

EDITORIALS

Smoking cessation strategies

Time to be more realistic in our expectations of interventions to help quitters

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Telephone lines devoted to supporting smoking cessation (quitlines) hold great promise because they are relatively inexpensive and highly accessible.¹ Busy doctors who lack confidence in dealing with seemingly intractable smoking might be relieved to refer their patients to these specialised services, which are increasingly available worldwide. It is not clear, however, that they deliver the expected outcomes. In the linked randomised controlled trial (doi:10.1136/bmj.e1696), Ferguson and colleagues compare standard quitline support plus both free nicotine replacement therapy (NRT) and six follow-up calls with standard quitline support alone.² Importantly, this trial was conducted in England, where NRT is already free to smokers trying to quit. In addition to providing information about the effect of making the pathway for receiving NRT even more unimpeded than it already is, the study's findings help to answer two central questions about assisted smoking cessation.

Firstly, what proportion of smokers wanting to quit are interested in receiving support and medication in an environment where NRT is already provided free via doctors? Researchers in this field often note that many smokers do not use the treatment correctly or for sufficient time, and they suggest that professional support can improve outcomes. However, it is not clear how many smokers are interested in receiving such support. Of interventions to support smoking cessation, contacting a quitline involves the least inconvenience and cost. Yet research shows that very few smokers seem prepared even to call a quitline—6% seems to be the best rate achieved—despite such services being highly publicised, with quitlines being listed on all cigarette packs in some countries.³⁻⁵

The results of the current study invite questions about how acceptable the offered interventions are to smokers who express interest in quitting. Of 75 272 smokers who made contact with the quitline and expressed interest in quitting over the recruitment period, 26 468 (35%) agreed to receive further support, but only 5355 (7%) agreed to set a quit date. Most calls to quitlines are therefore not from those on the cusp of quitting. Many who access quitlines may want to know how to go about quitting but are not yet ready to try. In this trial, it seems that some people who accessed the quitline may have done so via the web or by interactive television. They might therefore have

been less inclined to agree to a telephone based form of ongoing support because people tend to use the mode of communication they feel most comfortable with and online support is increasingly popular.

In the small group of trial participants who were motivated to quit and willing to receive further support, take up of the offered intensive telephone follow-up was similar to the use of such interventions among standard care participants, probably because these interventions are already widely accessible in England. This finding is important because it challenges the assumption that offering ever more intensive telephone support might increase quit rates and suggests that there is probably an upper limit to consumers' acceptance of more intensive support based interventions.

Secondly, does assisted cessation offered in real world conditions match the outcomes achieved in clinical trials of such interventions? Ferguson and colleagues report that, at six months, clients randomised to the offer of free NRT had marginally lower self reported cessation rates than those who participated in standard telephone interaction. They also reported that quit rates were significantly lower in this first group once validation by measurement of exhaled carbon monoxide was taken into account: 6.6% of those in the NRT arm were carbon monoxide validated as having quit, compared with 9.4% of those in the no NRT arm (odds ratio 0.67, 95% confidence interval 0.50 to 0.90).

Cross sectional and cohort studies of real world cessation mostly show that those who quit smoking unassisted have better long term success rates than those who use medication, which contrasts with the findings of clinical trials of treatment assisted smoking cessation.^{6,7} This difference could possibly be explained by more dependent smokers who have poorer prospects for cessation being more likely to use medication. However, indication bias does not apply in this study, because those who made contact with the quitline were randomised, and levels of dependency were comparable across all three arms of the trial. Yet in spite of this, being offered readier access to free NRT was associated with worse outcome. This may imply that providing NRT in a way that required very little effort on the part of the smoker might have had unintended consequences:

perhaps by undermining its perceived value to smokers or their commitment to using it properly. Provision of NRT is no substitute for determination to quit. Although, motivation to quit by itself is often insufficient too,⁸ most ex-smokers finally seem to quit without professional or pharmaceutical assistance.⁹

Even though clinical trials of NRT assisted smoking cessation show that the intervention has promise, such interventions seem to have less effect in real world population-wide circumstances.^{10 11} It may be a waste of resources to make NRT more easily available to those who are not inclined or not ready to use it, or to those who prefer to quit on their own. Expectations about the difficulty involved in quitting may be falsely lowered by routinely offering NRT, and this may reduce success per attempt.¹¹

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