give work a rest for 2 or 3 weeks.

Develop a group; avoid solo practice as much as possible. We don't train surgeons for 5 to 6 years to send them to remote areas to struggle alone. Grouping avoids this, although some communities in our vast country may suffer from lack of coverage. I would wager that most solo surgeons quickly lose their skills in isolation. The Quebec experiment of rotating coverage in remote communities is one that should be tried throughout our country.

Arrange periodic sabbatical leaves for both educational and social purposes. I was fortunate in my choice of a site for my study time away — I only wish I had taken the opportunity to do it sooner and more regularly in my 30 years of practice.

Give back to society more than it has invested in you. Aside from clinical practice, remember to support volunteer activities in your communities. Donate to charities of your choice, identify with projects that interest you, whether they be theatre, music, church or school. Surgeons should be role models in such behaviour. I have always felt that the excuse of our daily activities as being in some ways voluntary is just a "cop out." It adds to your stature in the community to participate in volunteering, it broadens your social network and it can be truly a fulfilling activity away from the daily grind.

Advocacy

My final category is advocacy. Get involved. Join and support your local, regional or national surgical associations. Bring your collective voices to the political arena. Be constructive. What administrators and politicians need to hear is a unified message from organized groups of professionals willing to stand up for their beliefs.

I have been extremely impressed by the effectiveness of Dr. Hugh Scully during his term as President of the Canadian Medical Association. This skilled surgeon has galvanized the profession into advocating high-quality, sustainable health care for all Canadians, restoration of an adequate work force, a renewed commitment to health care research and, most important, the re-establishment of the leadership role of physicians and surgeons individually and collectively in partnership with other health care professionals at all levels of government. The unification of the profession and the development of alliances at governmental and at community levels has brought physicians and surgeons closer to the decision-making processes that affect our daily lives and our ability to be productive caregivers.

There is an increasing tendency to militancy in our current disputes with government. I know how hard it is to continue working day and night in the absence of adequate numbers of surgeons in our communities. Many surgeons in British Columbia have adopted a strategy that leaves gaps in call schedules. Others have stopped covering emergency altogether. This rather strident behaviour is perhaps understandable in the circumstances. I believe it is unprofessional and ought to be minimized, if not stopped altogether. I think the surgeons who are affected agree with me but have found no solutions forthcoming from administrators and politicians to their more traditional pleas in the past. This situation must be put to an end right across the country. The essential work of general surgeons needs to be recognized and should be appropriately valued by society. We require more Hugh Scullys to explain our case. A mixed message that says we won't work because we're overworked and yet we will if you pay us more money seems a bit inconsistent and such an attitude does not go unrecognized by the public.

There it is, then. Advice to young surgeons that can be accepted, modified, selectively adopted or discarded. True professional behaviour requires a thoughtful response to the situation at hand. I hope that my remarks today have at least provided food for thought and a framework to avoid strident complaining in place of positive action. Whining just won't do.

Reference

1. *Skills for the new millennium: report of the Societal Needs Working Group. The Royal College of Physicians and Surgeons of Canada's Canadian Medical Education Directions for Specialists 2000 Project. September 1996.* Ottawa: Royal College of Physicians and Surgeons of Canada; 1996.

Corrections

In the February 2002 issue of the Journal, the Surgical Images department, musculoskeletal images section (pages 11–15), Figs. 4 and 6 on page 13 were reversed. Fig. 6 should go with the legend to Fig. 4 and vice versa.

The authors of the article "Standard anatomical medullary locking (AML) versus tricalcium phosphate-coated AML femoral prostheses" (*Can J Surg* 2001;44[6]:421-7) would like to acknowledge the research grant given by Depuy, J&J, Raynham, Mass., to support this project, and to thank J.A. Murphy, biostatistician, for his assistance with the analysis.