of patients. You will find that I have frequently voiced my concern about the direction of the Change Workforce Programme's (CWP's) pilot programme for the development of a medical care practitioner grade. Fortunately, I believe there has been a major change in the direction of that programme, driven by our experience with American physician assistants. Originally, the CWP's intention was for pilot sites to train nurses, and allied professionals while in post, to do front-line work. There is huge pressure from chief executives and the government for this model of 'training on the job', because of the workforce crisis and the current demand for front-line workers. Like Dr Heath, I believe that the best front-line workers are doctors, but when there are insufficient of these, we can bury our heads in the sand and let practices — particularly those serving the most needy — go to the wall; or we can look for alternative solutions. The RCGP seems to be taking the former route, whilst the Royal College of Physicians has taken the view that if the only way out of the crisis is to have a mid-practitioner grade, then we need to properly define the grade — so that everyone, including the patient, knows what they are getting. Work is being completed by the Royal College of Physicians in conjunction with our physician assistants and a medical school to define what those competencies should be. Unfortunately, by taking the stance it has, the RCGP will not be able to influence these.

I would be less concerned about the RCGP's stance on medical care practitioners, and in particular their view on American physician assistants, if they had actually come to see what they are achieving in Sandwell. It is all well and good maligning a profession from one's ivory tower. I, too, was cynical until I met and started to work with physician assistants, but I challenge Dr Heath and members of the RCGP Council to come and see and meet physician assistants at work and talk to the patients they are dealing with, before they make their minds up. The evaluation of their work in the UK is on the website of the Birmingham University Health[2] Services Management Centre and makes very positive reading. There are more than 50 000 physician assistants in the US and much evidence base to support the role, including the fact that litigation rates are lower in establishments that employ them.

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We were saddened to read Iona Heath's editorial 'The medical care practitioner: Newspeak and the duping of the public'.[1]

Iona has failed to look at the evidence base concerning the physician assistant (PA) role both in the US and the UK. If she had done so she would have found that PAs are both clinically safe, and positively received by patients.[2,3] She would have also discovered that the PA role is not particularly a primary care practitioner role. PAs are generic medical practitioners working to assist physicians in all areas of medical practice, not independently of them. Rowley Regis & Tipton PCT was the first primary care organisation (PCO) in the UK to employ PAs trained in the US to undertake clinical work, after the first of our two nurse-led PMS practices appointed one and suggested the role might be generalisable within the UK. Now we know of at least six other trusts (PCOs and NHS hospital trusts) that employ them in a number of diverse roles. Before recruiting we carried out extensive research, including visits to US universities delivering PA educational programmes. Two of us who went on these visits both felt that the level of skills, knowledge and experience of the US trained PAs was similar to that which we had had as GP registrars. We now have almost 2 years experience of PAs in general practice and plenty of data, both quantitative and qualitative, on all aspects of care provided by PAs and patients' experiences of them. We have also recruited PAs to work in our local A&E departments and our GP co-op out-of-hours service. One of us is an RCGP member (as are many of our doctors who have PAs working alongside them) and the lead director for the PA project for the PCO, the other is the PCO Professional Executive Committee (PEC) chair. Both of us are practising GPs.

Iona has failed to be critical of her sources. There are a number of so-called mid-level practitioner projects being developed in the UK at the present time involving various medical specialties and the professions allied to medicine. The Changing Workforce Programme (CWP) has, indeed, led some of these projects, but others have arisen spontaneously in advance of the CWP's project in response to local need, as ours has. I wonder whether Iona has really thought about whether there is no role for a mid-level practitioner in general practice at all, or whether it is just the CWP's model she doesn't like.

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Author's response

A number of correspondents appear to have misunderstood the nature of my objection to the training and deployment of medical care practitioners. I welcome unequivocally the extension of skill-mix and team working within primary care,

but I am profoundly suspicious of the change of name from physican assistant to medical care practitioner. The former describes a role that can be clearly understood, the latter seems designed to mislead and to suggest to the patient that the professional they are consulting is medically qualified. I note that none of your correspondents offers an explanation or a justification for the change of name, and until such is forthcoming, I will, with regret, remain profoundly sceptical about the whole initiative.

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Children with 'flu: not to be sniffed at

We would first like to congratulate Cécile Viboud *et al*[1] on the successful completion of the study of risk factors of influenza transmission in households as reported in the *BJGP*. We are sure it will yield much valuable information on the burden of disease as well as on its transmission.

The authors discuss diagnostic criteria and point out, quite correctly, that many people with influenza infection do not necessarily have a fever exceeding 38°C. However, few would argue that the likelihood of high fever is greater in children, and particularly in young children, than in adults. Hence, in the sensitivity analysis using a stricter case definition, the risk of secondary infection was increased in young children.

The study is based on 395 subjects with confirmed influenza who completed the follow-up. They were distributed across France, with between two and 61 cases reported from each region. Their mean age was 38.4 years: 10 children were aged 0–5 years and 28 between 6 and 15 years, together accounting for 13.6% of indexed subjects. The authors conclude that children play a major role in the dissemination of influenza. Given the increased likelihood of a febrile response to respiratory illness in children, the relatively small proportions of children recruited to this study seriously challenges their own conclusions. If epidemics are spread more from children than adults, it would be logical to expect an increased proportion of children at recruitment over the final proportion among contact cases.

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Loving communication

We have reflected in detail on the articles on communication in January's *BJGP*,[1–3] and have indulged in various emotive responses, mostly mildly despairing — 'so if we don't do that, what are we meant to do?', 'try playing a difficult bass riff without practising the parts', and 'helpful — not'. Some reasons for our 'gut' reactions were that, as Skelton[4] implies, consultation skills teaching and research has a history that leaves its mark — the skill set most espoused, researched, and championed by primary care, which has taken years of marginalised effort (evangelism?) to see its effective penetration into undergraduate and postgraduate programmes. We are also critical of educational naivety in all four contributions: the point of learning microskills in a systematic and reproducible way[5] is to unpick the building blocks of expert practice for the purpose of helping novices (think of being taught to put in your first chest drain). Edwards'[3] generalised plea for wider patient involvement goes against the skilled use of time when congruence is close and decisions simple. Skelton's examples of poor performance will still need training in the fluid use of multiple microskills, even though the diagnosis and needs of the doctors go broader than that.

And what of love (used here in its altruistic sense)? No one expects that being able to execute a technical task will in itself evoke empathy or respect in the doctor's response to their patients: attitudes underpin behaviours and emotional responsiveness. Skelton's 'solution' that reflection on attitudes needs to accompany skill development is likely to be fruitless if done as an abstract intellectual exercise. Working with the interpersonal self can be threatening to our sense of identity,[6] and learners need both positive regard[7] for their potential from tutors and support for their feelings to be able to develop insight and to attempt deep change.[8] The key to coupling consultation skills with attitudinal development is not to dump the skill set but to teach it with feeling. This needs a particular willingness of tutors to enter into a personal dialogue,[9] and the methods (one-to-one feedback, time-intensive, person-centred) also become crucial. These still remain under threat where competition for resources is rife, and emotional defensiveness can masquerade as an attack on 'touchy-feely stuff'. We can move on in the research agenda, but the challenge of loving our learners into loving their patients remains, and the battle to protect such learning is not yet over.

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