical Association [CMA], the 10 provincial resident associations and the 10 provincial and three territorial physician associations). AR is bilingual and was able to review source content in both English and French without the need for translation services.

We required that the source specifically make use of the term 'trauma-informed' for inclusion, as descriptions of principles that seemed trauma-informed to us as reviewers may not have had that intent if not explicitly stated as trauma-informed, and we wanted to avoid misinterpreting the intent of institutions and organizations with respect to the documents we reviewed. We excluded sources centered on trauma-informed patient care as our focus was on trauma in residents. An initial scan of policy sections in these organizational websites failed to identify any policies specifically focused on RF-TIME. We therefore decided to broaden the focus of the environmental scan to include policies and standards that acknowledged trauma, educational resources related to trauma, and supports for learners experiencing trauma. Note that we focused on psychological trauma and excluded content that focused only on physical trauma.

For the medical schools, AR reviewed all publicly accessible sections of websites, including governance (vision and mission statements, strategic plans, policies and procedures, committee terms of reference), undergraduate medical education, postgraduate medical education, wellness and support, and equity, diversity, inclusivity and accessibility (EDIA). Our scanning of these websites was guided by themes identified in a metanarrative review of trauma [2] and a study of residents' experiences of trauma. [8] We looked for references to the learning environment, mistreatment, harassment, discrimination, violence and assault, workplace injury, environmental disasters, assessment, remediation, adverse patient care events, relationships, death and loss, personal illness, disability, and mental health. AR extracted data into a reporting template that included the name of the organization, the date reviewed, names of websites reviewed, types of trauma-related content, details of the content, and the intended audience. AR also reviewed the public websites of partner organizations involved in resident physician regulation and certification, including governance (vision and mission statements, strategic plans, bylaws, policies and procedures, committee terms of reference), certification (including standards of training, examinations), training program accreditation, physician wellness and support and EDIA. While extracting data, AR made note of whether there were policies that might be considered as 'exemplar' and recorded memos of notable gaps. The research team defined 'exemplar' as being directly focused on RF-TIME, as well as being comprehensive and well-written, and defined 'gaps' as the absence of anticipated RF-TIME content as well as apparent inconsistencies and misinformation. Researcher judgment was used in identifying exemplars and gaps, as we were unable to identify any standards on RF-TIME policy that could guide our decision-making. Following data extraction, we collectively reviewed the data along with the memos recorded to identify broader themes within the dataset that reflected trends across institutions. We identified and applied the following categories as a way of organizing our source data: strategic planning, statements, standards, policies, guidelines, reports, educational initiatives, and supportive resources.

Results

We discuss the findings of our study in relation to trauma-related content identified within medical schools and partner organizations, followed by broader regularities and implications.

1. Medical schools

Of the 18 medical schools in Canada, we found that 13 had content on their websites related to trauma. We use the following identifiers in referring to these schools in the text that follows: i University of British Columbia; ii University of Calgary; iii University of Manitoba; iv McMaster University; v Toronto Metropolitan University; vi University of Toronto; vii Northern Ontario School of Medicine; viii Queens University; ix University of Ottawa; x McGill University; xi Université de Montréal; xii Dalhousie University; xii Memorial University of Newfoundland.

We found references to trauma within a wide range of materials including strategic planning, policies not focused on trauma, reports, educational resources, and support resources, and across multiple website sections including those related to governance, undergraduate medical education, postgraduate medical education, student wellness, student affairs, student mistreatment, sexual violence, and equity, diversity, inclusivity, and accessibility (EDIA). Trauma was not acknowledged in any of the documents we reviewed related to assessment, appeals, remediation, leaves of absence, disability, safety, critical incidents, or public health emergencies. One school [viii] acknowledged trauma in their website for Indigenous students, and no schools mentioned trauma in their websites for Black or other racialized students. RF-TIME content within specific types of documents is described below and summarized in Figure 1 and Supplemental Material Tables 1 and 3.

