get any complaints (however hopeless you are at real medicine). The evidence from medical protection societies backs this up.

2. You only need to know about 10 medicines really well — that should cover most problems, from high blood pressure to urine infections. Steroid or antibiotic creams work for most skin rashes.
3. It's considered professional to know your limits and that means you can look things up. The *British National Formulary (BNF)* is a sort of doctors' bible on drugs and explains everything you need to know about prescribing in the UK. Anything else, you can look up on a website called *GP Notebook* — an online textbook of general practice, covering most things you're likely to see.
4. Anything not covered by 1–3; refer to a specialist.

How hard can it be? I can't wait.

Dr Imposter exists only in the imagination of the author, and no real patients have come to harm in the writing of this column.

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Tobacco harm reduction: thinking the unthinkable

We all know smokers who can't or simply won't stop smoking. They cough, they wheeze, and they completely fail to respond to our NICE-approved brief interventions, indifferent cajoling, or spittle-flecked threats of impending doom. It has been over 60 years since Doll and Hill published the landmark study on the harmful effects of smoking yet since then millions of Britons have died of tobacco-related disease.¹ Doctors offer up a stark choice to patients: stop smoking or die. The profession has a visceral hatred of Big Tobacco but it is clouding our judgement when it comes to public health policy. Faced with the potential of a billion smoking-related deaths in the 21st century we need to consider a third way: tobacco harm reduction.

Smokeless tobacco comes in a variety of forms; Swedish-style snus is a moist tobacco product placed under the upper lip. E-cigarettes produce a vapour composed of water, propylene glycol, and nicotine, so users are not exposed to all the toxicants, the carcinogens, and the free radicals formed when tobacco is burned. We know how staggeringly difficult it is to give up smoking. Cessation rates for smokers are rarely better than 10% and in people with mental illness or other addictions, smoking remains near ubiquitous. The most disadvantaged groups in society pay the biggest price with devastating health consequences that widen inequalities.²

The Royal College of Physicians published a report in 2007 which recognised the case for tobacco harm reduction and NICE will publish guidance on the topic in 2013.² The reduction of harm from smokeless tobacco is around 98–99%. The evidence that smokeless tobacco acts as a 'gateway' to cigarettes is not there. The concern that smokeless tobacco will deter and delay full abstinence is dwarfed by the mathematical relationship governed by the relative risks. If this wasn't tobacco and if there wasn't the bogeyman of Big Tobacco casting his shadow it would be a no-brainer. We all know that nicotine is highly addictive, but the harm from cigarettes comes from all the other substances piggy-backing, not the nicotine per se. One back-of-a-fag-packet calculation has suggested that smoking for just 1 month is more dangerous than switching to a smokeless

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nicotine product for a lifetime.³ It could save millions of lives.

The opposition to smokeless tobacco verges on the fanatical. Perhaps it's an understandable gut response from the health profession who have borne witness to the misery and death inflicted by tobacco but, whether it is Swedish-style snus or e-cigarettes, we need to recognise that the health risks associated with these are several orders of magnitude less compared with normal cigarettes. For some it is unthinkable but GPs, who pride themselves on their pragmatic patient-centred approach to medicine, need to keep an open mind to the potential of tobacco harm reduction to benefit our patients. The next time you are faced with a raddled, wrinkled smoker unable or unwilling to stop it may be worth remembering the third way.

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