surgical colleagues, performing epidemiological, pathophysiological, and interventional studies along with medical assessments. A European consensus document on the 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 with regional vascular units, extending the scope of peripheral vascular disease services and coordinating preventive vascular medicine in collaboration with colleagues in general medicine, cardiology, neurology, vascular surgery, interventional radiology, and general practice. Acknowledge the need and help us secure training and accreditation in angiology, and we will provide further proof that we are needed.

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Europe already has them

EDITOR,—Innovative proposals never meet with universal approval, yet we welcome the debate C P Warlow has sparked regarding the role of medical angiologists.[1]

We do not feel it necessary to analyse the prevalence of vascular diseases, nor their related human, social, and financial costs, as the importance of the clinical area is not in dispute. As befits the *BMJ*, Warlow's article defines the situation from his perspective, with a special accent on Britain. We accept that, in some situations, the various agencies currently involved in care should if coordinated meet the needs of patients with vascular disease, but we suspect that such arrangements are neither universal nor rational. Indeed, the particular value of the medical angiologist is that his or her interest in the vascular system is not limited by anatomical site or risk factor. Given the ubiquitous nature of atherosclerosis and clustering of risk factors, this holistic view is very important. It is also important to remember that vascular diseases concern arteries, veins, the lymphatic system, and microcirculation.

Warlow's call for us to prove our worth belies the fact that there are, in continental Europe, numerous centres in which medical angiology is well acknowledged in terms of both research and patient care. Medical angiology is also recognised as a specialty or a subspecialty in Switzerland, Italy, and Germany. France is moving in the same direction.

Specialisation produces tangible effects: in Switzerland, for example, the specialty of medical angiology has been in existence for three years, with improvements in screening, diagnosis, and treatment of vascular disease. Furthermore, the desire to establish a specialty in medical angiology and vascular medicine is not just a European goal. Even though medical angiology has deep historical roots in Europe, the United States is rapidly developing centres, and the specialty is also recognised in Australia.

There is a need to train specialists who have an understanding of the vascular system in its entirety rather than a traditional, organ centred approach. There will be a continuing requirement for basic training in internal medicine to underpin such knowledge, in common with the European Community's position on other medical specialties. We believe there is an important role for the medical angiologist but that cooperation with specialists in closely related fields will remain fundamental. 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.

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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[1] has been of two types: that showing common sense derived from experience—as, for example, the letter from the cardiothoracic unit at Wythenshawe Hospital[2]—and that displaying the misplaced idealism of non-combatants.

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 on the understanding that 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 vindictiveness: 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 patients are made to take responsibility for their condition. When the seriousness of their predicament is fully explained most patients who smoke have the sense to stop.

Occasionally we have to operate on a smoker because of an urgent cardiac condition. There is no doubt that such a patient has a much higher risk of developing serious respiratory complications than a non-smoker, as well as being less likely to do well long term if smoking is continued. Over the past year we have had a few patients who required ventilation for several weeks because of post-operative adult respiratory distress syndrome; almost all had smoked until shortly before surgery. It is both our Hippocratic and our economic duty to prevent such cases whenever possible, for the sake of both the patients concerned and those non-smoking patients whose operations would be cancelled because of blocked beds in the intensive care unit.

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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 a 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 scheme, therefore, health care 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.[1]

Perhaps those doctors who have decided that coronary bypass surgery should not be offered to smokers[2] should reappraise their attitude as employees of the NHS and, indirectly, of taxpayers.

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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 surgeons to refuse cardiac (and possibly other) surgery to patients who smoke.[1]

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 almost as therapy, and I don't know what I would have done without them."