sued for lack of funding; that no health care system could ever provide every potentially useful service to everybody, always, regardless of how small the benefit and how large the cost; that choices must be made. Aye, there's the rub! Perhaps the absolute "best" and most expensive prosthesis must be denied if it means that more patients can be appropriately treated using a less expensive but perfectly acceptable one.

Those responsible for making the decisions about resource allocation simply cannot adopt the ostrich approach on the larger questions. We have managed in Canada to maintain professional judgement, but we still must exhibit common sense within the freedom we enjoy. Choosing a best consensus antibiotic or hip prosthesis, or care map, involves compromise but makes clinical and economic sense. Such choices are ethical, responsible and necessary.

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Traditionally, the relationship between physician and patient has been on a 1:1 basis. The patient was paying the bill and the physician owed the patient full dedication and attention in providing health care. Those who could not afford the fees appealed to the physician's sense of duty and generosity, and the physician cared from them without any reward. In this modern and not so simple world, and particularly with the advent of third-party payers for health care, be it insurance agencies or governments, the privileged patient–physician relationship on a strictly individual basis is challenged. Physicians, in taking care of the sick, cannot forget or neglect their social duty. Formerly, they did so by honoring the Hippocratic Oath in the care of those who could not pay. Today, in Canada, the state has taken over the responsibility for the delivery of health care and secures all costs. This new reality cannot be ignored.

In his paper, Dr. Gross discusses the issue of the cost of surgical devices and supplies in regard to the surgeon's obligation to act in the best interest of the patient. He takes the stand that "surgeon is responsible for the choice of implant and the consequences of that choice." Although this is absolutely true both ethically and legally, we must not forget that physicians also have a responsibility and duty of optimal utilization of resources over which they have control as a result of their social contract with society. This must not deter the physician from providing services of the highest quality, but this is only one side of the equation, the other being at the lowest possible cost. This is the new paradigm that applies not only to private enterprises in order for them to remain competitive but also to public organizations so that they can continue to provide services at a cost that society can afford, without hampering public finances. Unfortunately, the medical community as a group has not yet been very aware of or sensitive to this aspect of medical practice.

The fundamental issue comes down to the following questions: Since in our society neither the patient nor the physician pays the expenses generated by the use of devices and supplies, can absolute individual freedom of choice be granted to physicians, based on their own preferences, as Gross seems to propose? Or, on the other hand, is it acceptable that physicians be dictated choices made by others, strictly on the basis of cost, not taking into account the ultimate benefit of the patient? The answer to that dilemma is: get involved and participate in the debate and in the decision-making process!

In a cost study performed in my department at the Montreal Heart Institute, it was found that for the same surgical procedure in similar patients and with comparable outcomes, there were differences between surgeons of up to 38% in the cost of surgical supplies, laboratory tests and drug prescriptions and of 26% in the average length of postoperative hospital stay. For our small department of surgery with only 8 surgeons at the time, such differences meant excess costs averaging $375 per patient or a potential saving of over $500 000 annually in supplies, tests and drugs, and the possibility of treating 25% more patients or doing 350 additional operations with the same hospital and surgical facilities. Discussions with members of our department resulted in an average decrease of 18% in the cost of these items and of 28% in the average patient stay postoperatively, within 1

year. This observation demonstrates that with hard data it is possible to change attitudes of physicians in regard to their treatment choices and habits. Refusal to take costs into consideration is most often the result of not being aware of this factor and of what it may represent in the end.

The attitude of the medical community has always been defensive whenever changes were proposed in the delivery of health care. Let us remember the negative reaction to the introduction of the health insurance program in 1970, culminating in the strike of physicians in Quebec. Twenty-six years later, physicians are among the fiercest advocates of the Canadian health care system. Because of costs spiralling in later years, several options have been looked at in order to limit health care expenses to a more acceptable level in regard to our total wealth, which is measured in terms of annual gross national product, and physicians will be faced with a profound mutation of the system if it is to survive. Rather than oppose and fight necessary changes, it would be more appropriate for physicians to become agents of change and put forward constructive solutions. The possibility of participating in the re-engineering of the health care system should be viewed by physicians as an opportunity to have a major impact on its future and a significant influence on the changes that are to be implemented.

If one believes, as Gross does, that the choice of devices and surgical supplies should not be imposed on physicians, then our stand should not be denial of the problem or refusal to change but rather participation and leadership in the decision-making process. Bulk buying offers obvious advantages in terms of costs. Gross contends that when it is instituted, it prevents the process of choice based on performance characteristics of the product that would best fit the particular patient's need. What, then, if surgeons as a group would decide on the devices that should be available in the best interest of the patient? Is it necessary to have all medical devices available on the shelves, just in case? Or is it not possible that all surgeons involved develop a consensus to choose a single device with the optimal characteristics in regard to the needs of most patients and offering the best cost:quality ratio? A good example in my field of practice, is the choice of heart valve prostheses. A wide variety is available on the market. Absolute liberty of choice would probably mean 5 or 6 different prostheses on the shelf. An imposed selection would lead most probably to only 1 type of prosthesis being available, either mechanical or biological, which obviously would not meet the requirements of all patients. The acceptable solution is a decision reached by the surgeons themselves to confine their choice as a group to only 2 prostheses, 1 biological and 1 mechanical, based on a comprehensive evaluation of all significant factors. Does this approach satisfy everyone? Probably not, but it gives a powerful bargaining power that otherwise would not be possible, while satisfying the needs of the patients and the desires of most surgeons. Needless to say, such a decison has to be re-evaluated periodically. In Quebec, this approach has been used for several years, and as a result it is now well known, if not yet fully accepted by industry, that manufacturers have to offer the best prices if they want to maintain their business in this very price-sensitive market.

Not withstanding their duty to the patient, physicians cannot forget their social responsibility, which includes the cost of health care. The current trend to reducing costs of supplies and treatments and the length of hospital stay is irreversible. Developing cost-consciousness among physicians, standardization of processes and modes of practice, ongoing evaluation of patient management, practice guidelines and practice review committees will play an increasing role in everyday medical practice. We, as physicians, might as well take a leadership position in the process rather than merely wait for others to impose their own choices on us.

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The article by Gross is very topical, and he is to be commended for bringing the issue of ethical allocation of resources to the attention of his colleagues and readers of the *Canadian Journal of Surgery.*

The core of his argument relates to the practice of bulk purchasing schemes by hospital administrations. When applied to the area of major joint replacement, Dr. Gross identifies ethical peril. In particular, he argues that such practices create a number of problems, among which are:

- insensitivity to individual patient requirements;
- indifference of individual surgeon's skills and training;
- failure to consider resource implications other than the cost of the prosthetic joint (e.g., staff morale);
- lack of consideration of outcome analysis and the complexity associated with analysing "continuous, longer term events";
- undervaluation of elective proce-