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

Hardeep K Bhupal,

GP, Forensic Physician, Northamptonshire Police Force.
E-mail: hkbhupal@hotmail.com

REFERENCES

1. Wright NM, Sheard L, Adams CE, *et al.* Comparison of methadone and burprenorphine 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 buprenophine 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.

Edoardo Cervoni,

Tarleton Group Practice, The Health Centre, Gorse Lane, Tarleton, PR4 6UJ.
E-mail: cervoni@nhs.net

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.

Joanna Loudon,

Medical Student, 64/5 Thirlestane Road, Edinburgh, EH9 1AR.
E-mail: J.Loudon-2@sms.ed.ac.uk

Susie Nickerson,

Murrayfield Medical Centre, Edinburgh.

Published online first 19 August 2011
DOI: 10.3399/bjgp11X595620

A non-traditional method of teaching general practice to medical students: notes summarising

For some medical students, it is necessary to undertake part-time work alongside their medical studies. Graduate students on 5-year courses, who do not receive NHS bursaries like their peers on graduate-entry courses, and students from low-income families may be in this group. The looming rise in tuition fees to £9000 per year may increase the number of students needing to work. While traditional student jobs such as bar and retail work are also open to medical students, healthcare-related jobs may be more beneficial. Healthcare assistant jobs are popular among medical students and a call has been made by Louden and Nickerson for GPs to employ students as phlebotomists.[1] Here I present another option: medical records summarising.

Locum GPs and trainees, especially, may not be familiar with a patient's long history. It is helpful for a summary of the patient's history to be presented in a readily accessible format, in other words, to be summarised. A summariser reads all the correspondence in a record and highlights the pertinent details. For medical students, this is an opportunity to learn how to write clinical letters and the GP approach to a wide range of presentations. I first learned of psoriatic arthritis by noticing that many patients with psoriasis also had arthritis, before my dermatology and rheumatology rotations, showing the educational value of summarising. Students also benefit from having a paid, usually flexible, position to increase their funds. The GP benefits by having employees who do not require costly medical terminology courses, and are possibly quicker and more accurate, as students already know what medical history is relevant.

Problems could arise if the practice is located at a university campus where the student might know some of the patients registered. However, such problems could be avoided by giving students clear guidance and education on their obligations in safeguarding patient data. Doctors should also ensure that students' part-time duties do not interfere with their medical education and it may be helpful to have more than one student. To dissuade students spending too long 'learning' rather than summarising, my GP employer awards 10 pence per record summarised, above the basic wage.

Having assisted in the auditing of records for the QOF, I feel I have gained an insight into general practice above the level expected for a medical student. I therefore urge more GPs to consider advertising summariser jobs with their local medical schools in the first instance.

Nigel Mabvuure,

Brighton and Sussex Medical School, Audrey Emerton Building, Eastern Road, Brighton, BN2 5BE.
E-mail: N.Mabvuure1@uni.bsms.ac.uk

REFERENCE

1. Loudon J, Nickerson S. Let us take blood. *Br J Gen Pract* 2012; **62(595):** 69–70

DOI: 10.3399/bjgp12X625076

What do we actually know about the referral process?

Whatever the true picture regarding GP autonomy and variation in referrals to secondary care, it seems likely that most of us have at least some interest in how our referrals compare with others.[1] Inevitably this has come under the current financial spot light. We are being told to make less referrals, find cheaper solutions, still practise safe, evidence-based medicine and, on the sharp end of NHS care delivery, explain all this and apologise to patients.

Our local PCT provided us with data related to our referrals to hospital outpatient clinics that resulted in patients being seen only once. Their interpretation of this crude data was that these referrals could therefore be seen as unnecessary. When I looked more closely at the cases involved it included One-Stop Clinics (for example, haematuria and DVT) and suspicious moles and breast lump referrals.

Ask any GP and there are often multifactorial reasons behind a referral. If some of these referrals are truly inappropriate then by all means provide us with feedback, but at least make certain the data is meaningful and accurate so that reasonable and valid conclusions can be drawn. And don't make sweeping policy decisions based on erroneous conclusions.

Peter Perkins,

Southbourne Surgery, Bournemouth.
E-mail: peter.perkins@dorset.nhs.uk

REFERENCE

1. Davies P, Pool R, Smelt G. What do we actually know about the referral process? *Br J Gen Pract* 2011; **61(593):** 752–753.

DOI: 10.3399/bjgp12X625085

Physical activity and health: it is a democratic right to ignore scientific evidence and common sense, but it is not wise

Some readers, while possibly entertained by Dr Fitzpatrick's tabloid-style column, should wonder how it is possible for his opinions to be published in a peer reviewed journal, based on research he confesses he has not read or is not aware of, therefore not understood and unable to suitably reference. Like his original article,[1] he cites his opinions as if they are fact and is unable to refer to any relevant research to justify his views.[2]

Fitzpatrick's heartfelt extremism on public health matters is very unbalanced and personal. We hope most readers will thankfully not be able to take these opinions seriously. More worryingly, with new NHS GP commissioning, there is now nothing stopping a person with such unjustifiable views from becoming a public health service commissioner.

Fitzpatrick's assumptions about physical activity reflect as much about his own dire educational needs as they do a medical education system that appears to have failed and is still failing him.[3,4] There is an enormous body of scientific evidence on the health benefits of physical activity, and he