it is in the home, it may be seen as a means of striking back at people.”

The unresolved questions are whether the residents considered the hospitals to be their “homes” and whether the institutions could have taken any action to prevent the deaths.

Jacyk, who is coordinator of the Manitoba Medical Association’s (MMA) Physicians at Risk Program, said the suicides make him wonder if institutional safeguards failed. “Was there anything in place that could have headed this off?”

He noted that the MMA’s program is designed to assist doctors who are under stress but may be afraid to access assistance programs at their hospitals. “Residents in particular don’t want to be perceived as being vulnerable,” Jacyk said. “Often, residency programs will have an internal system in place to help doctors, but residents are too afraid to access it for fear of reprisal.”

“I certainly wouldn’t want my patients to have my job”

Are the pressures of modern-day medical training proving insurmountable for some residents? Dr. Stephen Brown, president of the Canadian Association of Internes and Residents (CAIR), says today’s residents face work-related and social pressures that are far more complex than program directors may recognize. He cited enormous workloads and financial and domestic issues as pressures that may be more severe today than for residents in the past.

One example is the 28-hour rule, still not implemented in some provinces, which specifies that residents can only be required to work in hospital 28 hours at a time. “It’s ludicrous, isn’t it, a 28-hour day?” Brown said. “Granted, it’s historically the nature of the business and the way it’s been done. Precedent has been set by generations of past physicians who are now the people making the schedules. It’s ingrained in the medical culture that these sorts of hours are standard.

“We’re saying, ‘let’s re-examine this.’ Is it humane, is it necessary and is it safe? You can only go so far with historical arguments. We want to change the culture from within. This is no longer acceptable.”

Brown said medical technology has played a significant role in preserving the health of very sick patients, but residents are expected to keep up with the exponential increase in knowledge. “There’s a higher proportion of sicker patients than there used to be and . . . a tremendous amount of life-and-death decision-making. But residents are expected to know everything, all the time.”

Brown also believes that the financial pressures of a residency program, particularly for doctors with families, are producing high levels of stress. Exacerbating the domestic and financial pressures are the worry that in the current health care climate, no one can be assured that they will have a job to go to when a residency is completed.

“A first-year resident has already gone through 6 years of schooling prior to medical school. Our salaries are regularly being cut. The average resident in Ontario makes $40 000, pre-tax, which is the highest rate of pay in Canada. They get that in return for working 80 to 100 hours a week, with $50 000 to $80 000 worth of debt to service. Certainly the reality of medical residents’ lives is substantially different from the public image that people have of doctors.”

Despite institutions’ stated goals of treating residents humanely, said Brown, “there is still a lot of intimidation, both internally and externally. From a medical point of view, it is a staffing issue. That’s the biggest resistance that we find to the concept of humanizing resident’s working conditions.”

He added that the long hours spent working tend to divorce residents from their family and friends. “Often time spent outside the hospital is spent studying. Or, after your 28 hours you go home and fall asleep. Your support mechanisms fall apart if you’re not careful.”

Brown thinks the deaths of the Winnipeg residents should serve as a reminder that “stress overload” may be playing havoc with residents’ lives across Canada.

“You don’t want to abuse the facts of the situation but you want to use them to highlight the potential problems. It has to be taken seriously because we need to help other residents.”

“We’re addressing the known problem, and our members will benefit from making the working environment more humane. Every single problem has a solution, from contract negotiations at the provincial level to better hours and better working conditions and the process of accreditation of residency programs.”

He said data on the rate of suicide among doctors are unclear and CAIR is not certain whether there is a higher rate among residents than practising physicians. “In a global sense we have to change the notion that this environment is acceptable, and that’s a slow process. It boils down to everybody being treated fairly.”

Brown concluded that the medical-training process is a system that no doctor would recommend to a patient, because the multiple professional and personal stresses are not conducive to good mental health.

“Doctors would not advise their patients to try this. I certainly wouldn’t want my patients to have my job.”