Resiliency training

During a time when resident doctor suicides are increasingly in the media and much more resident distress undoubtedly goes unreported, *Canadian Family Physician* is to be commended for calling for interventions to reduce resident distress.[1] Resident Doctors of Canada (formerly the Canadian Association of Internes and Residents) is proud to be developing one such intervention to improve wellness in Canadian resident doctors. Based on the evidence-based Road to Mental Readiness curriculum,[2] which has been developed and implemented over the past 7 years by the Canadian Armed Forces, the Resident Doctors of Canada curriculum will teach residents practical tools for identifying stress and improving resilience. On February 20, 2015, a summit on this topic was held in Ottawa, Ont, to gain feedback from national medical organizations, wellness experts, and resident doctors. We are thrilled by the overwhelmingly supportive comments we have received, and excited to bring this to medical training across the country very soon, in order to benefit the mental health of physicians across Canada.

—Nureen Sumar MD CCFP
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Former president, Canadian Association of Internes and Residents
Mono, Ont

Competing interests
None declared

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Resident speaks about mental health

Thank you for the article "Distress among residents" in the February issue of *Canadian Family Physician*.[1] I have experienced some very stressful times during residency, through a combination of both personal and workplace factors. Just like the students that Dr Ladouceur discussed, I entered residency without mental health problems but am finishing residency while taking medication, despite my best efforts at work-life balance. I do not regret my career choice and am looking forward to entering practice, but I can now understand the physicians I have met over the years who commented that they would never want their children to go into medicine.

I definitely think that giant leaps have been made in terms of identifying learners in distress and providing them with support. However, the oversight lies in the lack of effort to prevent learners from becoming distressed and entering a crisis state in the first place. Just like in treating our patients, we cannot get hung up on treating crises and acute illnesses—we need to focus on prevention, and simply having a mandatory lecture about the importance of sleep, regular exercise, and healthy diet is not the right prescription.

—Kate Slivko MD
Chilliwack, BC

Competing interests
None declared

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Job-sharing story

The article by Sacks et al, "Are 2 heads better than 1? Perspectives on job sharing in academic family medicine,"[1] in the January issue of *Canadian Family Physician* highlighted what we think might be a growing trend in our profession as baby boomers age and younger physicians try and find new and creative ways to balance professional and personal demands on their time and energy. We believe it is important that readers who are not in academia consider similar solutions, and so we present Bob and Celeste's story.

Bob and Celeste's story

Two years ago Bob was approaching the traditional age for retirement and it was clear to him that he was not interested in continuing to practise with the same intensity as had been his pattern for the past 40 years. As a community family physician with a large practice, he decided that neither of the most common solutions to this problem—complete retirement or doing locums for others—were attractive. Complete retirement would place a huge burden on his colleagues in the small rural

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