worth bearing in mind the increased risk of overdose, hospital admissions, morbidity, and mortality associated with methadone, that may negate the cost difference.

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REFERENCES

1. Wright NM, Sheard L, Adams CE, *et al.* Comparison of methadone and buprenorphine for opiate detoxification (LEEDS trial): a randomised control trial. *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X613106.
2. Petitjean S, Stohler R, Déglon JJ, *et al.* Double blind randomized trial of buprenorphine and methadone in opiate dependence. *Drug and Alcohol Depend* 2001; **62**(1): 91–104.
3. Pinto H, Maskrey V, Swift L, *et al.* The SUMMIT Trial: a field comparison versus methadone maintenance treatment. *J Subst Abuse Treat* 2010; **39**(4): 340–352.
4. Nielsen S, Dietze P, Cantwell K, *et al.* Methadone and buprenorphine related ambulance attendances: a population-based indicator of adverse events. *J Subst Abuse Treat* 2008; **35**(4): 457–461.
5. Bell JR, Butler B, Lawrance A, *et al.* Comparing overdose mortality associated with methadone and buprenorphine treatment. *Drug Alcohol Depend* 2009; **104**(1–2): 73–77.
6. Jones ES, Moore BA, Sindelar JL, *et al.* Cost analysis of clinic and office-based treatment of opioid dependence: results with methadone and buprenorphine in clinically stable patients. *Drug Alcohol Depend* 2009; **99**(1–3): 132–140.

DOI: 10.3399/bjgp12X625058

QOF should be more about disease and risk factors prevention

I urge a radical re-thinking of the obesity QOF system. QOF should be far more about disease and risk factors prevention. As there may be debate around the concept of obesity as a problem rather than a disease, there should be little doubt that obesity is a significant problem.¹ Obesity has been associated with cardiovascular disease, premature death, stroke, non-insulin-dependent diabetes mellitus, gout, gallbladder disease, GORD, asthma, joint problems, and several types of carcinomas. Abdominal obesity [increased waist-to-hip circumference ratio (WHR)] should be recorded as more closely correlated with metabolic disease and even malignancies.² Clinically I find it difficult to accept that patients may be diagnosed as obese without

being first warned to be overweight and advised accordingly. Healthy lifestyle education should be a core activity of primary care workers and I am concerned that some non-profit organisations may be better at managing weight than GPs are.³ The paper from Phillips and colleagues told us that dietary counselling by clinicians in primary care is sub-optimal, and perhaps the same could be said about physical exercise advice.⁴ Bobbioni-Harsch and colleagues have shown how metabolically normal obese subjects could be at increased risk of cardio-metabolic diseases. Furthermore, their findings suggest that high BMI, alone or with fasting insulin, negatively affects the cardio-metabolic profile.⁵ Interestingly, patients may be more upset by being told that they are obese, or scared of having their weight checked, than being told about high cholesterol or abnormal glucose tolerance. GPs tend to avoid using the term 'obese' and often prefer to use a euphemism. They are aware that the term obese may upset the patient. It has been shown that the term obese makes patients believe that the problem has more serious consequences and makes them feel more anxious and upset than when the same symptoms are labelled using a euphemism. I strongly advocate for more regular use of the weight scale in primary care, as there is a continuum from normal body weight to obesity and the early identification of a trend of excessive weight gain may be both clinically more beneficial and less upsetting for the patient.

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REFERENCES

1. Heshka S, Allison DB. Is obesity a disease? *Int J Obes Relat Metab Disord* 2001; **25**(10): 1401–1404.
2. Björntorp P. The associations between obesity, adipose tissue distribution and disease. *Acta Med Scand Suppl* 1987; **723**: 121–134.
3. Jebb SA, Ahern AL, Olson AD, *et al.* Primary care referral to a commercial provider for weight loss treatment versus standard care: a randomised controlled trial. *Lancet* 2011; **378**(9801): 1485–1492.
4. Phillips K, Wood F, Spanou C, *et al.* Counselling patients about behaviour change: the challenge of talking about diet. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X616328.
5. Pataky Z, Makoundou V, Nilsson P, *et al.* Metabolic normality in overweight and obese subjects. Which parameters? Which risks? *Int J Obes (Lond)* 2011; **35**(9): 1208–1215.

DOI: 10.3399/bjgp12X625067

Let us take blood

Medical students nowadays often report difficulty in gaining experience in performing routine venepuncture. In the past, students were regularly expected to take blood from hospital patients, allowing them to become very competent in the procedure before qualification. However, phlebotomists now do the majority of in-patient venepuncture, leaving few opportunities for students to learn and improve their confidence with this procedure.

One excellent way to overcome this problem is for GP practices to take on students as phlebotomists. This benefits both the student and the practice staff. Not only is the student given extensive opportunities to practice blood-taking, but he or she also gains experience of working efficiently in a clinical setting and putting knowledge from medical school into practice. In addition, if the post is paid, this can help fund student life [although many students will still be prepared to undertake this work on a voluntary basis].

Having a medical student phlebotomist allows the practice to offer more appointments for venepuncture and allows practice nurses to carry out more specific nursing tasks. The university holidays are times when practice staff will want to take holiday, so the student can be employed on a regular basis during the vacation periods. Staff can delegate simple patients to the medical student for venepuncture and blood pressure monitoring, in order to focus their own time on more complex patients or on management tasks.

As a medical student, I was extremely keen to work as a phlebotomist when the opportunity arose and have now worked at the same GP practice for three vacation periods. Due to my relative inexperience with venepuncture initially, I was given 4 days of training by the practice nurse. Learning to use the computer system was also an important skill that I had to get to grips with early on. There is no doubt that my ability to communicate and relate to patients has really been enhanced by this experience.

It appears that taking on medical students as phlebotomists is uncommon in general practice, even on a voluntary basis. This seems a shame as employing a student to take blood can be highly advantageous to everyone involved. We would really urge GPs to consider this option in the future when approached by medical students.