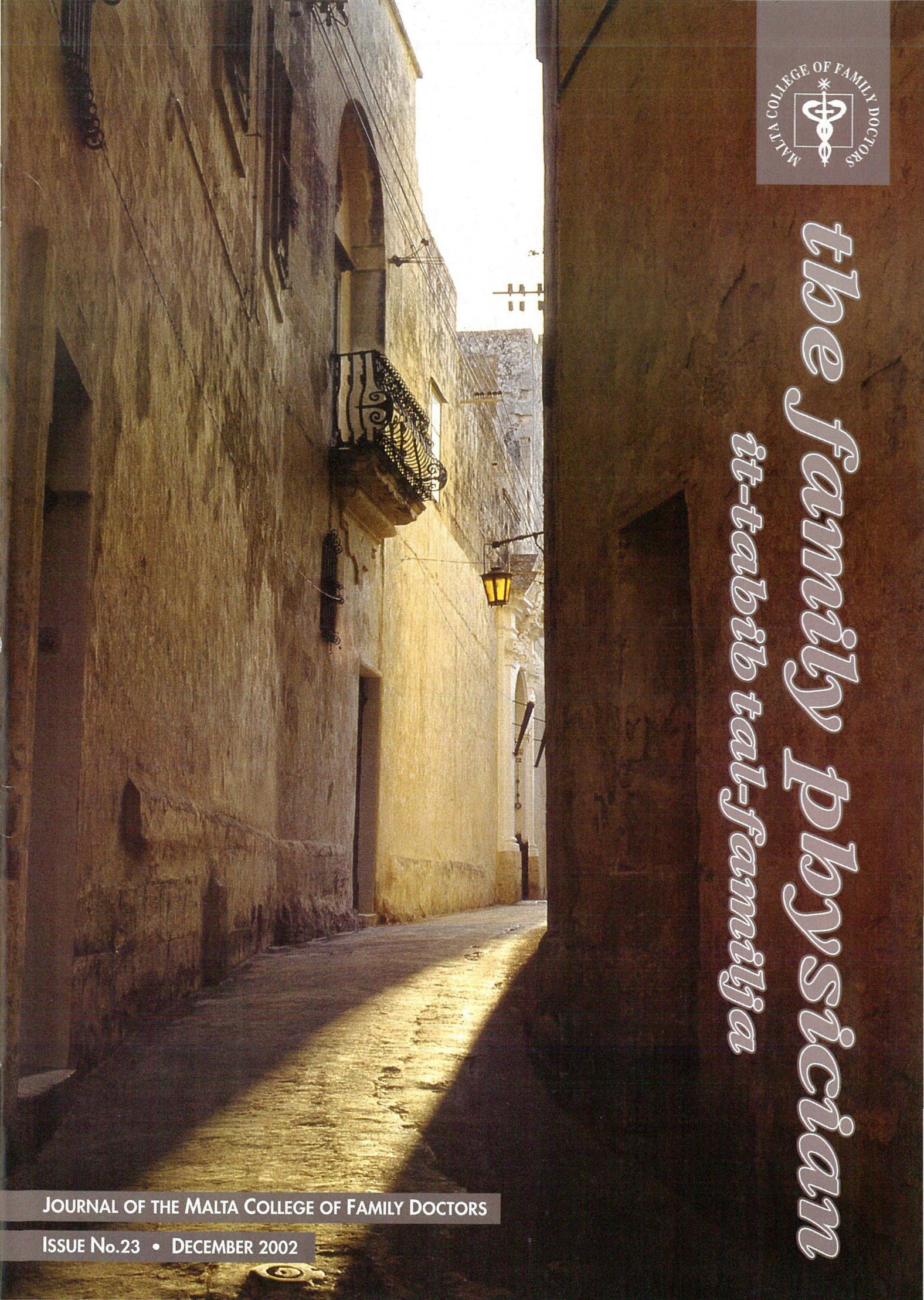

# the family physician

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# Editorial

*Dear Readers,*

*We are fortunate to be treated to three articles directly related to family practice in this issue.*

*Vinker et al analyse discharge summaries in Israel, and throw light on this important element of the interface between primary and secondary care. It is obvious that there is much room for improvement in the use of this instrument of communication between doctors, and I assume that we can apply some of the comments made to our local situation.*

*Svab invites us to take a new look at independence, and the complex relations between the general practitioner, the patient and society.*

*Yaman looks at residents' perceptions of working conditions in Turkey. Some of their perceived problems, such as dissatisfaction with management and poor appreciation of work done, may be found in other countries too.*

*I hope that you will find our colleagues' research and experiences illuminating, and stimulating. It would be very nice to see similar research performed locally.*

***Jean Karl Soler***
*Editor*




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# Should Family Doctors Counsel Patients on Genetic Testing and Screening?

Pierre Mallia & Henk ten Have


## ABSTRACT

*Family Doctors are in an ideal situation to counsel patients on most medical technologies and new developments. In this sense they are in the best position to guide and counsel patients on genetic testing and screening. Indeed most often it is the patient who seeks counsel from the Family Doctor (General Practitioner). The special nature of genetic tests and the potential to exploit people's money with dubious testing puts the doctor in a special situation. Whilst it is argued that the Family Doctor maintains a strategic position to impart information to the patient, it is also argued that the new nature of genetic tests and the way the family may be affected, (including the multitude of ethical dilemmas these tests may pose), favours the position that Family Doctors should be the health professionals who should impart generic genetic counselling. Specialised genetic counsellors may then continue to dedicate their time to special cases. Tests should not be made available over-the-counter. It is the onus of the Family Doctor to refer patients for further counseling should this be necessary. Colleges and Academies of Family Physicians are in the ideal place to outpace industry especially in second and third world countries.*



**Key Words**

Genetic Testing, family doctors, exploitation, counseling, specialist genetic counselors, continued medical eduction (CME).


