Letters

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Motivational interviewing for smokers

Soria and colleagues used trained physicians to give motivational interviewing (MI). Physicians recruited and randomised using sealed envelopes. The distribution of patients favours MI with 114 people in the MI group and 86 in the brief advice group. The *P*-value for the χ^2 for goodness of fit to the binomial distribution is 0.048. Patients in the MI group were more likely to intend to stop smoking or consider it than those in the brief advice group measured by stage of change ($P = 0.036$). Neither of these values prove that randomisation was subverted, but sealed envelopes are notorious for this. Were checks made?

Five people in the MI group received bupropion, but none in the advice group. Bupropion doubles the likelihood of cessation.[1] The authors used logistic regression to potentially adjust for confounders if significant, but this leads to important confounding. Epidemiologists recommend adjusting for a range of potential confounders regardless of their statistical significance.[2]

The outcome assessment makes interpretation difficult. The outcome is point prevalence abstinence for an undefined period measured by the physician giving treatment. MI patients had up to three sessions with the outcome assessor to motivate cessation, while those in the brief advice arm had one. Might those in the MI arm have felt pressure to declare abstinence when it was not fully achieved? Most smokers have an exhaled carbon monoxide in the non-smoker range by overnight abstinence.[3] Additionally, most who are point prevalent abstinent do not achieve lifetime abstinence, which is the outcome linked to health benefits. If the authors have the data, it would be preferable (and in line with recommendations)[4] to report sustained abstinence for 6 months between 6 and 12 months, as around 30–40% of these patients will achieve lifetime abstinence.

Soria *et al* compare the odds ratio for MI in this study (6.25) to the odds ratio from the meta-analysis in the Cochrane review (1.56) of individual behavioural support for smoking cessation.[5] These are not comparable interventions. MI, like brief advice, primarily motivates patients to attempt to stop smoking. Behavioural support assists people who have already stopped smoking. In the UK, we have a network of smoking cessation services, but the rates of advice to stop smoking given by GPs are low and more than 90% of quit attempts do not use this support.[6] The test for MI is whether teaching GPs these skills could change this.

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Ever been HAD?

If I may be allowed to respond to Dougal Jeffries' letter in the November Journal,[1] I would like to come back with the following:

I must apologise to Dougal Jeffries if I wrongly assumed that his column was suggesting that the use of depression severity measures like the Hospital Anxiety and Depression Scale will encourage antidepressant prescribing.[1] On re-reading his original column, I note that he suggests that the QOF is 'a Trojan horse' aimed at 'subverting general practice to the ends of … the pharmaceutical industry, and their academic comrades-in-arms'.[2] I took this to imply that he thought the use of measures like the HAD scale would encourage prescribing. Clearly, I have perceived a subtlety in his column which he didn't intend.

Dougal is not surprised that use of the HAD scale leads to more selective prescribing of antidepressants, but seems to dismiss this as rather unimportant. He challenges me to respond to the deeper thrust of his opinion piece. I share his concern that the routine use of depression scoring scales may detract from the human interaction between doctor and patient, but I think he is wrong in suggesting that it would be almost impossible to gather evidence for and against this proposition. Together with colleagues in Liverpool, we are just about to start qualitative interviews with doctors and patients on their views of the new depression measures. It wasn't really possible to gather such evidence until after the depression measures had been introduced into the contract, since practices who had decided to use the measures voluntarily would not be representative of all GPs.