

ceased or reduced smoking before surgery compared with less than 10% of those in the control group.¹¹ The intervention group was much less likely to experience postoperative complications, especially wound healing and cardiovascular complications, and to need secondary surgery. A Cochrane review found that intensive behavioural interventions with patients admitted to hospital were associated with higher quit rates when linked to follow up contact for at least a month.¹²

Given this evidence, it is arguable that resources expended on smoking rooms might be better used to fund a concerted effort to implement a smoking ban and to expand smoking cessation activities. Hopefully other hospitals facing a similar situation will act differently in the future.

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Comparing cannabis with tobacco

Smoking cannabis, like smoking tobacco, can be a major public health hazard

Britain now has 13 million tobacco smokers. This number has been steadily decreasing due to public awareness of the harm caused by tobacco smoking. At the same time the number of cannabis smokers is increasing. Between 1999 and 2001, the number of 14-15 year olds who had tried cannabis rose from 19% to 29% in boys and 18% to 25% in girls, and a Home Office document estimates that 3.2 million people in Britain smoke cannabis.^{1 2} However, the harmful effects of smoking cannabis are widely known and have recently been highlighted.^{3 4} Although the active ingredients of the cannabis plant differ from those of the tobacco plant, each produces about 4000 chemicals when smoked and these are largely identical. Although cannabis cigarettes are smoked less frequently than nicotine cigarettes, their mode of inhalation is very different. Compared with smoking tobacco, smoking cannabis entails a two thirds larger puff volume, a one third larger inhaled volume, a fourfold longer time holding the breath, and a fivefold increase in concentrations of carboxyhaemoglobin.⁵ The products of combustion from cannabis are thus retained to a much higher degree. How is this likely to translate into adverse effects on health?

We already know that regular use of cannabis is associated with an increased incidence of mental illnesses, most notably schizophrenia and depression,⁴ but it is also worth examining its potential to cause other illnesses, especially those of the heart and respiratory system.

At present, there is an understandable dearth of epidemiological evidence of cardiopulmonary harm from cannabis, because its use is a relatively new phenomenon and its potency is changing. The amount of the main active constituent, tetrahydrocannabinol (THC), in cannabis has increased from about 0.5% 20 years ago to nearer 5% at present in Britain, whereas "Nederweed" (the variety smoked in the Netherlands) has an average of 10-11% tetrahydrocannabinol. At the same time little study has been undertaken of any concomitant change in the content of tar. Case-control studies are difficult to perform since cannabis cigarettes do not come in standard sizes, which makes dose-response relations difficult to establish. Furthermore, most users of cannabis also smoke tobacco, which makes it difficult to dissect out individual risks. As with tobacco, there will be a latent period between the onset of smoking and the development of lung damage, cardiovascular disease, or malignant change.

Tobacco smoking is responsible for 120 000 excess deaths each year in Britain, 46 000 from cancers, 34 000 from chronic respiratory disorders, and 40 000 from diseases of the heart and circulation. However, there are indications that smoked cannabis may cause similar effects to smoking tobacco, with many of them appearing at a younger age. Smoking cannabis causes chronic bronchitis, emphysema, and other lung disorders, which were recently summarised in a review released by the British Lung Foundation.³ A striking feature of cannabis smoking is that it is associated with

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bullous lung disease in young people.⁶ Inflammatory lung changes, chronic cough, and chest infections are similar to those in cigarette smokers, but may also be commoner in younger people.⁷⁻⁹ Premalignant changes have been shown in the pulmonary epithelium, and there are reports of lung, tongue, and other cancers in cannabis smokers.

Tetrahydrocannabinol has cardiovascular effects, and sudden deaths have been attributed to smoking cannabis.¹⁰ Myocardial infarction is 4.2 times more likely to occur within an hour of smoking cannabis.¹¹ However, despite these alarming facts, there is no evidence at present on whether smoking cannabis contributes to the progression of coronary artery disease, as smoking cigarettes does. More studies of the cardiovascular and pulmonary effects of cannabis are essential.

It may be argued that the extrapolation from small numbers of individual studies to potential large scale effects amounts to scaremongering. For example, one could calculate that if cigarettes cause an annual excess of 120 000 deaths among 13 million smokers, the corresponding figure for deaths among 3.2 million cannabis smokers would be 30 000, assuming equality of effect. Even if the number of deaths attributable to cannabis turned out to be a fraction of that figure, smoking cannabis would still be a major public health hazard. However, when the likely mental health burden is added to the potential for morbidity and premature death from cardiopulmonary disease, these signals cannot be ignored. A recent comment said that prevention and cessation are the two principal strategies in the battle against tobacco.¹² At present,

there is no battle against cannabis and no clear public health message.

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People missing as a result of armed conflict

Standards and guidelines are needed for all, including health professionals

Mass graves from past or present conflicts, massacres in the Balkans, disappearances—South American style—and the missing in action are politically sensitive. One reason is that they usually entail violations of international humanitarian law (the wartime rules that protect people who are not in combat or no longer in combat) or human rights law. International criminal tribunals to try individuals believed to be responsible for the violations attract equal attention. Why these events and the reactions to them by the international community are of direct concern to health professionals is not immediately obvious, although it has been widely recognised that they have an important part to play in upholding such laws.^{1 2} However, the specific roles, responsibilities, and expertise of the profession either in ascertaining the fate of the missing or in helping affected families have not been as widely recognised.

The story of people unaccounted for as a result of armed conflict or internal violence is told differently according to the narrator's discipline. Each discipline has its own work and objectives. Lawyers uphold international law and attempt to prosecute the perpetrators of violations; forensic specialists identify remains, contribute to the reconstruction of events surrounding the death, and establish the cause of death. Psychologists address the kind of mental torture associated with

uncertainty of the whereabouts of a family member. Military bodies emphasise the importance of measures such as the wearing of identification tags and registering deaths of their personnel. Red Cross workers respond to families' requests to trace a missing person and to visit and register prisoners of war. This is an incomplete list, and each discipline has worked largely in its own sphere. Furthermore in a given situation there are different actors each employing, manipulating, or even hindering the work of the different disciplines. These actors may be the governments, military bodies, international organisations including the United Nations, and non-governmental organisations. Clearly it is time for standards and guidelines on best practice for all professionals.

The International Committee of the Red Cross has been forced into undertaking an initiative, "The Missing," which has taken the form of a series of expert workshops and studies and a review of its own practice over time and by continent. The outcome has revealed ambiguity about the legal and ethical basis of any action involving forensic specialists, the lack of best practice guidelines to guide these specialists, the difficulty of accommodating local customs and culture in an investigation, and recognition of an inconsistency of the International Committee of the Red Cross's own practice with regard to missing people. At centre stage, however,