Strategic planning. Three schools[v,vi,viii] had EDIA action plans that mentioned trauma. They all recognized EDIA matters as a potential source of trauma, for example, "the intersectionality of racial trauma and microaggressions with student, physician, and staff well-being."[vi] One indicated plans for trauma-informed pedagogy and trauma- and violence-informed approaches to support well-being,[v] and another mentioned a "trauma-informed framework" for faculty retention.[viii]

Policies. In none of the school websites scanned did we find a policy specific to trauma; where trauma-related policy existed it was embedded within other policies. Nine schools had policies in which trauma content was embedded,[i-iv,vii-x,xii] and for most of these schools, trauma was embedded within a single policy. These policies were either medical school-specific or applicable across the larger university, and were related to sexual violence (n = 8 schools)[i,ii,iv,vii-x,xii], discrimination and harassment (n = 1)[iv], racial violence (n = 1),[iii] accommodations (n = 1),[viii] and student misconduct (n = 1).[xii] We found that there were different terms used for similar concepts at different institutions. For example, while the term sexual violence was relatively common, other apparent synonyms included sexual and gender-based violence, sexual violence and prevention, sexualized violence, sexual misconduct, sexual harassment, sexual harassment and discrimination, sexual harassment and sexual assault, and sexual abuse. Most accommodations policies did not mention trauma, with one exception–one school's[viii] policy acknowledged trauma as one of several "extenuating circumstances" for which accommodations could be considered, although the document did not subsequently describe how the presence of trauma might influence the approach to student assessment, remediation or support.

Guidelines. One school[vi] had a guideline on learner mistreatment that included a trauma-informed approach as a guiding principle.

***Reports*.** One school's[ii] report on undergraduate medical student mistreatment recommended that "all responses [to mistreatment] should be trauma-informed." It was unclear whether these recommendations had been or were being implemented as the associated websites on learner support did not describe trauma-informed approaches. Another school's[iv] report on the activities of the office responsible for responding to concerns about the learning environment and mistreatment across undergraduate and postgraduate medical education indicated the office "strives to take a trauma-informed approach when managing learner mistreatment," with a hyperlink to a Government of Canada website on trauma and violence-informed approaches to policy and practice. A third school[vi] had a report on anti-black racism that acknowledged racial trauma and trauma-informed approaches to support.

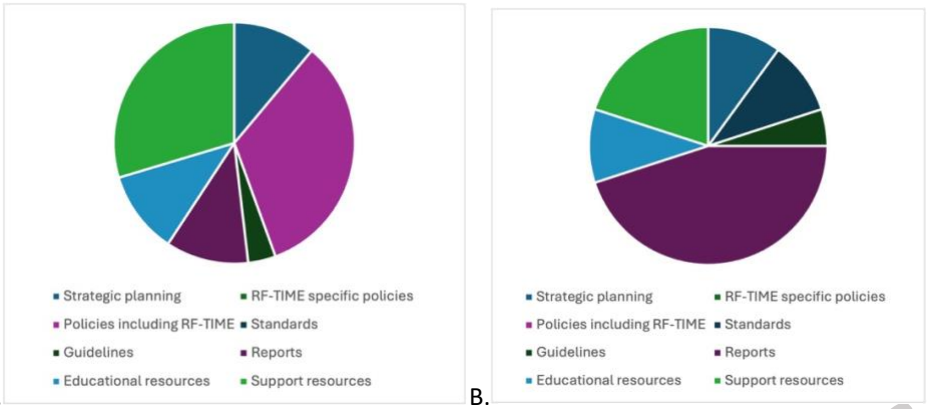

Figure 1. RF-TIME Content Across Canadian Medical Schools[a] and Partner Organizations[b]
The data associated with Figure 1 is provided in Supplemental Material Tables 3 and 4.

***Educational resources*.** One school[ii] had a guide on supporting students in distress that acknowledged past trauma as a source of distress, and one school[iv] had a sexual violence and prevention response office guide that mentioned trauma-informed support. Another school [vi] had a health and wellness guide for residents that prompted program staff to consider "traumatic clinical content" as a "wellness issue" and "debriefing opportunities after a traumatic clinical exposure" as a way of "teach[ing] trainees about potential wellness issues and ways to mitigate their negative impact on wellness". None of the schools mentioned professional development on trauma-informed approaches to medical education.

