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.

IONA HEATH
General Practitioner, Caversham Group Practice, London.
E-mail: aque22@dsl.pipex.com

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.

DM FLEMING
Director, Birmingham Research Unit of the Royal College of General Practitioners, Birmingham.
E-mail: kgoodwin@rcgpbhamresunit.nhs.uk

AJ ELLIOT
Primary Care Scientist

REFERENCES

1. C Viboud, Boëlle P-Y, Cauchemez S, *et al.* Risk factors of influenza transmission in households. *Br J Gen Pract* 2004; **54:** 684–689.

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.

AMANDA HOWE
Primary Care Group, School of Medicine Health Policy and Practice, University of East Anglia, Norwich.
E-mail: Amanda.howe@uea.ac.uk

CHRIS ABELL
Practice development tutor

BOB FLEETCROFT
Practice development tutor

REFERENCES

1. Hammond P. Trust me, I'm a communicator. *Br J Gen Pract* 2005; **55**: 3–4.
2. Innes A, Campion PD, Griffiths F. Complex consultations and the edge of chaos. *Br J Gen Pract* 2005; **55**: 47–52.
3. Edwards A, Elwyn G, Wood F, *et al.* Shared decision making and risk communication in practice: a qualitative study of GPs' views. *Br J Gen Pract* 2005; **55**: 6–13.
4. Skelton JR. Everything you were afraid to ask about