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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Your correspondent Jill Thistlethwaite[1] asks the question: 'If we learn the techniques of "patient-centred" consulting and demonstrating empathy without really liking patients or agreeing with patient partnership is this a problem?'. I would suggest that it is not a problem at all, that it would be unreasonable to expect a GP to like or feel empathy towards every single patient at every consultation, and that we are required as GPs to behave in a professional way at all times even if it does not come naturally. The evidence comes from sociology and our colleagues in the acting profession.

In 1959, the American sociologist Erving Goffman[2] wrote about his enquiries into how motivation manifested itself as behaviour. He concluded that it was quite possible to explain behaviour as a set of 'fronts' — pieces of behaviour that people use in order to pursue relationship objectives. The use of such fronts becomes internalised so that they become part of unconscious normal behaviour. He argued that all people in all aspects of their interpersonal interactions use behaviour in a way designed to bring about the required result.

Does this mean that behaviour that is not 'from the heart' is immoral or unethical? Not at all. Dr Thistlethwaite also mentions the 'method' school of acting, which was prompted by the writing of Constantin Stanislavski[3] even longer ago. It was he who also wrote of 'emotion memory' — if an actor is trying to express a particular emotion, his advice was for the actor to search his own life experience for a situation when he felt that emotion for real, and then to duplicate the behaviour. The behaviour used is accordingly an accurate demonstration of how that actor would behave when genuinely in that emotional state. If the portrayal is to be convincing, then an actor must be acutely aware of his own life and behaviour and not just that of his character.

Even longer ago, a certain William Shakespeare was moved to include in *As You Like It*:

> *'All the world's a stage,*
> *And all the men and women merely players:*
> *They have their exits and their entrances;*
> *And each man in his life plays many parts ...'* (Act two, scene seven.)

So there is not a problem. People, including GPs, cannot on occasion avoid behaving in ways that are inconsistent with how they feel at the time. The problem is when this fact is not accepted, and when the motivation becomes more important than the delivery.

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Chaotic consultations

The authors of 'Complex consultations and the edge of chaos' (Innes *et al*)[1] are to be congratulated on making complexity theory accessible and on linking it so clearly with the consultation process. In these times of over-rationality and managerialism any explanatory model that helps GPs to acknowledge and make use of the inherent uncertainty of front-line encounters is to be applauded. However, I couldn't help but feel that this was just another way of conceptualising the importance of the unconscious in human behaviour and interaction, as understood through a basic knowledge of psychoanalytic theory. The 'edge of chaos' of complexity theory may be the same as the 'flash' of insight that the psychoanalyst Michael Balint and his colleagues taught previous generations of GPs to generate and use in short consultations.[2,3] This is not a criticism of complexity theory; indeed, if several different theoretical perspectives all point to the importance of working with uncertainty and non-rational behaviour this not only highlights the importance of such interventions, but allows general practitioners to base it on the theory that they feel most comfortable with. Having at last grasped what complexity theory is, I look forward to the deepening of understanding that will come about as it is tested out in practice.

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Buprenorphine versus methadone — safety first?

I was concerned that the otherwise very thorough review by Simoens *et al*[1] gave little emphasis from their findings as to the superior safety profile of buprenorphine as a maintenance agent. It would have been useful to have some comments in the review as to the comparative overdose and mortality statistics in the studies examined.

Methadone has gained notoriety in the medical press on many occasions in the past, on account of the substantial mortality associated with it, and the Advisory Council on the Misuse of Drugs report, *Reducing Drug-Related Deaths,*[2] confirms our suspicions. However, for many years methadone has been the