***Support resources*.** Eight medical schools[ii,iii,vii,viii,x-xiii] had support resources that were explicitly described as being trauma-informed. At one school[ii] these resources were specific for medical students and residents, at another school[iii] they applied to learners across all health sciences programs, and at the other six schools[vii,viii,xi-xiii] the resources were broader university resources available to all students. Resources were either general (*n* = 4 schools),[ii,iii,viii,xiii] specific to Indigenous students (*n* = 1),[viii] or directed towards students encountering sexual violence (*n* = 5)[iii,vii,x,xi,xiii] or substance use (*n* = 1). [xii]

2. Partner organizations

We use the following identifiers in referring to partner organizations with RF-TIME content: a AFMC; b CFPC; c RCPSC; d College of Physicians and Surgeons of British Columbia; e College of Physicians and Surgeons of Alberta; f College of Physicians and Surgeons of Manitoba; g College of Physicians and Surgeons of Ontario; h College of Physicians and Surgeons of Nova Scotia; I College of Physicians and Surgeons of Newfoundland and Labrador; j CMPA; k CMA; l Resident Doctors of BC; m Alberta Medical Association; n Saskatchewan Medical Association; o Doctors Manitoba; p Ontario Medical Association; q Medical Society of Prince Edward Island.

Seventeen partner organizations, consisting of three of five resident-inclusive certification and residency program accreditation organizations,[a-c] as well as six of 14 resident-inclusive provincial physician regulatory organizations,[d-i] and eight of 23 resident-inclusive provincial physician associations[j-q] had various RF-TIME content within their strategic plans, standards, guidelines, reports, educational resources and/or support resources. None of the organizations had public-facing policies specifically related to RF-TIME or included RF-TIME in other policies. We were unable to find any content related to RF-TIME on the websites of CanERA, CACMS, FMRAC, RDoc, and many provincial resident-inclusive physician regulatory organizations and associations. We describe RF-TIME content within specific types of organizational documents, summarized in Figure 1 and Supplemental Material Tables 2 and 4.

***Strategic planning*.** A national physician association's[j] strategic plan mentioned the intent to develop member-focused learning experiences that include trauma-informed approaches. One provincial resident-inclusive physician association[p] had an advocacy document on physician burnout that acknowledged post-traumatic stress in the context of disease outbreaks. Other than these examples, we found no mention of RF-TIME in other organizations' strategic plans.

Standards. In terms of competencies, one certifying organization[b] had a specialty-specific document[19] on assessment of competence that included recognizing psychological trauma in team members as a priority topic in assessing competence. Another certifying organization's[c] discipline-specific competencies[20] for Forensic Psychiatry and Child Maltreatment Pediatrics

mentioned competency to recognize and address the personal impact of vicarious trauma. None of the training requirement documents or discipline-specific accreditation standards that we reviewed mentioned RF-TIME.

Guidelines. One provincial resident-inclusive physician regulatory organization[e] had a guideline that recommended education on trauma-informed practices, inclusive of members of the healthcare team.

Reports. A national organization's[a] report on mental health activities[21] acknowledged that trauma can impact mental health during medical training although did not elaborate or discuss implications or ways of addressing this. Another national organization[k] had a report of a roundtable on equity, diversity and discrimination[22] that acknowledged that sharing personal experiences can be re-traumatizing. Three provincial resident-inclusive physician regulatory organizations[d,g,i] reported training their staff in trauma-informed practices related to registration or investigation of complaints, and one[h] indicated a trauma-informed approach to complaints. Three provincial resident-inclusive physician associations[m,o,q] described education on trauma-informed leadership, and one[m] had also provided physician education on addressing their own trauma.

Educational resources. One organization's[k] Physician Wellness Hub Resource Centre included 22 articles related to trauma in physicians. Most of these briefly mentioned trauma, such as naming an experience as traumatic without describing the experience or how it was traumatic or the effects of trauma, and some contained incorrect information (such as describing compassion fatigue and vicarious and secondary trauma as synonymous).[23] Other articles provided more in-depth reviews of trauma-related considerations, including Trauma-Informed Education[24] and Responding To and Recovering From Distress.[25] One provincial resident-inclusive association[p] had a physician burnout toolkit that included information on coping after a traumatic event.

Support resources. One provincial resident-inclusive regulatory organization[f] and two provincial resident-inclusive physician associations[n,o] indicated that their provincial physician health programs provided support for physicians with trauma. One provincial resident association [l] had parental support resources that acknowledged pregnancy loss as a source of trauma.

3. Recurring issues

In conducting this study we noted a number of recurring issues:

Challenges in locating RF-TIME content. Content was not always easy to locate. In some instances, we were only able to identify materials after comprehensive searching that involved following multiple links and sub-links. In other instances, direct links to trauma-related content were broken, although we were able to locate some of these documents by searching for the name of the file using Google.

