In his 2001 presidential address to the Canadian Association of General Surgeons, the author offers advice to young surgeons, based on his lifetime experience as a surgical educator, researcher and practitioner. He offers the following samples of wisdom for young surgeons: they should be prepared for a lifetime of learning and be willing and able to adapt to new advances; they should listen to their patients as they describe their presenting complaints and not be tempted to interrupt; they should take time in an emergency situation and remember that split-second decisions can affect the patient for a lifetime; they should be willing to take advice from fellow professionals; they should take time to maintain a quality family life and take adequate time away from the workplace; they should be active be a role model in their community; and, finally, they should get involved and adopt an advocacy role in their profession.

The temptation to rail against the forces that daily tear at our souls as we strive for excellence in our professional lives has been discarded as generally unproductive. First, I sense that we are beginning to see a turnaround in political and administrative circles with increased understanding of the fact that we exist and that we work hard on behalf of our constituencies. Second, we are seen as a necessary cog in the increasingly complex machine that is Canadian medicine today. Third, whining is a soul-destroying activity that seldom rewards the whiner. I enjoy what I do and I feel privileged to be given the opportunity on a daily basis to serve my patients, my students and my peers.

Thus, I have chosen to gather some crumbs of advice from my lengthening career as a general surgeon and to impart them free of charge to the young surgeons of Canada. You will no doubt recognize many scenarios in which you may already have learned these lessons the hard way. You may extrapolate as to how much of a personal confession...
this address represents. I will arrange my remarks into 5 categories: learning behaviour, practice behaviour, interprofessional behaviour, social behaviour and advocacy.

Learning behaviour

In the educational arena I recommend that young surgeons dedicate themselves to lifelong learning. We have at our fingertips many aids to this task. With the development and expansion of the Internet, facts are just a click away. Meetings such as this one where science is imparted in a more personalized way are, of course, a more traditional and highly appropriate way to maintain one’s scientific base. Remember, too, that we are all educators. Don’t forget to involve your peers, colleagues and patients in your educational activities and share with them the pearls of wisdom that you have gleaned from the various sources at your disposal. Pass on the torch to young surgeons in your communities and your environment so that our knowledge base will continue to grow and thrive in the future.

The Royal College of Physicians and Surgeons of Canada has given us the opportunity, through the Maintenance of Certification program, to evaluate our continuing medical education activities and is prepared to advise and “remediate” those of us who find it difficult to keep up in our increasingly complex sphere of surgery.

Remember and adapt the key competencies that have been so well enunciated in the CanMEDS 2000 Project. Each of these roles is a critical component of your formation through the residency program and your continued role as a professional in our society. A specialist is a medical expert, a communicator, a collaborator, a manager, a health advocate, a scholar and a professional. It is interesting to note that the American Board of Medical Specialists has embodied similar qualities, both in their training programs and in their plans for maintenance of certification. They have categorized their general competencies into medical knowledge, patient care, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice. This parallel activity south of the border lends further strength to the argument that we must continue to update our skills and education on a regular basis.

Practice behaviour

Young surgeons perhaps receive too much well-meaning advice in this area. Let me provide a few thoughts of my own. First, listen to your patients and their families. Don’t be tempted to interrupt their initial presenting complaint as we are told so often happens in our busy offices. Remember patients are members of a family, and the family members should be incorporated into all discussions where appropriate. Don’t be judgmental. The patient has learned to live with his or her condition and may have a different view of how it should be managed. Remember to accept alternatives that seem reasonable to you. Don’t be too sure of yourself. It is far better to worry about a surgical decision than to be too cocky as you approach a patient in the operating room. Don’t do too much in an emergency situation. When you have a drowning patient, save their life, don’t give them a swimming lesson. Let the patient live to fight another day. Get help when you are out of your depth unexpectedly. One cannot always anticipate events, especially in the operating room. Take your time. Decisions you make in an instant can affect a patient for a lifetime. Know your own results. The use of information technology is highly recommended in this computer age. I regret the fact that I did not document better my case series. With computer programs, this is now much more readily accomplished. Be the patient’s advocate and practise evidence-based surgery. Don’t be forced into doing something you feel won’t help. In my experience, far too frequently the situation exists when a medical specialist insists on surgery as a solution for the patient and you as a surgeon believe that watchful waiting is a more appropriate course of action. Don’t be badgered into the operating room. Enter it with the confidence of your own convictions. And finally, communicate your thoughts to your patients clearly, and document your conversations and your plans well in your records.

Interprofessional behaviour

Accept the role of fellow professionals in managing your patients. Consult, don’t surprise. Listen to advice from all sources in the conduct of your practice, from nurses on the wards and clinics to the physiotherapists, social workers and technologists whose skills have an impact on the results of your work. Engage all your colleagues willingly in the management of your patient. Don’t criticize in public. Recognize and thank those who help you in your work. This simple civil behaviour pays dividends in the long run.

Social behaviour

Remember, we are social animals. We need to live together in harmony. Don’t play God. Set aside time for relaxation and sleep. Why have we not learned to take a short day after a long night on call? Are anesthesiologists and residents really that much smarter than we are? Dedicate quality time to your family life. No one expects meaningful relationships to thrive on sleepy conversations between midnight and one in the morning.

Take adequate holidays completely away from your work environment on a regular basis. It takes time to understand that the world doesn’t grind to a halt when you...
Advocacy

Activity away from the daily grind. Work and it can be truly a fulfilling experience. It broadens your social network and allows the community to participate in volunteer activities. It adds to your stature in the profession. I have always felt that the exclusion of the public from decision-making processes that affect our profession and the development of alliances at governmental and 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.

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, the restoration of an adequate workforce, 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 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 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


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.