## *INTRODUCTION*

Genetic information has a tremendous potential to harm as well as to help and stands to affect a broad number of family members (McCanse, 2001). Even well educated patients may be ill- prepared to understand or deal realistically with the results of genetic tests. The primary care culture is different from the genetics culture but primary care doctors are more patient-oriented asking what specific aspects of a genetic approach to this health problem (or potential problem) are likely to benefit this patient. Howard Brody warned family doctors about the perils of genetic testing and the role the family physician must play (Ibid., p.1). The ability to genetically screen for diseases far outpaces the ability to treat conditions, such as breast cancer, Alzheimer's disease and prostate cancer. Nonetheless people often consider genetic tests as some sort of cure or prevention of the condition (Lapp, 2002).

At the same time Chandros Hull and Prassas (2001) have shown how companies may use advertising to their advantage to entice people into believing that they should have genetic tests. They sometimes advise potential patients that there is no need to consult the family doctor or anybody else as their own 'experts' will guide the patients into what tests they should carry out. However genetic tests may not only affect the individual adversely, but also family members of that person carrying out the tests. In this context it is fair for family physicians and their societies and colleges to be wary of the effect these tests can have on family members. Conversely family doctors, without the proper Continuing Medical Education (CME) imparted specifically to meet the needs of ongoing ethical dilemmas in genetic tests, may find themselves ordering such tests too liberally, once it is the patient who request them, believing they are respecting the individual's autonomy.

Weber and Corban (1996) note that although today geneticists perform most testing and counseling for genetic disorders, in the near future family physicians will increasingly become responsible for this role. Whilst the reasons for testing may be simple, they are likely to ignite fierce issues regarding cost, ethics, insurability, patient expectations and information which family members may wish not to know. How should family doctors consider their role with regard to genetic testing and counseling?

### *What are the concerns of genetic tests?*

Why should genetic tests cause concern to family doctors more than any other form of test? The prime reason is indeed the novelty of these tests and the aura they are raising. Awareness campaigns sponsored by companies need to be considered for what they may actually be – an impetus for them to promote their product. While such cam-

paigning need not be bad in itself, if it is to be endorsed by the medical profession, the latter has the responsibility towards society not to be an accomplice in enticing patients to spend more than they should on such tests. Definitely not everybody need do genetic tests and therefore fears must be quelled. Who is in a better position to quell such fears than family physicians who enjoy the trust of patients and their families?

Consider the testing for the breast cancer genes BRCA 1 & 2. Those who test positive for the mutations of these genes via a commercially available genetic test are at an increased risk of having breast cancer compared to the general population. Some may argue therefore that once these tests are available it is not the onus of any physician to try to convince someone not to do them. Yet people may not be aware of the implications the result of such a test may have on employment and insurability. Furthermore, it is uncertain whether they know what, if anything, can be done with such knowledge and how this will affect their mental well being and that of their family. In the event such a test is positive, it does not necessarily imply that the person will have cancer; yet it puts them into a high risk category justifying insurers to charge a higher premium or not to insure them at all for breast cancer. This has enticed many States in the USA to introduce laws protecting against inappropriate access of such tests to the public. In other countries such laws do not yet exist.

Recent studies on bilateral prophylactic oophorectomy vs. radical mastectomy (Kauff, 2002; Rebbeck, 2002) show that this is a highly evolving field in which it is wise to seek the advice of a doctor. Haber (2002), analysing the relevance in the statistics of such results, shows only that more studies are necessary. Thus by no means is there any certainty about outcomes of BRCA testing other than to recommend it to women past childbearing age and counseling them on oophorectomy should they test positive. Again this operation does not protect them completely from breast cancer, especially when there are as yet no studies to show whether the required Hormone Replacement Therapy (to prevent premature side effects of the artificially-induced menopause; namely increased cardiovascular risk and osteoporosis) may itself contribute to an increased incidence of breast cancer which the oophorectomy is being performed to eliminate. Even though the effectiveness of bilateral prophylactic radical mastectomy was demonstrated recently (Meijers, 2001), the controversy over such radical treatment remains.

### *Role of the Family Physician*

Whereas it is undisputed that the General Practitioner is in an ideal position to counsel patients on genetic testing (BMA, 1998, p. 120; Starfield et al., 2002) and to know when to refer patients for specialized counselling, Brody argues that a balance has to be struck between the physicians' hunches, the patient's wishes and the evidence of clinical trials (Lapp, 2002). One concern which is not being addressed adequately, for example, is the implications such tests pose for family members. A possible solution he proposes is that the family doctor is in a position to set up a 'family covenant' before an individual goes through with testing. Such a document would be negotiated among the family members with the help of the physician. Family members who 'opt in' set conditions are privy to the knowledge that comes out (Lapp, 2002). Yet the concept of covenant is lagging behind advances in genetic testing and it is doubtful how much such a covenant is possible before family doctors establish themselves as the agents of basic genetic counselling.

The BMA document argues that primary care physicians should be able to identify patients and families who would need further genetic counselling by specialists, arguing that the rapidity with which genetic technology is developing and the complexity of the decisions to be made in relation to genetic testing mean that specialized genetic counselling, both pre-test and post-test, is likely to be required (BMA, 1998, p. 121). This however only refers to identification of individuals and families who need specialist counselling. It is unlikely that genetic counsellors can reach the public as easily as family physicians because of their smaller numbers and their inferior accessibility, especially considering the increasing number of generic genetic tests being advertised. Moreover the family doctor already knows much about the family and its requirements and would be able to identify who would benefit from genetic information. He/she is familiar with the background and family dynamics in a way that a specialized counsellor can never be: it is information obtained over time within the context of practicing family medicine. Indeed if it were possible for the counsellor to arrive at such knowledge, it could be argued that this would be a repetition and waste of time for health professionals and patients alike.

