surgical colleagues, performing epidemiological, pathophysiological, and interventional studies along with medical assessments. A European consensus document on management of critical limb ischaemia emphasises the importance of medical input to minimise morbidity and mortality.4 Every good vascular unit deserves an interested physician because surgeons and interventional radiologists cannot treat all the bits of a body affected by systemic atherosclerosis.

We agree with Warlow that stroke is treated haphazardly. The general physician-angiologist can readily define the overall risk of vascular disease in a patient with stroke (who is more likely to die of a cardiac or pulmonary event than a further neurological event) and can institute secondary prevention of vascular disease in survivors of stroke as well as in patients with peripheral vascular disease.

In conclusion, five part time angiologists in Britain is too few, but we agree with Warlow that the immediate appointment of 1000 is clearly too much for the NHS. It seems reasonable, however, to suggest a planned increase to one per million population by the end of this century under the aegis of a British modification of the European working group’s proposal. Initially it seems reasonable to appoint angiologists to work as regional vascular units, extending the scope of peripheral vascular disease services and coordinating preventive vascular medicine in collaboration with the various agencies currently involved in vascular diseases. Our goals are to improve the understanding and management of vascular diseases. We do not believe that the arrangements that Warlow describes are best placed to match these challenges.

**Access to heart surgery for smokers**

**Persuade smokers to give up before surgery**

EDITOR,—Correspondence following on from M J Underwood and colleagues’ article discussing whether coronary bypass surgery should be performed on smokers has been of two types: showing common sense derived from experience—as, for example, the letter from the cardiothoracic unit at Wythenshawe Hospital—and that displaying the misplaced idealism of non-smokers.

At Manchester Royal Infirmary our cardiologists are more lenient towards smokers than are the cardiologists at Wythenshawe Hospital; our policy as surgeons, however, is to list patients for cardiac surgery only if they will stop smoking. If a patient has smoked recently the operation is usually deferred for a few months to allow time for the lungs to recover. This is not vindicтивес: optimising the patient’s condition before operation is a basic surgical principle that surgeons ignore at their peril (even in the private sector).

With such a policy it is not a question of surgeons choosing whether or not to operate on smokers; the doctors will decide to operate or not base their decision on the patients’ smoking status.

**Wartime cigarette rations hooked a generation**

EDITOR,—I am retired. I am not and have never been a smoker. I am dismayed at the decision of some who have operated on cardiac (and possibly other) surgery to patients who smoke. I studied and qualified during the second world war. At that time many young men, and some women, of my age group were in the forces, having a pretty hard time. Cigarettes were provided for those in the services at prices they could afford and, indeed, were sometimes free. People in the services were actively encouraged to smoke during the war. My husband, who was in the Royal Navy throughout the war, has often said to me: “A cigarette was your friend then, it helped you to get through the fear, the loneliness that you sometimes had; it helped you to go without food during action stations. We were encouraged to use cigarettes as ‘a quick energy boost’ and I don’t know what I would have done without them.”

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Smokers pay taxes too

EDITOR,—In his Rock Carling monograph in 1988 Sir Cecil Clothier, formerly the parliamentary commissioner and health service commissioner, stated: ‘In normal year a healthy working man or woman may pay several hundred pounds per annum towards health insurance and pay it compulsorily by deduction from earnings at source. Under the national health service, however, the patient’s experience is free only at the time of delivery. The patient’s contribution to the care received is not negligible and a healthy person may have paid a very substantial part of the cost of the service actually delivered to him or her by the time some illness requires hospital treatment. Because a bill is not rendered and a cheque received at the time of discharge, some doctors have come to feel that patients are the recipients of charity or a “welfare hand-out” for which they should be humbly grateful.’

Perhaps those doctors who have decided that coronary bypass surgery should not be offered to smokers’ should reappraise their attitude as employees of the NHS and, indirectly, of taxpayers.

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