

Manitoba suicides force consideration of stresses facing medical residents

Lynne Sears Williams

In brief

THE SUICIDES OF 3 WINNIPEG MEDICAL RESIDENTS WITHIN 15 MONTHS shocked Manitoba physicians and raised concerns among interns and residents across Canada. The cluster of self-inflicted deaths has observers wondering if the stress of residency programs was a contributing factor in the tragedies.

En bref

LE SUICIDE DE 3 RÉSIDENTS EN MÉDECINE DE WINNIPEG EN 15 MOIS a bouleversé la communauté médicale du Manitoba et soulevé des préoccupations au sujet des internes et des résidents partout au Canada. Cette grappe de suicides incite les observateurs à se demander si le stress imposé par le programme de résidence en médecine a contribué aux tragédies.

The suicides of 3 Winnipeg medical residents within 15 months have shocked Manitoba's medical community and sparked national concern among interns and residents.

Dr. Stephen Brown, president of the Canadian Association of Internes and Residents (CAIR), says the deaths — in October 1995, November 1995 and January 1997 — have generated worry and speculation that intense working conditions may have contributed to the doctors' decisions to take their lives. The residents were all enrolled in specialty programs; 2 died by lethal injection, 1 by gun shot. Two committed suicide in the hospitals where they worked. The cluster of self-inflicted deaths has observers wondering whether the deaths should be considered a commentary on residency programs in general, or are simply a statistical anomaly.

"We have to get the facts and the numbers and seek expert resource people for input on this situation," Brown said in an interview. "Is this statistic higher than would be expected in a normal population? If so, are there any common themes? Even if there are additional factors involved, we know that a common denominator is stress from working conditions."

Dr. Bill Jacyk, chair of the National Conference on Physician Impairment, says the fact that 2 of the suicides occurred in hospitals is disturbing. Studies suggest that victims may choose where to die for a variety of reasons, but a predominant one is the choice of "home" as the location.

"We are talking about the concept that 'this is my most familiar place or the place where I live the most,'" said Jacyk. Sometimes the location can be linked to a desire to shock survivors. Another possibility is that the 2 who died in hospital were hoping for an 11th-hour reprieve and believed their chances for successful rescue were best in a hospital.

Availability of means

A Calgary institute that studies suicide says that choosing a hospital could also mean that the victims felt they had the best opportunity and means to take their lives there. A spokesperson said the "availability of means" often affects the suicide equation. "Means is sometimes the determining factor, although at other times, *where* a person commits suicide is indicative of the person's state of mind. If



Features

Chroniques

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Dr. Stephen Brown: the common denominator is stress



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.”



Dr. Peter Markesteyn, Winnipeg's chief medical examiner, says high workload and associated stress definitely affect residents' lives. "But it is a quantum leap to go from analysing the abuse of residents that may go on in the hospital system and suggesting that that has caused the suicides."

While Markesteyn said work-related stress can exacerbate suicidal ideation, the 3 Winnipeg residents had psychosocial factors in common that went beyond the stresses of their residency program. Two left notes, but

Markesteyn said neither attributed their decision to die to their residency programs.

"Suicide is a very complex matter, and while stress makes pre-existing things worse, it very seldom causes things," he noted. "If people have domestic problems, generally they can better work that out while they're on a vacation in Mexico, and it's very difficult to do that while you're working your guts out. But overwork is not a cause in my opinion."

Dear Sir: Re the deaths of our colleagues

Four representatives from the Manitoba Medical Students' Association, Ashok Modha, Garth Nicholas, Rochelle Vandavelde and Kerrie Wyant, sent the following open letter to Manitoba Health Minister Darren Praznik. It arrived at CMAJ Apr. 30 as the accompanying article was going to press.

Dear Minister:

The recent suicide of a resident in the Faculty of Medicine at the University of Manitoba has sparked a lot of discussion, not only among hospital and university staff but also among the public. This unfortunate incident is the third one in 2 years, giving our medical school the distinction of having the highest suicide rate among Canadian medical schools. Why are residents killing themselves? There is no simple answer, because a number of factors may contribute.

Each physician must go through 7 years of postsecondary education, followed by 2 to 7 years of residency training. This leads to the accumulation of large debts. Residents are paid salaries while training but these are minimal in relation to the number of hours worked.

Having to choose a field to specialize in during the middle of third year at medical school is another harrowing task. What do third-year students know about what sort of specialty they would be interested in? Once accepted in a particular program, residents are locked into this field for the rest of their lives. What if they hate it? What if they want to change fields? Unfortunately, that is not possible the way things stand. The final blow is delivered when the government decides where you can set up practice, how much you can earn, whom you can see, what you can do, and what you can't!

Further difficulties relate to long hours and the resulting stress, which often leads to academic and personal problems. One has very little time to spend with a spouse and children, or with friends and family. This often leads to strain and breakdown of relationships. The resident becomes a lonely person, often with no one to talk to.