Boxes 1 and 2 (Ibid., p. 123-124) show the process of genetic counselling and the framework for exploring decisions, laid down by both the BMA and the American Society for Human Genetics. Nothing in this list is in fact beyond the capabilities of the average primary care physician or family doctor. When patients seek the advice of the family physician, it is appropriate that the latter should be able to handle most generic questions and counselling, referring on to the specialist only those who have serious genetic inheritance problems. For those patients seeking to know more about cancer

genes, paternity testing and even genetic screening of the unborn, the family physician is in an ideal and maybe better position to impart advice. Family physicians are moreover prescriptive by nature and thus tend to be more directive than the average non-directive genetic counsellor (BMA, 1998, p. 122).

There are additional reasons why generic genetic counselling should be imparted by family doctors. The strategically placed position of the family physician favours the role that genetic counselling should play in primary care. It is the responsibility of family physicians as a group to take on the role of protecting families against commercial interest. This is particularly important because people may not be aware of the implications to other members of the family when doing a genetic test. Who else but the family physician is in the central stage to counsel directly family members? This is all more important because to await the development of genetic services and to wait for specialized counsellors to deal with the true impact of genetic testing is unrealistic even in the United Kingdom and the United States, let alone the rest of the world.

Of course the family doctor can never replace the role of the specialized genetic counsellor just as he can never replace the specialized radiographer or cardiologist. But the energy of the specialist counsellor is better spent on hard core cases like Huntington's chorea and Tay Sachs disease, rather than where the industry is striking hard, namely the cancer genes and such tests as 'cardiovascular panels' and 'thrombosis panels'. The latter are targeted to raise public awareness in order to satisfy a profit motive rather than a genuine social need.

Consider a country like Malta where recently a newly formed company started to offer genetic testing to the public. Presently it uses the services of specialists and family doctors for referrals. No form of counselling is offered to the patient, leaving this onus on the doctor. Indeed there has been little to promote awareness among the medical profession of the special nature of genetic tests and the implications they may have on the life of the person seeking those tests, and on his/her family. This fertile ground is the ideal incubator for releasing 'awareness information' onto the public catching doctors off guard. Before there is enough time to prepare for genetic counselling services, people will start believing, as happens in other countries, that there is some inherent cure in carrying out such tests (Lapp, 2002). Doctors, on the other hand, unaware of the implications of such tests, as has been the BMA's subtle warning will not counsel the public properly. Specialized services, even if they do exist in the main general hospital, are not enough to handle the everyday questions regarding genetic tests and definitely cannot inform patients adequately about what tests are really necessary. Appointments with the service may well run into months, and then just to handle the cases that truly need specialized counselling.

Family doctors are strategically placed to train themselves in imparting this counselling, this being a core medical subject already in their realm. It is the responsibility of colleges, associations and academies of family physicians to stimulate members to learn more about genetic counselling.

### *The coming of age of Family Practice*

Another important perspective is the coming of age of family practice. Whilst the history of medicine shows that the family doctor or community doctor was the traditional doctor (Porter, 1996, p. 118), the last century saw a surge of specialties and sub-specialities. In Britain the Royal College of General Practitioners was founded after the war and incorporated almost all general practitioners. It became the strongest political body in Britain to bargain with government over the structure of the National Health Service. In the United States, the American Academy of Family Physicians brought together Family Doctors raising the status of Family Medicine to that of a speciality. Similar roads were taken later in other countries.

Family doctors now provide more and more services, which services that can be offered to people at more reasonable rates making it more acceptable to insurance companies. GPs have always traditionally carried out minor surgery such as removal of sebaceous cysts, cautery of warts and injection of internal haemorrhoids. Nowadays more and more GPs take on more engaging non-invasive surgery such as removal of lipomas, injection of varicose veins, circumcision and even haemorroidectomies (Brown, 1992). Studies have shown (Siepel, 2000) that family doctors who attend a course in ultrasonography can perform ultrasounds as part of the physical examination, detecting pathology such as renal tumours, aortic aneurysms and others, before any signs and symptoms are noticed by doctor and patient respectively. Family doctors in the United States train to perform sigmoidoscopy, gastroscopy, colposcopy and can even have a whole radiological set-up if economically viable. All of this in the interest of quick diagnostics bypassing long referral lists and delays in a secondary care setting. In this setting it is reasonable to assume that the family doctor, with continued medical education (CME) is taking onto himself more and more diagnostic techniques which not only increase the scope of general practice but which result in more benefit to patients. With proper CME a genetic counselling service to people and

their families is within the scope and definition of family practice.

What is needed with the impact of genetic technologies therefore is a primary care setting that can explain tests to all people, not only to those who have some genetic disorder in their lineage. It is reasonable to assume that any woman may request information about whether she should have a BRCA test done. She may not know that she needs counselling (in terms of implications for herself and her relatives, for insurance purposes, etc). Family physicians can bring a broader scope to genetic counselling. They are trained to think of issues such as getting patients to get their house in order vis-à-vis insurance before getting tests done (Lavallee, 1999).

Conversely it is unreasonable to assume or request genetic counsellors to have to deal with this sort of mass population counselling. They would lose time that is valuable for what they are doing at present – counselling to those families, which may indeed be identified by family doctors, who require further in-depth evaluation. Unless genetic counsellors increase in numbers and become almost as common as family doctors they may not be able to handle the demand for information which necessarily would need to be imparted to keep up with the media and the rapidly expanding genetic industry. Starfield et al. (2002, p. 51) argue that when one considers genetic problems, in initiation of diagnosis and even management, primary-care-centred systems offer the greatest potential for improving health.

