

November Focus

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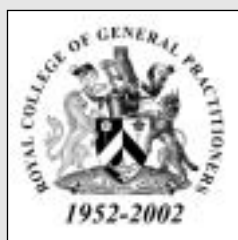
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In a speech to Congress in 1941, Franklin Delano Roosevelt named freedom from fear as one of four essential human freedoms. Yet, and I am not the first by a long way to remark this, one of the paradoxes of modern existence is that, as life becomes safer and more protected, we find more to fear. No matter that what we fear is a remote possibility. A paper by Donker *et al* on page 917, discussing the consequences of a disastrous plane crash in Amsterdam in 1992, and what residents attributed to it, states: 'plane crashes are at present among the most feared and dreaded disasters.' Fears can encourage us to narrow our own lives. In a study of falls in the elderly by Stoddart and colleagues, 46% of men and 40% of women over the age of 65 had restricted activity through fear of falling (page 923). Or we can project our fears onto others and make public policy out of our fears, to restrict others. In the Back Pages, on page 953, Helen Lester's Viewpoint mounts a spirited attack on proposed UK legislation governing care of those with mental disorders, and argues that it is our own fears that we have to confront. Public policy itself can reduce or exacerbate fear, so that our willingness to walk the streets or use public transport is strongly influenced. On page 883, Allyson Pollock takes issue with the current age's belief in market solutions for all problems, taking a similar line: 'market-driven health care denies access to care and freedom from fear.' Internalised fears remain powerful. In his tribute on 964, Marshall Marinker quotes Paul Freeling's advice to his daughter not to be afraid of being disliked. Not that the fears always prevail. In a counterpoint to an earlier paper on MMR in the *BJGP*, Ramsay *et al* report on page 912 that the fall in MMR coverage has been modest and that attitudes remain generally positive.

One reason for the preoccupation with fear is the complex nature of life in the 21st century and because there is so little sense that individuals can control what is going on and what influences their daily lives. In the NHS a sense of powerlessness seems to pervade and underpin much of the frustration felt by those who work in the service, with a widening gap between the rhetoric and the reality. On page 895, Craig and colleagues try to explore the reality behind one of these recent rhetorical flourishes, the 'primary care-led NHS'. If clinicians greet with weary cynicism how little was felt to have changed, they might be surprised to learn how little power the managers felt they had to implement change. Interesting to note, in passing, the view of one manager that 'consultants fear losing power and status if there are too many shifts.' In the same vein, Peter Bower, on page 926, finds little evidence to support the appointment of large numbers of primary care mental health workers, but acknowledges that it's going to happen anyway.

For those who enjoy the vision of sacred cows being taken for ritual slaughter, there are two such pleasures in this month's *BJGP*. On page 901 Mercer *et al*, in a careful exploration of the nature and importance of empathy in consultations, conclude that the length of consultations has little influence — the *BJGP* will be returning to the topic of time in consultations soon. And on page 965 Roger Neighbour makes the most astonishing, if temporary, U-turn. The sound of squealing tyres will reverberate throughout the nation (with apologies for the mixed metaphor).

Real mortality remains a source of potent fear. Fiona Dowson on page 959 talks movingly about her own bereavements and the need to confront our own fears rather than avoid or hide them. More importantly, we need to affirm grief as part of normal life and not collude in allowing it to become a medical problem — 'turning grief into an industry'. As FDR said on an earlier occasion 'The only thing we have to fear is fear itself.'

DAVID JEWELL
Editor

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INFORMATION FOR AUTHORS AND READERS

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All research articles should have a structured abstract of no more than 250 words. This should Background; Aim; Design of study; Setting; Methods; Results; Conclusion; Keywords. (Up to six keywords may be included, which should be MeSH headings as used in *Index Medicus*.)

'Where this piece fits'. Authors are asked to summarise, in no more than four sentences, what was known or believed on the topic before, and what this piece of research adds. *Main text*. Articles should follow the traditional format of introduction, methods, results and conclusion. The text can be up to 2500 words in length, excluding tables and up to six **tables or figures** are permitted in an article. **References** are presented in Vancouver style, with standard *Index Medicus* abbreviations for journal titles. Authors should try to limit the number of references to no more than 25. Authors submitting **randomised controlled trials (RCT)**s should follow the revised CONSORT guidelines. Guidance can be found at http://jama.ama-assn.org/info/auinst_trial.html or *JAMA* 2000; **283**: 131-132. Papers describing **qualitative research** should conform to the guidance set out in: Murphy E, R Dingwall, D Greatbatch, et al. Qualitative research methods in health technology assessment: an overview. *Health Technology Assessment* 1998; **2(16)**: 1-13.

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Reviews These are approximately 4000 words in length. They should be written according to the quality standards set by the Cochrane Database of Systematic Reviews. (www.update-software.com/ccweb/cochrane/hbook.htm).

Discussion papers

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The Back Pages

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