The Canadian Medical Association is promoting dialogue on improving health care through the use of best practices and better use of available technologies. Unless change takes place from the ground up, renewal becomes mere political rhetoric. I urge all family physicians to take up the challenge and become the instruments of much needed change in the Canadian health care system.

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Not getting any closer

I read with great sympathy the Commentary published in the February 2011 issue[1] describing the authors' challenges following Dr Charles Mooney's radical prostatectomy. I see couples like this every month, and I feel their frustration. Younger men are often led to believe that their erectile recovery will be better than that of older men. However, in my practice at the Manitoba Prostate Centre, I do not necessarily see this. Erectile problems after radical prostatectomy are the result of a complex set of anatomical and physiological factors, including nerve damage (even with nerve-sparing surgery), penile tissue hypoxia, and vascular insufficiency.[2] Aggressive penile rehabilitation after surgery remains controversial,[3] and as it is expensive for the patient with no immediate benefit, attrition is high. But perhaps what family physicians need to do *before* developing resources for counseling and for specialized erectile dysfunction treatment is consider the evidence for and against prostate-specific antigen screening. I have commented previously in this journal[4] about the role of family physicians in treatment decision making for men with prostate cancer; however, perhaps prevention is better than cure. These same physicians should take a much closer look at their screening practices, and consider the often tragic trajectory from screening to treatment to lifelong consequences.

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