than the cost of operating. Patients not given operations are unemployable, need sickness benefits, remain on multiple expensive medication, and require repeated hospital admissions for chest pains. Money is saved on the surgical units at the expense of the state.

"Has self infliction in any other condition ever barred patients from receiving proper care in Britain?"

But the real issue is not money but ethics. Limited resources should be a problem for the health care system. Instead of withholding treatment, doctors should use their influence in the proper channel.

One surgeon said he would not operate on smokers even with all the resources available in the NHS for he does not wish to construct walls for people who are busy knocking them down. If we accept this argument, then more than half the genitourinary clinics can close down. Asthmatic smokers will not be given nebulisers. It has been argued that damage caused by smoking is self inflicted, hence smokers do not deserve treatment. But has self infliction in any other condition ever barred patients from receiving proper investigation and treatment in Britain? I would like to believe that up to now doctors have always treated patients, irrespective of the degree of culpability of the person concerned. Drunken victims of road traffic accidents are never made to promise total alcohol abstinence before they are given first aid. Patients who attempt suicide are always treated. My view is that once we accept an absolute bar to surgery for smokers, we would next refuse lifesaving treatment to asthmatic smokers and soon may well be on the slippery slope to withholding treatment for the unmotivated and the unfit.

Human frailty should not be penalised

Roger Higgs

"Well, yes, I must admit I smoke."
"I am glad to hear it. A man should always have an occupation of some kind."

Lady Bracknell's marital history taking from the hapless Mr Worthing is still as funny as when Oscar Wilde introduced *The Importance of Being Ernest* to the stage a hundred years ago. But since then attitudes to smoking and to medical care have changed beyond recognition. The modern Mr Worthing's misfortune is no longer that he was born in a handbag, with or without handles. For the young man now who smokes and has coronary artery disease, the uncertainty is from the budgetary plans of the health authority over which Mrs Bracknell now presides.

M J Underwood and J S Bailey give her clear advice. This is an expensive operation, and should not be offered without careful thought. In an area of great complexity, guidelines are vital. Apart from the technical issues, there have been traditionally two separate levels of decision making about such treatments. The first is that of indications (or contraindications). At this level the evidence is carefully considered, based it is hoped on good research, and guidelines are established about the circumstances in which a particular intervention would be helpful. This is quite separate from the consideration of an individual case and should apply whatever the particular circumstances of the health care system in question.

The second level is that of engaged clinical judgment, or advice about an individual's medical care. Here the first level clinical guidelines are of great importance but are certainly not the only issues which lead to the decision. Of course it would be quite wrong from any point of view to recommend a procedure for anyone who would stand to run great risks and reap few benefits from it. But where a positive balance is to be struck, however small, other factors must be taken into account: the patient's wishes, the overall clinical picture, the social situation, and so forth. How widely the net is to be cast is not formalised, but this level of decision making is shared between doctor and patient. The autonomy of both is respected, and the need for mutual exchange of information and understanding underpins the decision. Medical care is not based on prescience but on probability—good guesses, perhaps, but no more. Nobody can predict with certainty the degree of benefit (or the lack of it) in the individual case, but it is assumed by all that the doctor is advising with the patient's manifest best interests in mind.

In between these levels, however, is a third and quite distinct type of decision making, based on the resources available. In a closed system, one person's benefit may be another person's loss or lack of benefit.

"To disenfranchise certain groups for certain types of expensive health care . . . should make us feel uneasy."

There is nothing new in this, except that until recently this has not been part of explicit clinical decision making at the other two levels. This causes confusion unless the reasons are clear and are made explicit. If we are forced to take resourcing factors into account, these have to be openly explained. The health authority must be told by clinicians what benefit could be obtained for whom and to what degree. The cut off point either way is for negotiation. Likewise, the clinician must be open to the patient about the degree of benefit and risks of harm to the individual, and the degree of benefit that the system can offer. Patients should be told which of the three levels they are receiving advice on: whether the treatment is indicated, whether it can be afforded, or whether in balance it is the best for them.

If the information to make the first level decision is available and valid, a scoring system for the individual level could presumably be created which could aid in the individual case. But within this, as Matthew Shiu points out, for coronary artery surgery, smoking would be just one factor among many, even before personal issues were taken into account. The obese diabetic non-smoker who takes no exercise and has a poor family history, for example, might well stand to reap fewer benefits than the exercising smoker without other risk factors, and so on. In selection for surgery, if we abandon the universally available queue and reject a lottery we should presumably be aiming at more overall quantification as an aid in the traditional process of clinical judgment.