Absence of alignment in content related to RF-TIME. We found little alignment between institutional values, policies, standards, education and support. Most institutions mentioned trauma in one of these domains, few in more than one, and no institution addressed trauma across these domains. We also found recurring discordance between intention and policy. Some schools that mentioned trauma in their general webpages had not followed this through to their policy documents. For example, one school [ii] had two reports on mistreatment which made recommendations on trauma-informed approaches although these had not been translated into policies, at least as far as we could see. Another school[vi] had a student guide to a sexual violence policy that mentioned a trauma-informed approach although there was no evidence of a trauma-informed approach in the policy itself. As a third example, one university's[xii] student code of conduct stated that they had a trauma-informed approach to investigating misconduct although this was not mentioned in any other document (including medical student and resident codes of conduct) at the same university.

Gaps in RF-TIME content. Sections of websites where we had expected to find RF-TIME associated content often did not include such content, for example webpages on 'safety' listed policies around issues such as blood/body fluid exposure, communicable diseases, and radiation exposure but not trauma. This seemed to reflect perspectives that considered only the physical and not the psychological aspects of acquired trauma. While trauma has been well-described among Indigenous and Black students, mention of trauma was largely absent from the websites designed for these groups. Across all data sources where trauma was mentioned, it was most often non-specific, such as using the term "trauma-informed" without elaborating on what this meant or how it was to be applied in the context of the policy.

National institutions which set the standards for medical training in Canada did not mention trauma in their overarching competency frameworks, namely CanMEDS[26] and CanMEDS-FM,[27] and the associated standards of accreditation also made no mention of RF-TIME.

A summary of the above findings is provided in Table 1 and Supplemental Material Figure 1.

Table 1. RF-TIME content categories across different types of institutions

	Medical schools (*N* = 18)	Resident-inclusive certification and/or residency program accreditation organizations (*N* = 5)	Resident-inclusive physician regulatory organizations (*N* = 14)	Resident-inclusive physician associations (*N* = 23)
Institutions with RF-TIME content (*n*, %)	13/18 (72.2)	3/5 (60)	6/14 (42.9)	8/23 (34.8)
Strategic planning (*n*, %)	3/18 (16.7)	0/5 (0)	0/14 (0)	2/23 (8.7)
RF-TIME specific policies (*n*, %)	0/18 (0)	0/5 (0)	0/14 (0)	0/23 (0)
Policies including RF-TIME (*n*, %)	9/18 (50)	0/5 (0)	0/14 (0)	0/23 (0)
Standards (*n*, %)	0/18 (0)	2/5 (40)	0/14 (0)	0/23 (0)
Guidelines (*n*, %)	1/18 (5.6)	0/5 (0)	1/14 (7.1)	0/23 (0)
Reports (*n*, %)	3/18 (16.7)	1/5 (20)	4/14 (28.6)	4/23 (17.4)
Educational resources (*n*, %)	3/18 (16.7)	0/5 (0)	0/14 (0)	2/23 (8.7)
Support resources (*n*, %)	8/18 (16.7)	0/5 (0)	1/14 (7.1)	3/23 (13.0)

A graphical representation of this data is provided in Supplemental Material Figure 1

Discussion

Our environmental scan identified an absence of dedicated policies on RF-TIME at Canadian medical schools and associated partner organizations within public-facing internet-based content, reflecting an underdeveloped agenda around RF-TIME. Where trauma was acknowledged, it was embedded within other documents and resources and mentioned only in brief. Notably, trauma was most often acknowledged in association with sexual violence, and absent from policies around student wellness and accommodations.

We found that where institutional content did consider trauma, it was typically in a cursory way, usually with reference to a 'trauma-informed approach' to supporting learners experiencing distress. Given that traumatic injury is complex and layered, we argue that simply stating that an approach is 'trauma-informed' is meaningless without defining trauma or describing what trauma-informed means and how it is operationalized. Without such specificity, implementation becomes open to interpretation, with inconsistency in its application and unclear metrics for evaluation.

