urologists can help their patients before, during, and after treatment through effective counseling of what to expect and of the sexual dysfunction treatments that are available. Physicians should:
• advise patients to be sexually active before treatment, which can improve their confidence and blood flow to the penis;
• ensure that patients and their partners understand that ED treatments might take a few tries to work, and that they should not give up if the first trial with medication is unsuccessful;
• advise patients that recovery of complete erectile function after prostatectomy can take time;
• inform patients that changes in ejaculation will occur after surgery; and
• advise patients to resume sexual activity when they and their partners are ready.

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References

Shaking up health care
Treatment through a collective perspective
Maxine Dumas Pilon, MD

Our health care system is going through a major crisis. In spite of deep cuts, there is a huge deficit, which has left medical professionals, politicians, and patients perplexed. Added to this is a severe shortage of staff. Waiting lists are getting longer. There is public outcry. This situation has left many physicians deeply dissatisfied.

Anatomy of a crisis
Our values as a society are at the heart of the problem. The core values of our society have created the context for the problems we are currently experiencing. One value that comes to mind immediately is the dominance of individual rights over collective rights. The period of virtual tyranny by the Church, during which citizens were rigidly defined by their social obligations, has ended, and the pendulum has swung the other way over the last 5 decades. People are now free to decide whether or not to contribute to their communities. Our society vigorously defends individual rights and freedoms but does not impose the responsibilities that come with them. To propose that it should would likely be viewed as sermonizing.
This mentality has had serious repercussions in the area of health. We hold the notion that our health care system should meet the needs of all individuals with the best means possible and within reasonable time frames. Members of the public are not simply citizens now; they are clients of the public service. Patients are not just patients; they are clients of the health care system. As the current deficit attests, our society does not have the means to provide this level of care for the entire population.

If we add to this society’s denial of disease, aging, and death, the pressure on our system increases tenfold. Improvements to health care postpone disease and death indefinitely, which in turn means that many patients undergo procedure after procedure to put off the inevitable, at considerable cost.

Talking about financial resources in the area of health care is always awkward. After all, how do we put a price on good health or, indeed, on life? Health care does, in fact, have a price. Whether we are considering staff, equipment, or medication, there is a price—a financial side that cannot be ignored.

Few members of the general population or the health professions accept this fact. As individuals, we seem to think that we are entitled to good health, regardless of the cost. As professionals, we seem to think that we owe it to our patients to do everything, or nearly everything, we can. With universal health care, this means that the system must handle unlimited demands with limited resources.

Is the government to blame?
The government generally assumes the management of this system; it is charged with the complex and, frankly, unpleasant task of making it work. Surprisingly, despite excellent health indicators, the public and health care professionals alike often accuse the government of gross incompetence and blame the complex bureaucracy.

We have a tendency to forget that physicians are the primary actors and spenders in this system and that the cost of the system is mainly a reflection of how we use it. We are encouraged to advocate for our patients. Some of us use the system to its limits out of professional concern, a sense of moral obligation, or even fear of being sued. Thus, “bad bureaucratic managers” who restrict access to the system are pitted against “good physicians” toiling on behalf of their patients. A futile dialogue ensues, in which a lot of gesturing leaves the public perplexed and cynical.

Then there are the recommendations of the experts and task forces that shape our practices. These groups also have the interests of patients and, sometimes, the interests of pharmaceutical companies at heart. They establish algorithms for diagnosing and treating various health problems based on scientific findings. They do not, however, have a mandate to ensure that their recommendations can actually be implemented (ie, to ensure that the system has the resources to implement them). For example, the recommendation that an annual sigmoidoscopy be performed on all patients 50 years and older who have a normal level of risk ties up a large number of gastroenterologists, limiting their ability to provide care in other areas.¹

Shock treatment: possibility of a partnership
How can we, as physicians, help to improve this situation while maintaining our sanity? One strategy would be to change our notion of the health care system, replacing it with a more realistic view that does not leave us embittered. Once the animosity has dissipated, a partnership with the government could be envisioned.

Three concepts—communicating vessels, a society in balance, and respect for fundamental truths—are very useful to this task. As we know, the further we push the limits of science, the more patients we save, and the higher the costs. This is usually the point in the discussion when a quasi-unanimous voice says “the government must give us more money”; however, we tend to forget the concept of communicating vessels.

According to this concept, the government has a finite amount of money to be distributed among
the various ministries according to set priorities. Any disbursement to one ministry is done at the expense of another, unless taxes are increased. If the priority is health care, then we can expect poorly maintained roads, underfunded schools, a lack of public housing, cutbacks in cultural programs, and so on. Within the amount allocated to health care, money used to update the infrastructure is no longer available for vaccination programs or for wage increases.

In short, the health of a society, which is probably intimately linked to its survival, depends in part on its ability to find a balance between needs and resources, and on its ability to maintain this balance.

**Notion of common good**

Reintroducing the notion of the common good can be very useful when it comes to accepting the limits of the system. In this sense, some of the difficulties we face as professionals come from widespread denial that we live in a society with limited resources trying to cope with unlimited demands, ultimately forcing us to make choices and set priorities.

Eastern philosophies, in particular Buddhism, might be useful here. Buddhism teaches that part, or even all, of our suffering is a result of a cognitive error that consists of denying certain fundamental truths, for example the inevitability of aging, suffering, and death.

Perhaps some of our frustration comes from the fact that we refuse to accept that, despite all the money we invest, we cannot escape these truths. Coming to grips with them could save us from chronic irritation. Energy expended fighting the system and its bureaucrat-managers could be transformed to energy used to reflect and set priorities effectively. Opposition to the government and its management of the system could be transformed into understanding and, eventually, partnership. The new partners could work toward a common objective: the best care for the greatest number of citizens with the available resources.

How can we, as physicians, become partners? We can cast a critical eye on our practices. Are the tests we order always relevant? Are there cheaper medications that provide the same therapeutic outcome? It is very difficult for physicians to pay attention to costs, due to a lack of time, energy, and, perhaps, even interest. Consequently, we need to create groups within our professional communities to examine these questions. Our biochemists, radiologists, and pharmacists could all help with this task. These considerations must be taught at university. Ultimately, we would need working groups to generate recommendations that take our collective resources into account.

As physicians, we will likely play a leadership role. We can increase awareness in our professional communities about the critical contribution that health care professionals can make to solving this crisis. We can bring this reality to the public as well.

The current health care system is in crisis. Physicians and patients are suffering as a result. One of the ways to lessen this suffering is to bring about a change in thinking and to transform our opposition to the government into a partnership. Why not adopt the environmental movement’s slogan: think globally, act locally.

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