

Health impact of smoking – an unforgiveable omission in a doctor’s repertoire

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Dear editor

Rahman et al¹ should be thanked for their discussion-provoking paper investigating the smoking behavior of patients and staff in a hospital based in Melbourne, Australia. The authors hoped to gather epidemiological data surrounding smoking, information on dependence to nicotine, and attitudes toward both the health impact and quitting strategies of smokers.

The authors decided to use a cross-sectional study design, limiting knowledge of the temporal outcome. This was further limited by a 2-hour time frame for data collection, meaning cohort inclusion was representative of a time of day rather than whole population. Data would be ideally collected over a week or month, for 24 hours each day to ensure adequate recruitment. The study would have been further reinforced by grouping of study participants, giving the reader further insight into smoking characteristics. The authors acknowledge smokers are less likely to have taken part in the study than non-smokers, also impacting on result reliability. This bias may even be more pronounced in health professionals due to potential embarrassment.

Limitations aside, this paper is of interest, with hospital staff less likely to smoke (7% compared to 16% in general population).¹ The paper raises a serious concern regarding the fact that hospital staff are not aware of the extent of smoking side effects. While this may include both medical staff and non-medical staff due to methodological oversight, it is concerning enough to warrant further attention and study. It also highlights the need for undergraduate education on smoking and for rigorous research skills, as without either of these, the problem identified will only continue.² The authors should be thanked for raising this pertinent issue.

Disclosure

The author reports no conflicts of interest in this communication.

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Dear editor

This cross-sectional study was undertaken as one of the awareness-raising activities conducted in the study hospital during the World Health Organization World No Tobacco Day and there was only a window of opportunity to collect data.¹ We agree that having a longer time frame, including a representative sample of both patients and health care staff, and categorizing the professions involved, would have revealed further useful data but it was beyond the scope of the study and practical feasibility. We aimed to have a 'snap shot' of smoking behavior in a large metropolitan hospital. The cross-

sectional study was deemed as anonymous (and therefore non-threatening), so people were happy to take part in it as there was no way of identifying them or of follow-up. It was designed with a view to providing pilot data and ascertaining if there was any cause for concern. This became evident in the results. The finding of lack of awareness among hospital staff, although not categorized, was alarming indeed. While Australia is considered as a pioneer in tobacco control and the hospitals are smoke-free, lack of awareness regarding health effects of smoking even among the non-medical staff working in the study hospital is not acceptable. We agree with Lemon regarding the need of undergraduate education to address this issue but raising awareness at professional workplaces to address knowledge gaps is also required. Most importantly, hospital policy needs to consider tobacco use as an important issue across the hospital, irrespective of admission departments and commencing from history taking until discharge of patients, following examples from New Zealand.²

Disclosure

The authors report no conflicts of interest in this communication.

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