

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

jive is such a fun and sociable form of exercise. It is not absolutely necessary to go with a (dance) partner, because partners switch around all evening and jive with everyone present. It is just as acceptable for the ladies to ask the guys for a dance, as vice versa.

As well as regular classes and dances, there are also dance weekends at some of the popular holiday camps. Modern jive is often described as a lifesaver, not only physically, but emotionally and mentally also, especially for those emerging from a 'broken' relationship. It boosts one's confidence and enables socialising with a very friendly crowd.

A list of jive clubs can be found on <http://www.uk-jive.co.uk/>, or alternatively a Google search for 'modern jive clubs' will find others. Just one warning, modern jive can become addictive!

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The God delusion

I could hardly disagree more with Simon Fraser's criticisms of Richard Dawkins' powerful book, *The God Delusion*, and his condescending comments on Simon Curtis' review. Given the content of his letter, with its heavy reliance on the views of Alister McGrath, I wonder if he has actually read the book himself.

Professor (not Mr) Dawkins has produced a thoroughly argued case against the existence of 'God' as traditionally understood by the world's major monotheistic religions: that is to say, a god who is responsible for the origin and evolution of life on this planet, who remains interested in the individual fates of its denizens, and who is responsive to intercessory prayer. Dawkins has read widely and writes with lucidity and intellectual rigour, and entertainingly as well. To describe his book as being marred by 'excessive reliance on bold assertion and rhetorical flourish' seems to me a travesty.

It is not true that Dawkins asserts that

'the elimination of religion would be a solution to the world's ills', but he clearly believes that it would help. Although I am an unashamed atheist, I'm not sure I agree with him. For what it's worth, my own view is that Dawkins greatly underrates the importance to many people of what might be called 'religion as metaphor': that is to say, the choice of many thoughtful people to follow a particular religious tradition (usually, of course, the one they happen to be born into) because they feel it gives them a practical moral framework to live by. I know many such people who would call themselves religious but do not believe in any literal sense in the creed that they espouse. At one point in his book Dawkins admits to failing to understand this stance: that, I would say, is his greatest weakness.

I shall keep a look out for Alister McGrath's book *The Dawkins Delusion*, but hope that open-minded Christians among your readership will read Dawkins' book as well and not rely on any second-hand critiques — whether by Simon Curtis, Simon Fraser or myself!

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The role of the primary care mental health worker

The two papers by Lester, *et al*^{1,2} describe studies on the role of the new 'graduate workers' in primary care mental health. In Luton, for some years, we adopted a model of using a team of more experienced nurses and social workers to act as links between primary care practices and mental health services. The theory behind this model has been described elsewhere.³

The role of these primary care mental health workers was conceived as acting as a liaison link with the CMHTs? and other secondary mental health services, and also to give advice to the GPs on the management of mental health problems, always referring to the consultant

psychiatrist as necessary. They were also expected to offer CBT and other interventions to some of the patients in the GP's surgery. They were expected to be seen as an integral part of the GP team, accessing the GP computer system. It was hoped that they would facilitate the rapid referral of early psychotic patients, seriously suicidal patients and other difficult cases to secondary services.

In practice, this team of workers were very effective in helping GPs manage depression in primary care. They attended CMHT meetings, and were seen as part of the CMHTs, as well as being primary care workers, therefore they served as a useful link between the GPs and the CMHTs, particularly the psychiatrists, ensuring rapid transfer of information between primary and secondary care about difficult cases, and implementing necessary action.

For early intervention in psychosis, this team did prove very effective.⁴ This was because the team members were very experienced, and could pick up relatively minor abnormalities in mental state. They were then able to contact the doctor in charge of the early intervention for psychosis service directly, in order to arrange an assessment within a few days.

Out of the first 86 referrals to the early intervention service, 12 came by this route. Of these, 11 entered the service as new psychotic patients. The success of this team, which is no longer extant, depended on the great experience of its staff. It remains unclear what forms of mental health problems in primary care are likely to receive effective treatment from the 'graduate mental health workers'.

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