We noted that policies that mentioned trauma were mostly related to sexual violence and rarely considered or acknowledged other causes of traumatic injury. This may reflect that sexual violence has long been recognized as a prevalent cause of traumatic injury on campus, whereas other causes of traumatic injury, such as those related to racism or unsafe learning environments, have only recently received greater attention in the literature.[28,29] The reasons for this could be related to structural factors that allow racism to persist for the benefit of the dominant culture,[30] and the discomfort schools may experience in acknowledging trauma and traumatic injury that occurs within their own institutions. Furthermore, with the widespread recognition of sexual violence, several provinces and territories require post-secondary institutions to adopt sexual violence policies.[31] In the United States, some organizations have advocated for trauma-informed patient care, which has led to the development of competencies for medical students.[9] Similar recognition and advocacy could help in accelerating a parallel process of RF-TIME in Canada. Indeed, specifying trauma-related competencies in specialty-specific training documents without including trauma-informed approaches to medical education within the accompanying standards of accreditation could be problematic. This lack of alignment suggests that programs are not aware of a need to accommodate or support learners who carry pre-existing traumatic injury or experience new trauma or re-traumatization in seeking to achieve trauma-related competencies.

With growing recognition of the importance of resident and physician wellness,[32] all schools had websites dedicated to wellness, although few mentioned trauma or included trauma-specific supports, such as counselors with training in trauma-informed approaches. We noted a similar trend in content directed towards Indigenous students and Black students. Not including trauma within

health and wellness sections of websites or within content intended for learners from historically marginalized groups risks denying the reality of learners who experience trauma and its impact on physical, mental, social, and spiritual aspects of health and wellness. Institutional silence around trauma risks centering dominant groups and 'normalcy'[33] while conveying the message that trauma is not to be openly acknowledged or discussed in academic settings. In doing so, structural stigma surrounding trauma is maintained, thereby discouraging learners with trauma from seeking support and leaving those who do want support uncertain as to how to proceed, who is safe to talk to, or who will listen and support them in a way that does not retraumatize. This can in turn perpetuate a culture of supremacy in medicine[33] as the absence of institutional acknowledgment of trauma can further be a form of erasure of learners' experiences, marginalizing them while absolving institutions of responsibility for the trauma that takes place within their walls. Further, not acknowledging trauma and traumatic injury within marginalized groups can perpetuate all forms of oppression.[32]

Most schools also recognized disability rights and had policies around accommodations, although trauma and traumatic injury was not mentioned within these discourses. The accommodations policy at one school acknowledged trauma as an "extenuating circumstance" for which accommodations may be considered, although it did not explicitly name trauma as a source of disability.[34] The disability literature has historically focused on physical aspects of disability and only recently have mental health concerns have been acknowledged as a form of disability.[35] On the one hand, a benefit of recognizing traumatic injury as a disability is that it would require accommodations policies to be trauma-informed. On the other hand, classifying traumatic injury as a disability might lead schools to require formal diagnoses of post-traumatic stress disorder for learners with trauma to access accommodations, further entrenching biomedical notions of traumatic injury along with the risks of diagnostic labeling and medically-focused approaches to support, while limiting learner access to support.

Table 2. Provisional suggestions for advancing resident-focused trauma informed medical education (RF-TIME) policy

Suggestions	Potential approaches
Engage partners in the medical education community in implementation of RF-TIME policies	Organize intentional RF-TIME conversations and debates around ways of advancing RF-TIME within and across institutions and organizations Include RF-TIME plenaries and workshops in medical education conferences Fund RF-TIME implementation and evaluation projects and initiatives
Develop standards for RF-TIME	Assemble working groups with diverse representation to develop recommendations Amend current national policies and charters* focused on post-secondary institutional learning environments to acknowledge trauma and provide guidance on the development and implementation of trauma-informed approaches to education Incorporate RF-TIME within accreditation standards
Contextualize policy development and implementation based on standards	Develop RF-TIME policies including but not limited to structures such as trauma reporting and disclosure; accommodations; technical standards; accessibility standards; equity, diversity and inclusivity initiatives; and learner mental health and wellness Embed RF-TIME principles within existing policies focused on other issues Apply a responsive trauma-informed approach to developing, monitoring and revising RF-TIME policies, with diverse representation from medical learners, educators, clinicians, and leaders
Implement RF-TIME policies	Implement RF-TIME policies using implementation science methods to enable refinement and adaptation within local contexts Ensure that RF-TIME policies are accessible and acknowledge complex adaptive systems Implement co-produced and partner-engaged education for learners, educators, clinicians and leaders around RF-TIME policies Ensure alignment between policies and standards, institutional values, education and resources for support
Monitor for continuous quality improvement	Monitor the effectiveness of RF-TIME policies through transparent and contextualized programmatic evaluation Develop and consistently apply accountability measures for breaches of RF-TIME policy Adapt RF-TIME policies to changing needs and emerging evidence using continuous quality improvement methods