*The responsibility of Associations and Colleges*

Family physician Nancy Stevens stresses the importance of injecting the family practice perspective into genetic medicine (McCanse, 2000). As this perspective is still underrepresented in conversations of genetic medicine, it follows that patients of family practitioners are underrepresented. For example, she points out that only one from a high-risk family tends to benefit from BRCA testing. Once it is accepted that the family doctor has this role to play in imparting knowledge and genetic counselling to patients, associations and colleges have an obligatory role to see that its members get the CME in genetic counselling that is required. Family doctors, by their very nature, are already in a position to give evidence-based information, genetics being one specialty they have always had in their curriculum. It would be unreasonable not to accept their role in providing such evidence-based counselling.

Associations and colleges of family doctors, which strive to guarantee excellence, have a special role to play here. But primary-care-centred systems may pose a risk of under-detection and under-management of genetic problems if information and other educational networks do not actively support practitioners (Starfield et al. 2002, p. 51). Whereas it may be obvious that a family doctor intending to carry out diagnostic ultrasonography would require training, it may not be that obvious that to provide genetic counselling one also needs training, because genetics has always formed part of the medical undergraduate curriculum. The focus of counselling is not on Mendelian inheritance explained in layman terms, but is a matter of explaining the social, legal and ethical implications of these tests and also of having a clear understanding of why they are so different from simply having a blood count. Doctors need to understand and explain that genetic tests are largely non-therapeutic and predictive. The patient therefore needs to be empowered with information by someone who understands the full potential of these tests and how industry may exploit fear of disease without concern for implications on employment and insurability and impact on other family members.

Associations must guarantee that their members will explain the harm/benefit of genetic testing and screening. They must also guarantee that they will continue to seek the interests of the family and not only of individual people seeking testing. In other words family doctors need to maintain the trust of the public, demonstrating that financial gain is not the main motive of for the counselling as may be the case for the company providing that test.

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## Box 1

The description of genetic counseling set out by the American Society of Human Genetics is as follows:

Genetic counseling is a communication process which deals with the human problems associated with the occurrence or risk of occurrence, of a genetic disorder in a family. This process involves an attempt by one or more appropriately trained persons to help the individual or family:

1. comprehend the medical facts, including the diagnosis, the probable course of the disorder and the available management;

2. appreciate the way heredity contributes to the disorder, and the risk of recurrence in specified relatives;

3. understand the options for dealing with the risk of recurrence;

4. choose the course of action which seems appropriate to them in view of their risk and their family goals and act in accordance with that decision;

5. make the best possible adjustment to the disorder in an affected member and/or to the risk of recurrence of that disorder.

## Box 2

The British Medical Association states that genetic counselling consists of a series of activities which make a coherent whole. For ease of analysis we separate them in the list given below. In reality, however, they are not separate entities, but facets of one process. In general terms, genetic counseling includes:

- taking a family history and establishing a diagnosis;
- gaining an understanding of the social and cultural context within which a patient and his or her family live and the values they bring to the counseling process;
- listening to the questions and anxieties of the patient;
- providing information about the condition, its inheritance pattern, and its management and raising questions about the potential significance of sharing information with other family members;
- giving information about reproductive options; and/or
- giving information about predictive options (if applicable);
- providing the opportunity to reflect upon the options (implications counseling);
- providing the opportunity to reflect upon the options (implications counseling);
- providing emotional support; and
- initiating sustained help, if necessary, to enable individuals to adjust to particular life circumstances (psycho-therapeutic counseling).


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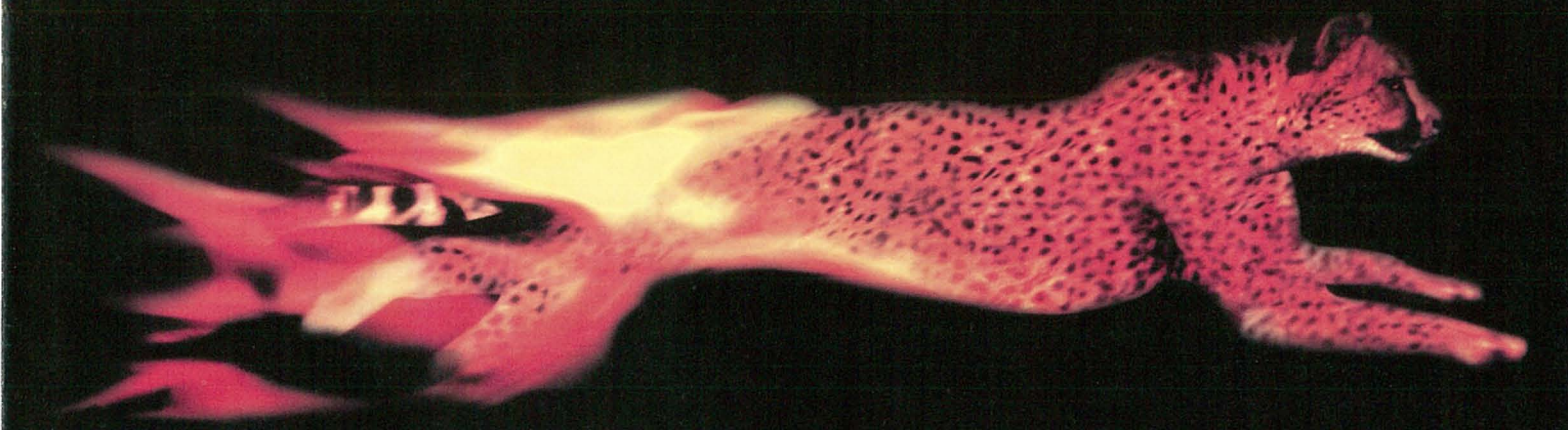