Good clinical judgment is thus seen as consistent and

fair, but also imaginative and flexible for individual need. Although it may seem a neat solution to disenfranchise certain groups for certain types of expensive health care, nevertheless it should make us feel uneasy. People with self destructive behaviour or an addiction are clearly less able to control their own decisions; they are less autonomous. There are huge internal and external pressures on some individuals to smoke. After the second world war, when cigarette smoking had almost become part of the war effort, George VI's death from lung cancer was a tragic symbol of its potential effects. Mrs Thatcher's involvement with the multibillion pound international tobacco industry is a symbol of an altogether different type. Our government currently refuses to endorse the European Community's recommendations about restrictions on advertising. It is thus possible to see the modern Mr Worthing as a victim: to blame him and to remove an important line of treatment deals a double blow to his health and seems manifestly unjust.

Much ethical writing, in dealing with issues of justice in medical treatment, distinguishes between distributive and retributive justice.[1 2] It thus keeps separate the questions of allocation of resources and of punishment (or reparation). But there is an awkward connection here which is seldom noted. It is very easy to suggest that people whose medical ills can in some sense be blamed on themselves are somehow less deserving cases: and in so doing we come close to a different sort of judgment, and to prescribing punishment. When it comes to human frailty, our job is better seen as supporting rather than penalising it. Perhaps because smoking is not now common among doctors, it is easy to add this to the list of "deviant" qualities which make patients seem to be a different sort of breed. Substitute "drinking" or "overworking" for "smoking" and the picture becomes more clear.

The case that smoking greatly worsens the prognosis for cardiac surgery of this type is overwhelming, but a blanket ban on operations for smokers seems to derive from confusion between different levels of judgment and the evidence appropriate to each. It is not supported by clinical ethics or good sense, and probably not by the broader context of applied scientific thinking. Other things being equal, Mr Worthing should be allowed on to the waiting list.

1 Beauchamp T, Childress JF. *Principles of biomedical ethics.* Oxford: Oxford University Press, 1983.
2 Gillon R. *Philosophical medical ethics.* Chichester: Wiley, 1985.

Let the health authority take the responsibility

John Garfield

The tests of acceptability of any form of treatment or management lie in that word, much beloved of the lawyer, "reasonable." Unfortunately it is difficult to view ethical issues dispassionately, whereas semantics lends itself to cool logical argument. There lies the clash between emotion and intellect, and only the dishonest doctor would deny that we manage patients with a combination of both.

Within the limits of statistical validity, the expert cardiologist, cardiothoracic surgeon, and epidemiologist can produce figures for the failure rate, the early and late postoperative complications, the reoperation rate, and the prospects of success for coronary artery bypass vein grafting. As a layman in those fields, I am prepared to accept that the results in patients who continue to smoke are significantly poorer but that there are still some smokers who will derive benefit from surgery.

But today the expert brings before us some new weapons: the cost of each procedure, the limitation of resources available, and the army of non-smokers who patiently await surgery that is indisputably indicated. By contrast the general practitioner has fewer weapons in his sole duty to the individual patient, for whom he seeks benefit, however meagre the prospects of success.

The cardiothoracic surgeon's view is reasonable, because he supports it with "reason." The general practitioner is caught by emotion, and is freed unrealistically from any wider duty to a healthy and a sick society.

What neither seems prepared to do is to put the ball firmly in the public's court and to turn the problem on to the public umpire. The conclusion of the cardiothoracic surgeon should be that, in view of the much better results achieved with patients who stop smoking, he will give chronological priority to those patients. When there are no longer any limitations upon resources, the smokers will reach the head of the queue. Let the umpire produce the resources.

"Turn the problem on to the public umpire."

I am reminded of a chairman of a health authority who foresaw that we must practise medicine in a world of limited resources; the millennium had ended. I offered to stand at the front door of our department and to turn away patients with severe head injuries whom we knew had a 98% chance of either dying or surviving in a persistent vegetative state, despite our best and very expensive endeavours. The proviso was that the public umpire stood at my side. But answer came there none.