intrinsically unstable, and a new settlement for primary care will soon become necessary.

Peter Davies,
GP, FRCGP, Keighley Road Surgery,
Illingworth, Halifax.
E-mail: npgdavies@blueyonder.co.uk

REFERENCES

1. Irish W, Purvis M. Not just another primary care workforce crisis ... *Br J Gen Pract* 2012; **62**(597): 179–179.
2. Davies P, Moran L, Gandhi H. What is the work of primary care? In: *The new GP's handbook*. London: Radcliffe Medical Publishers, 2012.

DOI: 10.3399/bjgp12X641311

Authors' response

Thanks Peter.

Your point is well made. We have recognised the potential for extended roles of the GP, but the word limit was against us!

I think we could go further and point out that training too few/too many GPs is a binary decision but with unequal risk and consequence, in other words, too few GPs and the NHS implodes ... train 'too many' GPs and the flexible, adaptable, entrepreneurial nature of GPs is that they add value through extended roles, enhanced roles, and intermediate care roles. So you can have too few GPs with apocalyptic consequences ... but you can never really have too many GPs!

Hey, if we have enough GPs we may even be able to reconnect with urgent and unscheduled care out of hours.

Mark Purvis,
Yorkshire and the Humber Deanery, School of General Practice, Willow Terrace Road, University of Leeds, Leeds, LS2 9JT.
E-mail: Mark.Purvis@yorksandhumber.nhs.uk

Bill Irish,
School of Primary Care, Severn Deanery, Frenchay Hospital, Bristol.

DOI: 10.3399/bjgp12X641320

The BJGP

One of the pleasures of being an honorary

fellow of the College is that I receive a copy of the Journal, and, although deluged like everybody else with written material, I read it. I was an editor for 25 years, and as such I have a few observations on the Journal that may prompt some useful thoughts.

First, I notice that your editorial board has 17 members (assuming that you and your deputy are members), and yet there are only two women. Surely this is an embarrassingly low number. Judging by the names, I think that only one member comes from an ethnic minority. You are failing to reflect British general practice. I suggest that you scrap your board and make a fresh start. As I discovered, copying Margaret Thatcher in her abolition of the Greater London Council, it is easier to get rid of the whole lot than just one or two.

Secondly, I'm impressed that in your *Editor's Briefing* you have managed to make safety-net a verb. Truly there is no noun that can't be verbed.

Thirdly, what is the 'neo-liberal London consensus', which Calum Paton writes about? This reminds me of my days as a communist, but I suggest that it is a figment of Paton's imagination. He also refers to GPs being 'sold the dream of power only to find it has become responsibility'. But did any GP think it possible to have power without responsibility? I can't think so. In short, I think that this article would have benefited from tighter editing.

Fourth, the word cloud of the Journal contents is very interesting, but what may matter most is what's not there. Rob Atenstaedt notices the absence of any mention of countries outside the UK,² and I noticed the absence of safety, internet, comorbidity, and commissioning.

Richard Smith,
35 Orlando Road, London, SW4 0LD.
E-mail: richardswsmith@yahoo.co.uk

REFERENCES

1. Paton C. Competition and integration: the NHS Future Forum's confused consensus. *Br J Gen Pract* 2012; **62**(596): 116–117.
2. Atenstaedt R. Word cloud analysis of the BJGP. *Br J Gen Pract* 2012; **62**(596): 148.

DOI: 10.3399/bjgp12X641339

Editor's response

Richard Smith's editorial lineage goes back 25 years, and mine a bit longer, to the clinical editorship of *World Medicine* in the

early 1980s — nothing like a bit of badinage between two old hacks.

We are aware of the demographic asymmetry in the editorial board and do our best by advertising nationally for new members — but as for sacking my splendid colleagues, this isn't the *BMJ*!

Diagnostic safety-netting was a term coined by Roger Neighbour in his seminal *Inner Consultation*¹ and is a useful neologism which is firmly embedded in describing the diagnostic processes of primary care.²

Calum Paton can comment for himself about the neo-Liberal consensus and power *vis a vis* responsibility, but tighter editing by me would have stopped short at changing this sentence — general practice unfortunately has a long record of the exercise of power through claims to autonomy and clinical freedom without fiscal responsibility.

And finally all those terms missing from the cloud are very much on our minds, and all will appear in the titles of articles and papers to be published in the next few months.

Roger Jones,
Editor of the British Journal of General Practice, 1 Bow Churchyard, London, EC4M 9DQ. E-mail: journal@rcgp.org.uk

REFERENCES

1. Neighbour R. *The inner consultation*. 2nd edn. Oxford: Radcliffe Publishing, 2004.
2. Almond S, Mant D, Thompson M. Diagnostic safety-netting. *Br J Gen Pract* 2009; **59**(568): 872–874.

DOI: 10.3399/bjgp12X641348

Author's response

Richard Smith suggests that only communists and fantasists may detect a 'neo-liberal London consensus'. He goes on to suggest that the *BJGP* is UK-centric. May I suggest that his US-corporate-for-profit-health-care-tinted spectacles have actually stopped him seeing the UK health systems in the round, from which perspective the English obsession with recycling increasingly surrealist versions of failed 'market reform' models is quite striking. First rule of comparative health care: use it to understand yourself better!

'The London consensus' was of course my tart take on the well-known coinage,

'the Washington consensus'. Ironically, at a time when Obama has overcome at least some of the huge odds against humane health reform in Washington, Richard's stay with UnitedHealth may have taken him more Rightwards than he has realised even by Washington standards!