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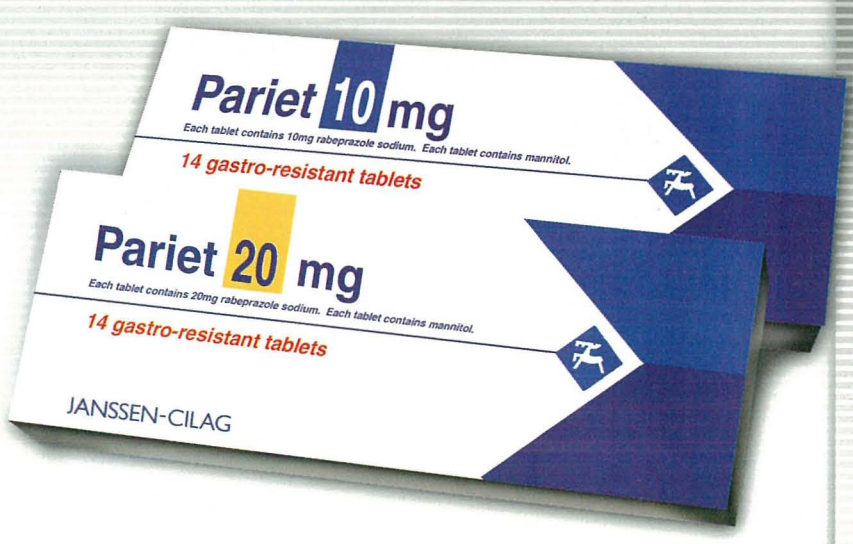


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# St. James GP Group Practice - A Success Story

Daniel Sammut - John Buhagiar

*INTRODUCTION*

The following is a history of the conception and development of a successful GP group practice working in the south of Malta. Fundamental concepts and practical aspects of its function and dynamics are discussed hereunder. We believe that these may be of interest to many Maltese GPs for whom this may be a new concept of general practice.

## HISTORY

St James GP Group Practice was founded in 1997 at St James Hospital, Zabbar, Malta. Dr John Buhagiar had been established as a single-handed GP since 1995. He had built up his clientele from scratch, since he had left Government service soon after ending his housemanship with the Department of Health.

In 1997, he joined forces with Dr Vincent Zammit, who came over from England for that purpose. Dr Zammit had worked for 20 years in a seven-partner fund-holding group practice at Studholme Medical Centre in Ashford, Middlesex. He had been one of the senior partners of that practice, and was also a certified GP trainer. He therefore brought along a vast amount of experience in the field of group practice work. In fact, we are very grateful and honored to have his ongoing guidance.

The two-partner practice thus began to function, but not without its teething problems. It was vital that partners have **absolute cooperation and trust** in each other, allowing them to **share all income**, expenses and workload. A contract between the partners was drawn up.

A most important issue from the outset was the need for **professional autonomy** from third parties. The practice was based in St James Hospital, although both partners held branch clinics in other areas. The GPs provide resident medical officer cover for in-patients within the private hospital, with a fee-for-service arrangement. However, they **remain general practitioners** in all other respects, and they provide clinic and domiciliary visit services. The GPs rent out two rooms within the hospital and have separate telephone lines. Working within St James Hospital holds several advantages such as receptionist and nurse backup. The environment also acts as a catalyst to generate GP work and provides a golden opportunity to learn continuously from consultants in all specialties.

Workload increased progressively so the practice decided to recruit a third partner. Dr Daniel Sammut joined in August 1999, after having worked for almost two years with the Department of Primary Health Care. In fact, he started off working part-time with the practice on a salary basis. For him, to work within the setting of a group practice was liberating. It was refreshing to work with doctors he could trust, in a relaxed and pleasant environment, to help patients with whom he could have a friendly relationship.

Dr V. Zammit retired from the group practice in January 2000, so a new partner was sought. This is when Dr David Sammut joined the team, bringing the number of partners back to three. He had also worked for a few months with the Department of Primary Health, and he adapted to our system very rapidly. Again, he was on a salary for the first year, but then started to earn a share of total income.

At this point in time, the practice realized that it had to improve its method of patient record-keeping. Up to then, this had been based on a card system, which was bulky, time-consuming, and inadequate. Therefore, we turned to the Malta College of Family Doctors for assistance, and we were provided with the **TRANSHIS database program** for patient records. A good database with networking of workstations is essential to a group practice, because patients visit more than one doctor on different occasions. In addition, this database is part of an international ongoing transition project for research in general practice. We are greatly indebted to Dr Jean-Karl Soler, who patiently taught us how to use the program and infected us with his enthusiasm. On several times he has come to our rescue when our database wouldn't function.

It then became important to find a **legal identity** for the practice. Since, to our knowledge, ours was the first true group practice on the island, we did not have guidelines to follow. After having consulted an auditor and an expert in company and cooperatives legislation, we concluded that we could only be a partnership with unlimited liability. We applied for a common receipt book, and took a medical malpractice insurance policy each.

With three partners the practice had stability and a certain degree of flexibility but when one doctor was away, the other two found it hard to cope with the workload. We noticed that whenever a new partner was introduced, work always **increased proportionally** to reach a new saturation point.

Hence, Dr Jason Bonnici was introduced as a fourth partner in December 2001. Incidentally, Dr Bonnici had been attached to the group practice as a medical student back in 1998, and had found the setup appealing. This goes to show how useful exposure to general practice can be for a medical student.

## PRACTICAL ASPECTS

Currently, St James Group Practice is made up of four doctors, who all give their contribution towards providing a **twenty-four hour high quality GP service**. During the week, one or more doctors is/are available within the clinic twelve hours a day. Weekends and public holidays are worked on a roster basis, with clinics held until noon. There is a doctor on-call every night for home visits of urgent cases for regular patients only. Of great importance is the fact that patients always phone at the hospital, and we **never give them our personal numbers**. Then, hospital staff passes on information using pager or mobile phone.

Each year every partner is entitled to 25 weekdays of vacation leave, 5 weekdays of study leave, and 40 weekdays of sick leave. I am sure that single-handed GPs will envy our **paid leave**.

