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
Vice President, Resident Doctors of Canada
Calgary, Alta
—Simon Moore MD CCFP
Former president, Canadian Association of Internes and Residents
Mono, Ont

Competing interests
None declared

References
1. Ladouceur R. Distress among residents. *Can Fam Physician* 2015;61:105 (Eng), 106 (Fr).
2. National Defence and the Canadian Armed Forces [website]. *Road to mental readiness (R2MR).* Ottawa, ON: Government of Canada; 2013. Available from: **www.forces.gc.ca/en/caf-community-health-services-r2mr/index.page**. Accessed 2015 Mar 4.

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

Reference
1. Ladouceur R. Distress among residents. *Can Fam Physician* 2015;61:105 (Eng), 106 (Fr).

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

community where he practised, and, given that they all had full practices, it would likely mean an unacceptable increase in the number of patients without family physicians. The loss of those patients to the family health team (FHT) would result in a considerable decrease in the FHT's roster numbers. At the same time, both of the traditional approaches would mean a substantial change in income, both in overall amount and in predictability.

Coincidentally, Celeste, a colleague with the same FHT, wished to decrease her clinical load to gain more time for her family and other interests. Celeste was Chief of Staff at the local hospital, a position Bob had held for a number of years previously. They began a conversation that started with "Wouldn't it be nice …" which eventually led them to an elegant solution.

Both doctors had large practices. They decided that they would each cut back their patient numbers to a level such that the total number of the combined practices was manageable by 1 physician. This was made much more attractive by the fact that a new physician was scheduled to open a practice in the community and agreed to take on all of the patients released by both Bob and Celeste. Bob and Celeste then agreed to cover each other's reduced practice on alternate months, resulting in half-time practices for both. Patients remaining in their practices were assured of coverage at all times through the year, with no holiday gaps. Those patients "released" from their practices were assured a new family physician if they so chose. More important, both physicians managed large inpatient loads at the local hospital and the care of these patients continued seamlessly. The hospital board agreed that Bob and Celeste could job share the chief of staff position.

We have now been practising in this way for 9 months. Most patients have accepted this solution happily, as we are both well-known physicians in the community. Sacks et al note from their literature review that "creating a successful job share requires trust, open communication, and shared beliefs."[1] To this list we would add a common work ethic and practice style. Each of us strives to ensure that at the end of our work month, all administrative work (eg, laboratory results, paperwork, insurance forms, messages) is complete. We share available office appointment slots equally between the 2 practices. We each take ownership of the various challenges of the chief of staff position, copying each other on important e-mail messages. As often as possible, only one of us attends meetings.

We have learned a lot over the past months, and would endorse the list of recommendations by Sacks and colleagues.[1] We have managed to work half time, and our income is settling in at roughly 50% of what we earned previously. Our patients, colleagues, and the hospital staff are pleased with our arrangement thus far. We recommend consideration of a similar solution to community family physicians who have need of greater time away from their practices for whatever reason.

—Robert W. Henderson MD CCFP FCFP
—Celeste Collins MD CCFP FCFP
Campbellford, Ont

Competing interests
None declared

Reference
1. Sacks J, Valin S, Casson RI, Wilson CR. Are 2 heads better than 1? Perspectives on job sharing in academic family medicine. *Can Fam Physician* 2015;61:11-3 (Eng), e1-3 (Fr).

Geography aside

A thank-you to Dr Vance for raising the important issue of the red tape around physician mobility in Canada in the February issue of *Canadian Family Physician*.[1] During my tenure as Chief of Staff at Moose Factory General Hospital (Ontario's most remote hospital), I was equally frustrated in our efforts to hire Canadian locums to cover staff physicians on leave. Most rural communities suffer because of the unnecessary obstacles to locum mobility in Canada. This is not just a supply issue. On the supply side, there are many young physicians like Dr Vance who are eager to explore Canada by working in rural and remote communities. On the demand side, we only need to look at the numerous classified ads in Canadian medical journals to comprehend the need. Dr Vance has some excellent suggestions; I would like to put out 1 more: a national medical licence. Given our geography, it will require provincial administration (as is the case with the College of Family Physicians of Canada). However, a Canadian national licence would greatly improve locum mobility and rural patients' access to health care, as well as give physicians a medical practice experience of a lifetime. It's time.

—Murray Trusler MD MBA FCFP FRRMS
Ottawa, Ont

Competing interests
None declared

Reference
1. Vance M. Provincial licensing process. Unnecessary barrier to locum coverage. *Can Fam Physician* 2015;61:169-70.