In London, of course, there are enthusiastic neo-liberals (Tony Blair, for example: if you doubt me, just read his political autobiography, *A Journey*); and then there are fellow-travellers. The latter may or may not be enthusiastic, but they have accepted the terrain of neo-liberalism as the place for debate. I include the King's Fund and the Nuffield Trust in this — pragmatists who have become just a bit too pragmatic.

And as Keynes knew, 'practical men' were often slaves to a defunct economist ... 'pragmatists' in London often fail to see the opportunity cost of both market reform and endless tinkering with market models, of which Lansley's 'La La Land' is merely the most absurd yet.

And Richard, yes, power and responsibility should go together, for GPs as well as for all of us. My point was exactly that: if you don't maintain the balance between the two, you're in trouble. The government's dishonesty — selling '100% the latter' as '100% the former' — is a sure way to disillusionment. Some GPs are often too trusting — at first — of reforms that promise to put them in the driving seat yet end up scorching their backsides in the hot seat.

And it's not just this government: Alan Milburn did the same in 2001, in New Labour's heyday. It's called the London consensus, you know!

Calum Paton,

School of Public Policy and Professional Practice, Darwin Building, Keele University, Keele, ST8 7LA.
E-mail: c.paton@hpm.keele.ac.uk

DOI: 10.3399/bjgp12X641357

Calling time on the 10-minute consultation

I read with interest the recent *BJGP* editorial on 'Calling time on the 10-minute consultation'.¹ As a recently qualified GP working in one of the most deprived and ethnically diverse areas of the UK the

concept of a one size fits all 10-minute consultation seems woefully outdated. As an individual practitioner I of course vary the length of my consultations based upon a multitude of patient factors, but there is always the underlying time pressure of a full surgery of patients waiting to be seen and of course the ubiquitous QOF targets. There is an undoubted effect of this time pressure on the way I practice, utilising time and follow-up appointments for complex cases. However, I wonder whether this time limitation could potentially impact on the ability of primary care practitioner's to make complex diagnoses early, a potential 'achilles heel' of general practice,² thus adding to diagnostic delay and error, the biggest cause of medicolegal claims against GPs.³ Recent research has shown that health systems with a gatekeeper function have lower cancer 1-year survival.⁴ Around 23% of patients consult three or more times with a GP before suspected cancer referral, with increased repeat consultations in those from ethnic minorities and for certain cancers before referral.⁵ A Cochrane review into the effects of changing the length of primary care consultations found a lack of evidence, with only five UK trials meeting the inclusion criteria, with most having methodological weaknesses.⁶ They make the case for further research in this area, as without evidence the 10-minute consultation may still be the norm in 20 years time.

Thomas Round,

Primary Care Clinical Academic Fellow, Kings College London, Primary Care and Public Health, Capital House, 42 Weston Street, London, SE1 3QD.
E-mail: thomas.round@kcl.ac.uk

REFERENCES

1. Silverman J, Kinnersley P. Calling time on the 10-minute consultation. *Br J Gen Pract* 2012; **62(596)**: 118–119.
2. Jones R. *Diagnosis — still the achilles heel of general practice?* John Fry Lecture. London: Royal Society of Medicine, 2011. <http://www.rsmvideos.com/videoPlayer/?vid=209&class=videoThumbOdd> [accessed 12 Apr 2012].
3. Kostopoulou O, Oudhoff J, Nath R, et al. Predictors of diagnostic accuracy and safe management in difficult diagnostic problems in family medicine. *Med Decis Making* 2008; **28(5)**: 668–680.
4. Vedsted P, Olesen F. Are the serious problems in cancer survival partly rooted in gatekeeper principles? An ecologic study. *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X588484.
5. Lyratzopoulos G, Neal RD, Barbiere JM, et al. Variation in number of general practitioner

consultations before hospital referral for cancer: findings from the 2010 National Cancer Patient Experience Survey in England. *Lancet Oncol* 2012; **13(4)**: 353–365.

6. Wilson AD, Childs S. Effects of interventions aimed at changing the length of primary care physicians' consultation. *Cochrane Database Syst Rev* 2006; **(1)**: CD003540.

DOI: 10.3399/bjgp12X641366

In their editorial, Silverman and Kinnersley present a strong case for moving on from the 10-minute consultation.¹ In 2011 an electronic 'consultation length' survey of all UK GP trainees (ST1–ST4) was undertaken by the RCGP Associates in Training committee. One of the key questions within the electronic survey was, 'what consultation length does your trainer offer for routine booked appointments?'

A total of 1492 trainees completed the survey (~15.8% out of ~9451 trainees contacted) providing proxy evidence of current consultation lengths offered by their GP trainers. The results of the survey are presented in Table 1.

When asked 'what would be the ideal consultation length be for routine booked appointments?' only 12.5% of trainees thought that 10 minutes was adequate. In contrast 55.9% believed that 15 minutes was needed. Reasons for trainees selecting 15 minutes included: 'time for preventative care', 'thorough exploration of presenting problems', and 'greater patient satisfaction'.

This survey suggests that even in those practices that meet the quality standards for GP training, 15 minutes is still far from the norm. Yet, at the same time, it would appear that the next generation of GPs would agree with Silverman and Kinnersley that we should indeed call time on the 10-minute consultation.

Table 1. GP trainer consultation length for routine booked appointments and trainee preference

Consultation length, minutes	n (%)	
	Trainers	Trainee preference
<5	4 [0.3]	0
5–9	32 [2.4]	4 [0.3]
10	1236 [82.8]	187 [12.5]
11–14	68 [4.6]	404 [27.1]
15	102 [6.8]	834 [55.9]
>15	22 [1.5]	63 [4.2]
No set time	28 [1.9]	0