Being in the hospital and working for 28-32 hours consecutively once every 3-4 days is an exhausting ordeal.

Most would describe this as inhumane and unhealthy. In addition, with government cutbacks and [fewer] residency spots, a smaller number of residents are left to do the same amount of work. This makes call more frequent and increases the number of patients each resident must look after. Why does the medical profession subject its trainees to this kind of labour? Is it truly in the name of education? Patients have also expressed concern about the quality of care and accuracy of diagnosis and treatment they receive from a doctor who has not slept for 24 hours. Is this kind of care fair to the public?

As medical students, we do not have a lot of the responsibilities that residents have, but we still have to be on call and work long hours. Both residents and students also have frequent examinations that require a lot of reading and research. Thus, even on nights off from the hospital we sit at our desks, burning the midnight oil. This leads to sleep-deprived, exhausted students and residents who are expected to work in a clinical setting looking after patients. Sometimes one wonders if it is the residents and students who should be receiving the care, and not the patients.

People argue that we knew all about these hardships and problems before getting into medical school and question why we chose this career path. But this does not make these rigours right. Medical students and residents work in a teaching hospital to receive good teaching and clinical skills. They are there to learn, not to provide cheap labour. After having invested so much time and effort in this field, the resident expects a good quality of life and a satisfying job. We are the future doctors of Canada and want to be well trained and educated to give our fellow Canadians excellent health care. We do not want to be bitter, burnt-out and cynical MDs at the end of our training, looking for opportunities down south!

We hope this letter outlines some of the concerns and stresses medical students in this province and in Canada feel. We would like you to address these issues, especially those you can directly influence, and hope to hear from you soon.



Common denominator

He said the major common denominator for most suicides may be any combination involving a history of mental illness, drug or alcohol abuse, and domestic problems.

If Winnipeg's Medical Examiner's Office uncovers evidence that the suicides were related to medical residency, an inquiry will be ordered. "I have a responsibility as the coroner," said Markesteyn. "If I feel that there is a problem in the medical community that leads people to their death, we could call an inquest to determine the cause of death. So far we have not done so. I agree this [cluster of suicides] is a statistical anomaly but not that it [necessarily indicates] some systemic problem."

He agreed that the stumbling block for residents under stress is a fear that if they do not pull their weight on the medical floor, future opportunities may be compromised. "Doctors are reluctant to seek help because if it's found out, you become tainted."

Jacyk stressed that residents shouldn't expect that med-

ical staff will be unresponsive to their problems. He has advocated on behalf of residents who knew they had severe problems and needed time away from the program to obtain help.

"I have always found the residency directors to be very supportive. Their universal reaction was 'he should have asked us himself.' I have never been turned down on a request for medical leave and I have found all the programs to be very accommodating. Some of the fear on residents' parts can be seen as just maturing and realizing, 'I really did make it and I really do belong.'"

Jacyk pointed out that residents may receive conflicting messages from the doctors in charge of residency programs. "The main message is that we're all human and you've got to look after yourself. Unfortunately, there's also [the thinking from] the previous generation that says you have to be top notch, you have to be top gun. Not only are we as senior physicians not consistent, there often aren't really good role models who can [exhibit vulnerability while] being on top of their fields.

"Many residents haven't crossed over to see themselves as being colleagues with the medical staff who supervise them. They still see themselves as students and perceive staff as being taskmasters. Perhaps that is one of our problems. We don't treat them as colleagues . . . and let them know we'll take care of them."

An associate professor in the University of Alberta's Department of Family Medicine says one of the hardest things for physicians to do is put themselves in the hands of another medical professional. Among all professionals, says Dr. Fraser Brenneis, physicians may do the poorest job of looking after themselves.

"Physicians often don't have family doctors, which tends to lead to fragmented medical care. It's easier for them to do it themselves. You can always talk to your friend the cardiologist or your friend the surgeon if you think you have a problem. I think the access issue is there and that doctors tend to find it hard to trust someone else to do that for them. It's hard for us to put ourselves in the hands of others."

Brenneis agreed that residency program directors are probably more approachable than residents believe. "I think it very much depends on the program directors and their own personal philosophy. They're often very much easier to deal with than the residents think." ?

The victims

Only 15 months separated the suicides of 3 University of Manitoba residents, the *Winnipeg Free Press* reports.

The most recent death, on Jan. 6, 1997, involved a male resident found dead of a drug overdose in a washroom in the Health Sciences Centre (HSC) in Winnipeg. Aged 28 and married, he was months away from completing a 5-year residency as an anesthetist.

A little over a year earlier, in November 1995, a 26-year-old woman who was a first-year resident in obstetrics died following a drug overdose. She too was found in a washroom in the HSC.

A month before that, a 39-year-old man who had just completed his residency in psychiatry shot himself. He was married.

The *Free Press* says there was also a suicide in the HSC in 1988, when a female resident who had switched specialties injected herself with a lethal dose of potassium.