Giving up smoking is easier for patients with access to telephone counselling

Research question Can telephone counselling help people to quit smoking?

Answer Yes. A series of calls from a counsellor works better than advice given during routine visits to a primary care doctor.

Why did the authors do the study? The US national action plan for smoking cessation recommends the setting up of telephone quitlines to provide counselling and access to drug treatments for people who want to stop smoking. Telephone counselling may be convenient for patients, but it's still unclear whether it works any better than the straightforward advice given by primary care doctors during the course of a routine consultation. These authors wanted to find out.

What did they do? 837 smokers from the American midwest took part in a randomised controlled trial. All of them wanted to quit, and most had already tried and failed at least once. Four hundred and seventeen participants had telephone counselling to help them through a maximum of three quit attempts over 12 months. They had a mean of seven calls each, or a total mean talk time of 123 minutes. They were encouraged to use drugs such as nicotine patches, which were sent directly to their home address by post. The 420 controls received self help material by post, but otherwise had face to face advice and treatment only if they visited their primary care clinic. Most made at least one visit during the 12 month study.

The study was single blind. The authors used intention to treat analysis to see which group of participants was most likely to quit for at least six months. They also looked at more short term abstinence from smoking (seven days) and at the proportion of patients in each group who had used additional drugs such as nicotine patches, gum, or slow release bupropion.

What did they find? By the end of the study, 13% (53/407) of participants in the telephone counselling group had stopped smoking for at least six months, compared with only 4% (17/414) of controls (odds ratio 3.5 (95% CI 1.99 to 6.15)). Those who had received help by phone were also more likely than controls to have quit for at least a week (40% *v* 10%; 5.84 (4.02 to 8.5)) and more likely to have used drugs such as nicotine patches or gum (90% *v* 52%; 7.85 (5.34 to 11.53)). All outcomes were self reported.

What does it mean? In this study, fairly intensive telephone counselling worked significantly better than ad hoc advice given during primary care consultations. As the telephone service included both counselling and direct, easy access to drugs, it's hard to say which component made the biggest difference. But it's likely that both were important, say the authors. The participants were mostly older men (mean age 57) who had smoked heavily for a mean of 40 years. Many had smoking related diseases, and most had already tried to give up and failed. So the results may not be generalisable to women, or to men with a less powerful addiction problem.

An LC et al. Benefits of telephone care over primary care for smoking cessation. *Arch Intern Med* 2006;166:536-42.

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Editor's choice

Where next for the research assessment exercise?

The rules for deciding who gets public money for research in the United Kingdom are set to change. The world's largest research assessment exercise (RAE)—which has dominated the lives of UK academics for the past 20 years—is to be ditched after the next round in 2008, and consultation begins next month to find an alternative. This week's *BMJ* carries the first of a series of contributions debating the future of research assessment in the UK and around the world.

Many will welcome an end to the tyranny of the RAE. It has clearly succeeded in concentrating funds within selected high performing institutions, which was the government's aim, but at a high cost, say its critics. The cost includes distorting the research agenda by favouring pure science over applied or practice based research and encouraging safe, mainstream research that will deliver publications within a few years. Riskier, longer term research, research in small fields, and multidisciplinary research are disadvantaged, as are academics who teach rather than do research. Eric Thomas, vice chancellor of the University of Bristol, quoted in this week's *News*, says that the system causes "massive planning blight" for 18 months either side of each assessment (p 994). Others complain that it has created a football-style transfer market, with institutions buying in research stars on inflated salaries.

Richard Hobbs and Paul Stewart are more upbeat about it (p 983). The cost is justified, they say, by the improvement in quality of research in the UK, and reforms to the system have addressed many of the criticisms. However much they are improved by these reforms, the RAE and other systems for allocating research funding around the world must take the blame for the neglect of basic clinical research highlighted by Peter Rothwell two weeks ago (15 April, pp 864-5). Roger Jones takes up the baton in a letter this week, calling for better funding for primary care and health services research (p 1036). With a dig at non-clinical researchers, he writes, "Translational (research) doesn't just mean getting the protein out of the test tube and into the zebra fish, but getting the therapeutic intervention into the patient and the population."

How do you think we should rate research? We would like your answers, as rapid responses via bmj.com.

And there are other questions in this week's journal. Should we screen for depression?—which in the UK means, should general practitioners be rewarded for screening for depression as part of the quality and outcomes framework (p 1027)? Is it possible to predict which students will struggle at medical school (p 1009)? And will Tony Blair's gamble on further healthcare reforms destroy him before it destroys the "old monolithic NHS" he so deplors (p 984)?

Fiona Godlee editor (fgodlee@bmj.com)

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