occur even in older patients with severe chronic obstructive pulmonary disease.

At a population level, the importance of smoking cessation is paramount. Peto has estimated that current cigarette smoking will cause about 450 million deaths worldwide in the next 50 years. Reducing current smoking by 50% would prevent 20-30 million premature deaths in the first quarter of this century and about 150 million in the second quarter. Preventing young people from starting smoking would have a more delayed but ultimately even greater impact on mortality.

Effective prevention of cigarette smoking and help for those wishing to quit can therefore yield enormous health benefits for populations and individuals. Promoting and supporting smoking cessation should be an important health policy priority in all countries and for healthcare professionals in all clinical settings. However, this has not so far generally been reflected at a policy level or in the practice of individual healthcare professionals.

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The ABC of smoking cessation is edited by John Britton, professor of epidemiology at the University of Nottingham in the division of epidemiology and public health at City Hospital, Nottingham. The series will be published as a book in the late spring.

Competing interests: RE is chairman of North West ASH (Action on Smoking and Health); he receives no financial reward for this work. JB has been reimbursed by GlaxoWellcome (now GlaxoSmithKline) for attending two international conferences, has received a speaker's honorarium from GlaxoWellcome, and has been the principal investigator in a clinical trial of nicotine replacement therapy funded by Pharmacia. Both these companies manufacture nicotine replacement products.

BMJ 2004;328:217-9

Stopping smoking before or in the first three to four months of pregnancy protects the fetus against the reduced birth weight associated with smoking. Preoperative cessation reduces perioperative mortality and complications

Key points

- Cigarette smoking is one of the greatest avoidable causes of premature death and disability in the world
- Helping smokers to stop smoking is one of the most cost effective interventions available in clinical practice
- Promoting smoking cessation should therefore be a major priority in all countries and for all health professionals in all clinical settings

Further reading

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My lousy doctor

My senior attending physician recently told me, "A physician who treats himself, has got a lousy doctor." This he said while being hospitalised just a few days after having a myocardial infarction. Feeling an uncontrolled severe reflux for two days, he had finally recorded an electrocardiogram "just in case." Seeing the inferior wall Q waves and remnant ST segment elevations, he still waited to show the electrocardiogram to a cardiologist, who eventually made him go to the emergency room.

Shortly after, on an unforgettable evening, I suddenly felt the worst abdominal pain I have ever had in my life. I knew, palpating my lower abdomen, that severe tenderness, rebound, and guarding are not good prognostic signs, but I ignored them and hoped everything would disappear by morning.

It didn't. I had mild fever the next day, and the pain subsided, but when, on the third day, my temperature rose I had to reconsider my situation. I thought that, although it is quite shameful for an internist (newly certified, mind you) to show up in the emergency department with a case of acute gastroenteritis, perhaps a surgical consultation would be appropriate. After receiving two litres of intravenous normal saline, I persuaded the surgeon that it might truly be a case of acute gastroenteritis. I decided myself to take a short course of antibiotics, and felt better. I even went back to work. I stopped the antibiotics after three days of treatment, because three days are enough.

That evening I felt much worse. The next day, I couldn't drag myself home, and the fever returned. We (that is, my wife) decided to pay another (reluctant) visit to the emergency room. The on-call resident diagnosed colitis. By now, I was running up and

down the differential diagnosis, but could conclude nothing. It was 3 am, and luckily the surgeon decided to hospitalise me; so I was now forced to stop diagnosing and treating myself.

After data revision, the "colitis" turned to be acute diverticulitis with a small pericolonic abscess. Yes, this disease is known to occur most commonly in elderly people, and, sure enough, when my good hearted colleagues came to visit they had plenty of jokes at my expense. One warned me of my next hospitalisation due to catheter related urosepsis, and another asked for my "Do not resuscitate" status and transfer to a long term facility. I had to stay in hospital for six days of intravenous antibiotics (and jokes).

These were surely the worst two weeks in my life. Can you imagine the daily "Do nots" from my wife? And being preached to by both my mother and mother in law? Pain and fever paled into insignificance compared with having to listen to my mother, every day, repeating, "A doctor must not take care of himself," and with my mother in law reminding me "You must rest" again and again.

I am now much better and back at work. In a month or so, I will have to experience the wonders of the gastroenterological evaluation, this time not as a doctor. Thus, my mother and mother in law were correct (I can't believe I just wrote that); so was my senior attending physician, although realising it a little late (I wonder if his mother preached to him too): "A physician who treats himself has got a lousy doctor."

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