Letters to the Editor

since the reference area of the hospital is one of the most disfavoured in the city of Barcelona. In our study, in fact, social conditions were not assessed because the absence of social issues is a requirement for admission to the short stay unit. In case of detection of a social problem, during the stay in the short stay unit, that will require the implication of social resources as a result of which an increase in the length of hospital stay may be expected, the patient is transferred to another service. In this case, the admission was considered inappropriate and excluded from the analysis. We should not relay on sociosanitary policies or on resources available in the 1980s and 1990s to criticise this aspect. As an example, at the present time our hospital has a 206-bed reference sociosanitary geriatric centre. Although social resources offered in our country are far from being hypothetically ideal, both social awareness and availability of resources have substantially improved in recent years.

In respect to a longer length of hospital stay for women compared with men because women are care takers, this opinion is merely speculative. Factors associated with this aspect were not the objective of the study and, therefore, were not evaluated. Again, Manzano-Santaella insists on the limited social resources available in Spain, without taking into consideration the progress achieved in the past few years.

Finally, we agree that social assessment is an indispensable task in older patients and that resolution of social problems influences length of stay in conventional hospitalisation units. In short stay units and due to their characteristics, this circumstance should not occur. A clinical study aimed to facilitate the decision-making process of individual patients in a particular unit should not be confused with a social-oriented study focused on social issues associated with health problems in subjects of old age.

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What determines the ability to stop smoking in old age?

SIR—In his overview on factors determining the ability to stop smoking, Dr Allen has provided a useful reminder that cigarette smoking remains one of the most preventable causes of disease and premature death, even in later life [1]. Physicians are uniquely positioned in a role through which they can ‘reduce the enormous toll of tobacco use by acting at the public health and public policy levels’ [2].

While among the barriers to smoking cessation by older people are the concept of ‘damage done’ and that of smoking being an ‘integral part’ of an older person’s life, one factor which did not feature in the review was clinician failure to promote smoking cessation in older people. A study in 2000 found clinicians less likely to promote smoking cessation to older patients: a cohort of hospital doctors from different grades and specialties showed marked disparities in their decisions to advise patients on smoking cessation, depending on the patient’s age. Seventy-five per cent of younger patients (65 or younger) would be offered advice compared with 64% over 65, 42% over 76 and 30% over 85 years of age [3].

Among the factors underlying this physician behaviour may be a low level of awareness of both the efficacy of smoking cessation and of the general plasticity of ageing in later life. Evidence of the positive effects of smoking cessation on older people is strong, with a reduction in the risk of death within 1 or 2 years for older smokers who quit compared to recalcitrant smokers [4]. At a broader level, in their paper aptly titled ‘It’s never too late’, Vaupel and colleagues showed that interventions in advanced old age can switch death rates to a lower, healthier trajectory [5].

Successfully addressing smoking cessation for older people is a worthwhile task, and with better clinician knowledge of inherent ageism among clinicians, we could find one less barrier to this important imperative.

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