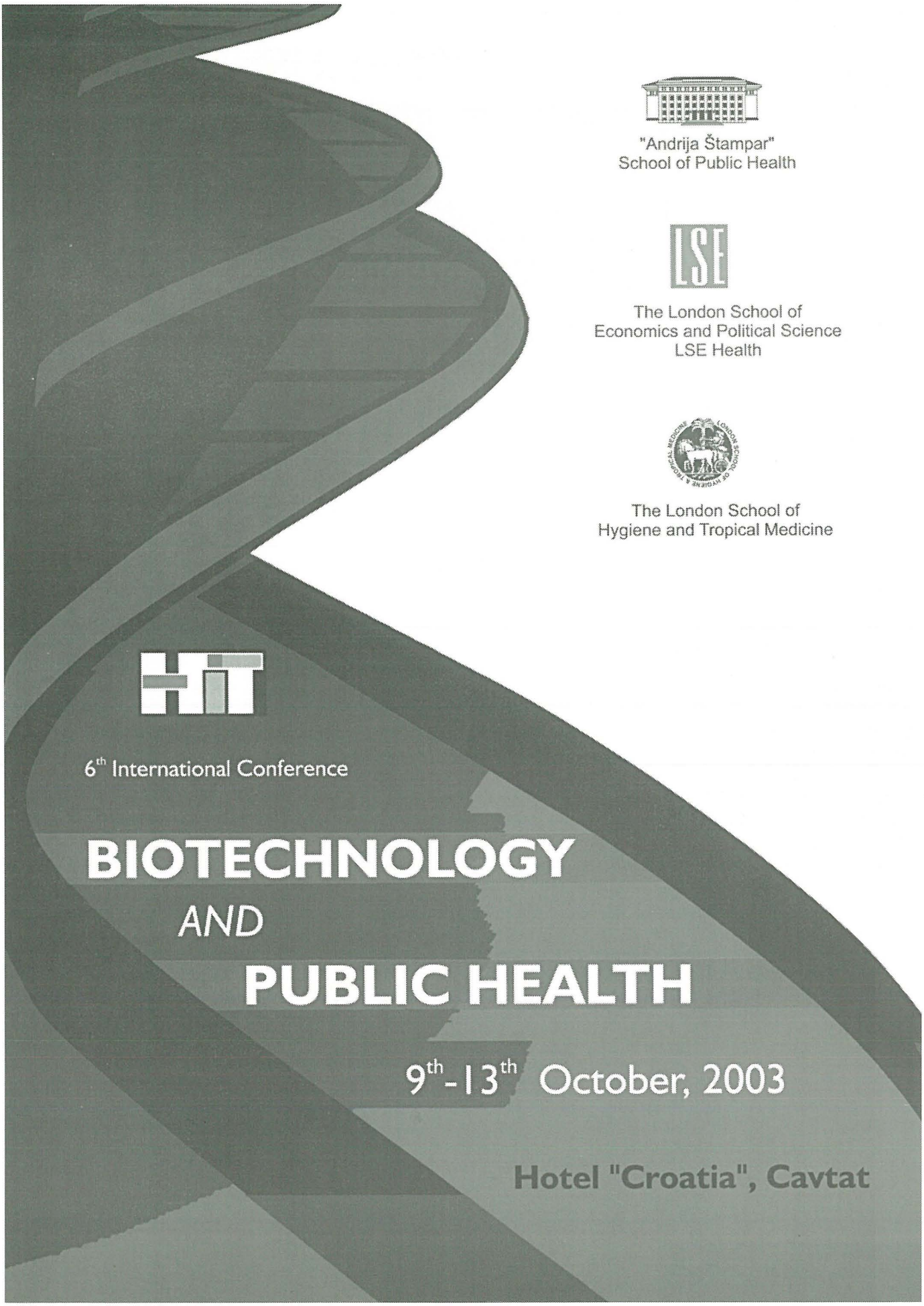
We share about four thousand patients between us. Most patients visit the same doctor when he is available, but do not hesitate to consult another doctor in his absence. Some patients swap doctors without problems. A few patients are loyal to only one doctor and will wait for his availability at all costs.

All doctors use special sheets to declare **all their income**, from whatever source, every day and pass on that income to the cashier. The latter meets expenses, and then distributes the net income to the partners each according to his share. In this way, every partner's income is remarkably stable over months. Naturally, all transactions are diligently recorded, and periodic reports are presented.

## ADVANTAGES OF TEAM WORK

There are many advantages of working in a team. A group practice allows GPs to be flexible without working 24 hours a-day. On average, we work 50 hours in a week. Teamwork ensures a continuous GP cover for clients, and the latter know that the doctors will communicate about their case either personally or through their database. Since every doctor has special skills and personal weak spots, a group practice permits **inter-GP consultation and referral**. We find this very stimulating. We also carry out CME tutorials between us. A team is more in a position to acquire large contracts such as company employee work and insurance medicals.

Most GPs in Malta prefer to work alone because they cherish their independence, but to provide a comprehensive service they must perforce be workaholics. We believe that the way ahead for a high standard primary health care service lies in the form of **state-funded GP practices**. Maltese GPs have to realize that ***"sharing sovereignty"*** gives them enormous advantage and better **quality of life** for themselves and for their patients.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# The MCFD's Participation at the ESGP/FM - Wonca Europe Conference '02

Mario R. Sammut

*INTRODUCTION*

The Malta College of Family Doctors (MCFD) was represented at the 2002 Conference of the European Society of General Practice / Family Medicine (ESGP/FM) – the European Region of the World Organisation of Family Doctors (WONCA Europe). The conference was entitled 'Promoting Excellence in Family Medicine', and took place on 9-13 June 2002 in London, U.K. under the auspices of the Royal College of General Practitioners during its 50th anniversary year. The MCFD representatives were Dr Denis Soler, College President, and Dr Mario R Sammut, Honorary Secretary, who made their own financial arrangements to attend.