**E.g.: Okanagan Charter[42] and Scarborough Charter[43]*

With the ever-expanding quantities of information provided on institutional webpages, accessibility of information remains an ongoing challenge, and ensuring that information can be found by those who need can be time intensive. Guidance exists around best practices for digital content management, including principles of universal design, accessibility, and searchability.[36] From a trauma-informed perspective, content that refers to persons in positions of power, such as leaders and support service professionals, should also include up to date names, photos and biographies.[37] Having a formal position dedicated to website design and maintenance can facilitate high quality online content such as organizational charts for institutions while fostering institutional accountability and transparency.

Implications

Based on the findings of this research we offer guidance for Canadian institutions engaging in the development and implementation of RF-TIME policies. These suggestions include engaging partners in the medical education community, developing standards for RF-TIME, contextualizing policy development and implementation, and monitoring for continuous quality improvement (Table 1). Institutions and organizations might consider applying principles of quality improvement and implementation science[38-41] to this work, prioritizing initiatives based on feasibility and anticipated impact, adopting a stepwise approach to development and implementation, and working collaboratively to optimize resources.

Limitations

We note several limitations to this study. First, we did not speak with institutional leaders and only reviewed public-facing content on institutional websites, such that we did not achieve an in-depth understanding of each institution's or organization's perspective on RF-TIME. Subsequent research could expand our approach to include a scanning mode that generates new data and seeking internal sources of data, for example, by distributing questionnaires to institutional leaders about RF-TIME policies in existence or in development, and interviewing leaders about these policies or the lack thereof. Additionally, there may have been trauma-related content that was only accessible through institutional login or not posted online, and it is possible that RF-TIME policies were in the process of being developed at the time of our study. In limiting our study to the Canadian context, we may have also omitted exemplar RF-TIME policies in other countries. Future research could broaden the geographic inclusion criteria to explore good practice more broadly.

Second, we only considered content as trauma-informed if it explicitly made use of the term 'trauma-informed' – there may have been content that spoke to trauma and trauma-informed approaches but that did not use those terms such that we did not identify it. A much deeper and longer reading of these materials might have identified such materials, but doing so would not reflect how others would likely use these materials. We also excluded sources focused on trauma-informed patient care, and it is possible that these sources may have embedded RF-TIME approaches within related content that was not available to us, such as detailed curricular lesson plans.

Third, as we were unable to identify standards for assessing RF-TIME policies, we applied our own judgement as researchers to determine whether website content was 'exemplary' and where gaps existed.

Fourth, we acknowledge that drawing attention and resources to trauma carries the risk of diverting attention and resources away from other important aspects of medical education, EDIA initiatives, and learner health and wellness. Trauma intersects with each of these areas and others; our hope in positioning trauma as a priority will further enhance the approach to all aspects of learning and learner support using systems-based thinking rather than privileging trauma over other initiatives.

Finally, we did not explore why gaps in RF-TIME exist. One possible reason for the absence of policy related to RF-TIME is a lack of awareness. While trauma-informed education has long been embedded in elementary education, post-secondary leaders are far removed from that context, and notions of trauma-informed approaches to medical education have only been discussed in recent years. [1] Another reason could be that institutions and their leaders are confronted with many issues and may have prioritized other issues over RF-TIME, for example, transitioning to competency-based medical education or a focus on current standards of accreditation. Strong policies also require foundational research and engagement from impacted groups–the former is still largely based on descriptive studies, while the latter would seem to be limited by stigma surrounding trauma and mental health. Developing policy around trauma establishes accountability for addressing trauma and the associated challenges, which may be daunting to institutional leaders for many reasons, such as limited awareness or knowledge

of RF-TIME, controversy, and resource constraints. Clearly, further research is needed.

Conclusion

Despite the prevalence of traumatic injury among residents, intentional and integrated policies to guide RF-TIME seem to be largely absent from Canadian medical training institutions and partner organizations. Failing to acknowledge trauma that learners carry and traumatic injury acquired in the course of medical education training further marginalizes learners and absolves institutions of responsibility to support learners with trauma. Developing, implementing and monitoring adherence to and the impact of trauma-informed policies within medical education is an essential step in advancing supportive learning environments that enable residents to navigate the challenges they encounter during medical training.

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