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

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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.

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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?[1] 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

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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

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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,