'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!

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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and ethnically diverse areas of the UK the concept of a one size fits all 10-minute consultation seems woefully outdated.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.

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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

	n (%)	
Consultation length, minutes	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