**WONCA Europe Council Meeting**

As a member of the Council of WONCA Europe, Dr Denis Soler participated actively in the council meeting that took place on the 9th June 2002. Among the topics discussed were the future use and implementation of the new definition and core competences of family medicine / general practice (see below) which were launched by the society at the conference.

**The European definition of family medicine / general practice**

General practice / family medicine is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical specialty orientated to primary care.

The characteristics of the discipline of general practice/family medicine are that it:

a) is normally the point of first medical contact within the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned.

b) makes efficient use of health care resources through co-ordinating care, working with other professionals in the primary care setting, and by managing the interface with other specialities taking an advocacy role for the patient when needed.

c) develops a person-centred approach, orientated to the individual, his/her family, and their community.

d) has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient

e) is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient.

f) has a specific decision making process determined by the prevalence and incidence of illness in the community.

g) manages simultaneously both acute and chronic health problems of individual patients.

h) manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.

i) promotes health and well being both by appropriate and effective intervention.

j) has a specific responsibility for the health of the community.

k) deals with health problems in their physical, psychological, social, cultural and existential dimensions.

*(Ref.: WONCA Europe, 2002. The European Definition of General Practice / Family Medicine. Copies of this booklet are available from Dr Mario R Sammut on mcfd@synapse.net.mt)*

**Conference**

The professional and scientific programme presented at the conference considered the variety of environments in which family practitioners work and the impact these environments have on patient care. Seven key themes were focused upon:

1. International cooperation in primary care research;
2. Core values, philosophy and aspirations in family practice;
3. Effective clinical practice in partnership with patients;
4. General practice / family medicine as a career;
5. Informatics and health;
6. Promoting quality in primary care;

7. Developments in the organisation and delivery of primary care.

Dr Mario R Sammut in fact presented two **personal papers** under the last of these seven themes - 'Developments in the organisation and delivery of primary care':

- An Evaluation of the Organisation and Delivery of Smoking Cessation Services in Maltese Primary Care;
- Primary Care in Malta: Provision, Problems and Proposals for Reform.

Dr. Sammut also participated in the following **joint presentations**:

- Prevention and Health Promotion in Clinical Practice: Final Results of the EUROPREV Survey, under the theme 'International Cooperation in Primary Care Research';
- Tobacco Cessation in Primary Care: Developing National and International Strategies, under the theme of 'Promoting Quality in Primary Care';
- Update in Prevention and Health Promotion by National Colleges in Primary Care: From Recommendations to Implementation (on behalf of Dr Artur Mierzecki), also under the theme of 'Promoting Quality in Primary Care'.

Moreover, Dr Sammut was invited to be **chairperson** of a session entitled 'Values Across Cultures' under the theme of 'Core Values, Philosophy and Aspirations in Family Practice'. He also took part in the following **meetings and workshops**:

- Council Meeting of EUROPREV - European Network on Prevention and Health Promotion in Family Medicine, in his capacity as member of the EUROPREV coordinating group;
- Open Meeting of EURACT – European Academy of Teachers in General Practice;
- Motivate Healthy Behaviours: Developing CPD Programmes;
- Research in General Practice across Europe: Getting Started and Keeping Going.

**Recommendations for promoting research in general practice in Europe**

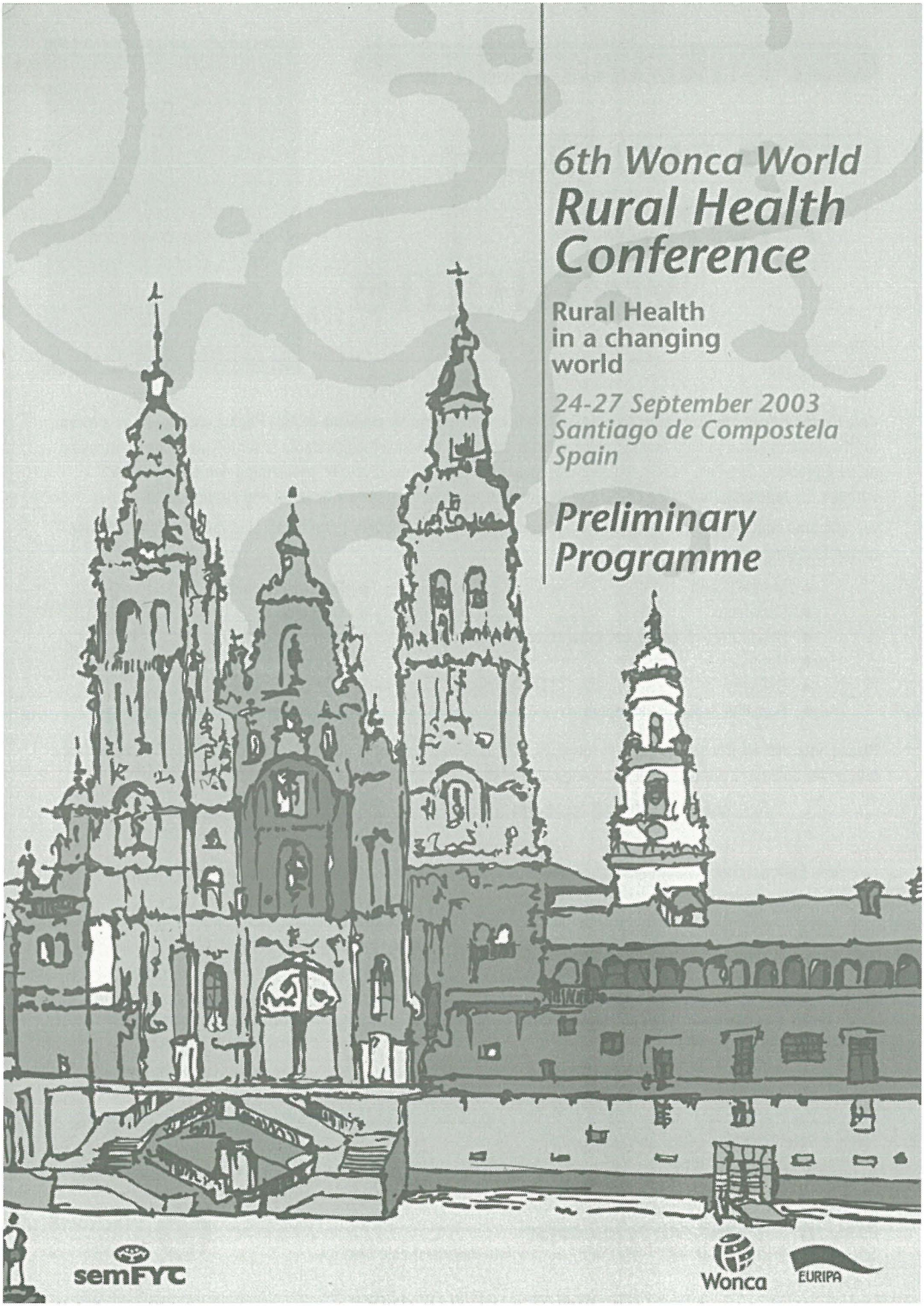
Arising from the last workshop, the following recommendations were agreed:

1. Lists of current/ongoing research projects need to be made easily available and 'searchable' on-line (e.g. through the websites of the European General Practice Research Workshop and the Royal College of General Practitioners), with a brief description of each project and the contact details of the researcher/s.
2. Universities, Departments and Colleges of Family Medicine need to:
   a) Provide teaching in research methods (e.g. self-directed courses) followed by mentoring and support;
   b) Stimulate on-going research by including a small research project in GP training programmes and CME curricula;
   c) Put pressure on governments to provide funding and protected time for research.

**Closing ceremony**

The highlight of the closing ceremony was an entertaining audio-visual presentation made by Prof. Igor Svab inviting participants to the 9th ESGP/FM Conference in Ljubljana, Slovenia, on 18 - 21 June 2003, with the theme of 'The Future Challenges of General Practice / Family Medicine'. If interested, please visit the conference website at http://www.woncaeurope2003.org for more details.

*Dr Mario R Sammut, Mrs Marie Soler and Dr Denis Soler (left to right) in front of the Maltese flag before the start of the opening ceremony at WONCA Europe 2002.*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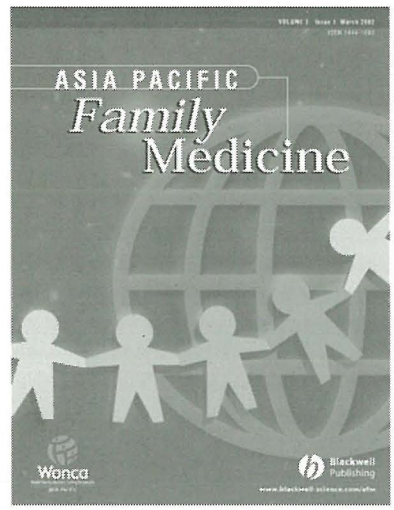


ISSN 1444-1683
3 issues per year

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# Comparison of Fear in Children With and Without Mental Retardation: A Study from Turkey

Pinar Bayhan, Ismihan Artan, Arzu Ipek Yukselen


## ABSTRACT

*Fear, which is present right from the very early periods of human life is one of the most common forms of emotion. Intelligence is also suggested to be among the major factors that affect fear. This study was designed and conducted to examine the fears of trainable mentally retarded children and those without mental retardation. Eighty-eight trainable mentally retarded childern aged 10-15 years and 122 children without mental retardation aged between 7-15 years were included in the study. The "Fear Survey for Children with and without Mental Retardation" developed by Ramirez and Kratochwill was used as the data collection tool. After statistical analysis, a significant relationship was found between mental retardation and the healthy states in terms of both the number of fear episodes and in its severity.*


About a century ago in 1897, Stanley Hall made the following remarks about fear: "There is no one who is not afraid. All humans fear, and indeed must fear. The problem from the pedagological point is not how to completely remove fear, but how to give the appropriate response to it.

Indeed fear, is present from the early states of human life and for children, represents a normal part of life and development (Robinson III, et.al., 1991, 187). Fear, is one of the most common emotional states that can be defined as "a natural response to both visible and invisible dangers, or in other words, response to a situation that is not well understood by living things" (Yavuzer, 1992, 75-76).

Kagan (1986), conducted a longitudinal research study on children from birth to age 8 years. Kagan, pointed out that children may have a genetic predisposition to fear but also asserted that the effect of the environment could not be overlooked. In his study he found that some children were more prone to fear right from birth. Later, he observed these same children for 8 years. He pointed out that those children who feared much in the period after birth could become less afraid, and those who feared little after birth could be come more afraid later. With this study, Kagan once again focussed attention on the diad of "genetics" and "environment" (Robinson III, et. al. 1991,188).

Most of the theoretical models available today seem to depend on a single base. The comprehensive model supported by Smith et al., is more detailed and combines the available studies. According to this model, fear is a dynamic entity affected by individual, environmental, social, and various interpersonal variables. According to the comprehensive model, fear is a normal developmental response to real or sensed danger (Smith, et.al.,1990, 151).

*Major factors affecting fear in children are as follows:*

* Intelligence,
* Gender,
* Socio-economic status,
* Social relations,
* Physiological conditions,
* Individual (Yavuzer, 1992,100).

During the entire growth period of the children, it was observed that they had different fears at different times. Some of these fears are specific to the period in which the child is found. For example, a one-year-old may have a fear of falling. For a child starting to walk, falling in a bad way may adversely affect his or her later attempts to walk. