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.

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