Access to heart surgery for smokers

Denying treatment is indefensible

EDITOR,—M J Underwood and J S Bailey believe that coronary bypass surgery should not be offered to smokers.[1] Medical professionals tend to ignore the fact that they are appointed in the NHS to provide service to patients on the basis of their clinical needs irrespective of their shortcomings and degree of culpability. After all, it is the money of taxpayers (smokers and non-smokers) that is used to train cardiac surgeons and to pay their wages. The taxpayers, in return, expect them to provide prompt and efficient service when required. I am sure that no cardiac surgeon would refuse to operate on a smoker if he or she was paying a handsome fee as a private patient.

We should all feel privileged to be in a position to make decisions affecting the lives and livelihoods of our fellow beings and resist the temptation to abuse our authority. Those who believe that smokers should not be offered necessary investigations and treatment solely on the basis of their habit, in my opinion, have an indefensible case. Gentle persuasion and counselling are the only decent ways of changing a patient's lifelong habit.

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1 Underwood MJ, Bailey JS, Shiu M, Higgs R, Garfield J. Should smokers be offered coronary bypass surgery? *BMJ* 1993;**306**: 1047-50. (17 April.)

Denying access more costly

EDITOR,—I am encouraged that ad hoc rationing of health care by some surgeons is being openly debated and exposed to public scrutiny.[1] If continued smoking is to be a contraindication for some operations then clearly a consensus view is needed, based on factual and ethical considerations, since for too long patients have been denied surgery that may substantially improve their quality of life simply because they have been referred to the "wrong" surgeon.

It seems, however, that the current debate is based not on fact but on prejudice. M J Underwood and J S Bailey seem to have two main objections to offering surgery to smokers: firstly, that the risks of perioperative complications and graft failure are increased and, secondly, that resources are being denied to non-smokers, who may benefit more from such surgery.[1] The second point is simply an assumption for which no evidence is presented, and, as Matthew Shiu points out, the cost of not operating may be higher.[1] Increased risks of surgery or lower success rates should not deter the surgeon as long as the overall odds remain in the patients' favour, yet Underwood and Bailey seem only to be saying that a risky operation is a little more risky in smokers.

Similar attitudes may be met with in peripheral vascular surgery, as some surgeons deny bypass grafting to patients with claudication if they continue to smoke. Rather than reflecting concern for patients' wellbeing such an approach is in keeping with the authoritarian medical persona, well described by Bennet,[2] or even the "contempt for the patient" which Balint has noted.[3] The doctor carries a latent resentment of the patient, who represents more work and stress, and this occasionally surfaces when the opportunity to castigate the patient arises, particularly if the patient's behaviour threatens to undo hours of hard work. Though understandable, such a patronising attitude is never justified. Experience has also shown me that rules regarding smokers may be bent for articulate middle class patients, and in private practice smokers are gladly taken on since an occluded graft means more money. Inevitably, therefore, lectures, threats, or actual denial of treatment to smokers simply seem to be another manifestation of power exerted by the medical profession, usually over the inarticulate or the poor, with a basis only in prejudice.

If surgeons wish to deny smokers treatment they should provide hard evidence to justify doing so; until then such denial must be considered unethical and an abrogation of the Hippocratic Oath.

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1 Underwood MJ, Bailey JS, Shiu M, Higgs R, Garfield J. Should smokers be offered coronary bypass surgery? *BMJ* 1993;**306**: 1047-50. (17 April.)
2 Bennet G. *The wound and the doctor.* London: Secker and Warburg, 1987.
3 Elder A, Samuel O, eds. *While I'm here doctor.* London: Tavistock, 1987.

Each patient a special case

EDITOR,—The following case might contribute to the debate on access to treatment for smokers.[1] Some years ago, Mr AB was referred to our psychiatric department by the cardiothoracic surgeon. Mr AB was a 49 year old man with a two year history of severe chest pain and syncopal attacks after a large anterior myocardial infarction. He was assessed as needing a heart transplant. Although he had been seen by the cardiac surgeon he had been told that he would not be placed on a waiting list for heart transplant surgery until he stopped smoking. Mr AB told me that he had been a very heavy smoker (60 cigarettes a day) all his life. He was the father of three young children and had been a successful businessman until he became ill. He was now near bankruptcy. He had drastically cut down his smoking to three cigarettes a day, which he felt very proud to have done. He knew that he could have died at any moment. I asked the surgical team to reconsider placing Mr AB on the waiting list while he was still smoking three cigarettes a day. He had a successful transplant and stopped smoking immediately.

I think this case illustrates the danger of "policy making" when dealing with individuals who are threatened by death because of their disease. Unfortunately the surgical team's policy on smoking had colluded with the patient's anger at his losses and at his life threating illness. Mr AB was angry at the surgeons who had failed to recognise his real effort at trying to stop smoking. In addition he had always been an active and independent man until his illness had made him totally dependent on others, especially doctors; being told to stop smoking was like giving up the last thread of control that he had over himself. M J Underwood and J S Bailey mention counselling for patients to help them stop smoking before treatment. I saw Mr AB only twice, did not try to make him stop smoking, and instead insisted that he should receive treatment despite his smoking. As Matthew Shiu points out, denying treatment because smoking is self inflicted could lead to flaws in clinical judgment which might be potentially lethal.

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1 Underwood MJ, Bailey JS, Shiu M, Higgs R, Garfield J. Should smokers be offered coronary bypass surgery? *BMJ* 1993;**306**: 1047-50. (17 April.)

Smokers waste valuable resources

EDITOR,—We agree with M J Underwood and J S Bailey that smokers should not be offered coronary bypass surgery[1]—and would add to this that they should also not be offered coronary angiography (which is, in most cases, pointless if there is no possibility of subsequent revascularisation). The key issue is limitation of available resources. For the reasons given by Underwood and Bailey, smokers consume more resources than non-smokers and the results achieved in smokers are worse. In addition, it is vital to motivate smokers as strongly as possible to give up smoking. Forceful advice to do so coupled with a policy of not performing angiography or bypass surgery on smokers is likely to be an effective way of doing this.

We therefore believe that the best use of resources is achieved by not offering angiography or coronary bypass surgery to smokers and that this is the overriding consideration in this argument. We also welcome John Garfield's point, that wider debate is needed on issues of resource allocation.[1]

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1 Underwood MJ, Bailey JS, Shiu M, Higgs R, Garfield J. Should smokers be offered coronary bypass surgery? *BMJ* 1993;**306**: 1047-50. (17 April.)

The NHS can't treat only saints

EDITOR,—In their endeavour to secure maximum benefit to patients from specialist treatment in the present climate of scarce resources M J Underwood and J S Bailey put forward a cogent case for not offering coronary bypass surgery to smokers.[1] They seem to base their argument on three counts: limited resources; an increased failure rate in smokers; and the fact that the damage caused by smoking is self inflicted.

Limitation of resources could be used only to