

Letters

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The meaning of the handshake towards the end of the consultation

During an appraisal I was challenged on how I recognise a consultation has gone very well. I suggested, in my experience, those ending in a seemingly spontaneous patient-initiated handshake may provide one important sign. However, there was no published evidence supporting this hypothesis.

Over a 12-month period all patients offering a handshake towards the end of their consultation were asked to complete a short questionnaire exploring the reasons for expressing themselves in this way. Patients were asked only once over the study period.

Sixty-six patient-initiated handshakes (55 males, 11 females, aged 23–86 years) were received. These occurred within 5368 consultations representing 1.2% of all consultations and over just one per week. Patients gave 145 reasons for offering a handshake. These were collated into identifiable groups,

Most handshakes (83%) were offered by men. This concurs with data from psychological settings where carer-initiated handshakes were more common between male than female dyads and least likely between cross-sex dyads.^{1,2} Most handshakes (79%) were given in approximately equal frequency over several age bands from 40–79 years.

The majority of reasons given for handshaking (87%) were related to patients' perceptions of the doctor, the consultation, and their clinical care. These reasons were grouped into the effect of the consultation on the patient (27%), perceptions of the doctor (19%), verbal communication (18%), outcomes of the consultation (12%), and overall satisfaction with care (11%). Only

13% of reasons related to patients' own social and cultural beliefs.

This small study suggests that most handshakes offered by patients towards the end of consultations reflect patient satisfaction — 'the happy handshake'. Indeed, many reasons were recorded using superlatives such as 'very' and 'much' representing a high level of patient satisfaction — 'the very happy handshake'.

Many patient-centred aspects of the patient–doctor interaction were associated with handshakes. Indeed, the handshake seems related to the interpersonal effectiveness of the doctor in terms of verbal communication, empathy, trust and compassion. These are human qualities, the expression of which, are known to be important in care,³ difficult to measure,⁴ and probably best assessed by patients.^{5,6} This behavioural patient feedback may compliment other methods of feedback currently in use for evaluating doctors' interpersonal effectiveness.⁴

Further research is needed to explore the patient-initiated handshake as a marker of these important aspects of quality of care in general practice

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Tuberculosis in primary care

I was glad to see a primary care-based study and accompanying editorial on tuberculosis (TB).^{1,2} For those of us working in areas where TB is no longer rare, reminders of the growing problem and diagnostic pitfalls are welcome. We know that at least one-half of TB cases are among people born abroad, in places where prevalence has always been high. In addition, among refugees arriving here, as many as 50% may be infected with TB; worldwide, over 17 000 refugees get sick with the disease every year.³ Tourism, international travel and migration are helping TB to spread. Other displaced people, such as homeless people in the UK, are at increased risk of being infected. Wherever it occurs, we need to recognise it is difficult to treat TB in mobile populations, and most of the challenge rightly falls on community and primary care services.

Yet, despite the Chief Medical Officer's action plan, there are still gaps in our management of TB in this country causing us to fall below internationally accepted standards of care. GPs deserve better, clearer guidelines on diagnosis and treatment, including:

- An emphasis on the need for sputum microscopy for detecting acid-fast bacilli as *the* definitive diagnostic test, with added value in public health terms of identifying infectious cases.⁴ Chest X-rays and other investigations are difficult to interpret and should not be recommended to GPs.
- On diagnosis, an explicit discussion with the patient to reach agreement on a treatment plan. GPs need to build a mutual accountability between patients and their

key health worker (such as a community TB nurse, ideally). The rights of patients to confidentiality, the health worker to concordance, and the community to patient care and contact tracing are complex and often neglected.⁵

- The adherence to standard uniform courses of treatment such as the highly effective WHO regimens. GPs are perfectly capable of initiating and monitoring treatment with these guidelines, and without them, are unnecessarily afraid of treating TB and leave it to respiratory physicians. There is plenty of evidence internationally that they are no better at curing TB with non-standard regimens, and consistency improves the chances of adherence to cure and the prevention of drug resistance.

Patients with TB want to be diagnosed and treated in the community with the support of their GP. Is it not time that the UK adopt a National TB Control Programme on international lines, and support primary care to deliver this?

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What students say about '5 a day'

In their qualitative study about obesity in young people, King, *et al*, found that GP's perceived there were significant barriers to patient compliance with advice on food intake and exercise.¹ By contrast, healthcare students are a group who may be more likely to comply with advice on healthy eating. In December 2006 we conducted a

cross-sectional, confidential questionnaire survey to assess the attitudes and behaviour of healthcare students towards eating five or more portions of fruit and vegetables per day.

Three hundred questionnaires were distributed in a lecture for first year healthcare students at St George's, University of London. Two hundred and twelve students responded giving a response rate of 71% (212/300). The mean age of responders was 22 years old and ranged from 18–54 years old. They described their ethnicity as white British; 49% (104/211), Indian; 14% (30/211), and 37% (77/211), were from other ethnicities. The students were studying medicine; 44% (93/211), physiotherapy; 16% (34/211), biomedicine; 13% (27/211), nursing; 9% (19/211), diagnostic radiography; 13% (27/211) and therapeutic radiography; 5% (11/211).

Although 61% (128/211) of responders said that they tried to eat '5 a day', we found that only 17% (35/210) reported actually eating five or more portions of fruit and vegetables on the previous day. This is identical to the 2005 Health Survey for England in which the rate for five-a-day consumption of 16–24 year olds was also 17%.² In our population we found no difference in fruit and vegetable consumption between men and women, but British white students and postgraduate students were more likely to eat '5 a day' than the remainder. Therefore, 22% (23/104) of British white students ate five or more portions the day before compared with 12% (11/105) of students of other ethnicities ($P = 0.023$) and 26% (12/46) of postgraduates ate five a day compared with 14% (22/162) of undergraduates ($P = 0.043$).

Through asking the students to answer how many items of a given fruit or vegetable would constitute a single portion we also found that many healthcare students did not have a good understanding of portion size. For instance, only 11% (23/203) were able to guess the correct number of apricots that make up a single portion of fruit (the answer is three). Half (105/210) of the students also felt that there is not enough promotion of '5 a day'.

We found over 80% of this group of UK healthcare students failed to eat five portions of fruit and vegetables daily. As

King, *et al*, imply, it is scarcely surprising if GPs feel they have an uphill struggle to change the behaviour of many of their obese patients!

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Dance as a form of exercise

I read 'Dance as a form of exercise' by Zoe Bremer, with great interest.¹ One form of dance which wasn't mentioned in her essay, is 'modern jive' also known as 'french jive', 'Ceroc', 'Le Roc' among others, and is very extensive in the UK, especially in London and the South-East.

This is a very exciting form of partner dance that can be done to almost any type of popular music and looks a little like rock'n'roll to the unpractised eye. It is often advertised as the dance for anyone with two left feet, because there are no specific steps to worry about, most of the moves being lead from the upper body, but one nonetheless needs to move around the floor a lot, thus providing excellent aerobic exercise.

A normal evening of modern jive consists of the beginners' lesson, followed by a short period of 'freestyle' whereby one can practice what has been learned, to music. This is followed by the intermediate lesson. At this point, some clubs will also provide a beginners' consolidation lesson in another room. The intermediate lesson is followed by freestyle dancing to the end of the evening at about 11 pm. Most clubs will provide 'taxi' dancers who are there specifically to help the beginners practice the moves; and all for about £6. Modern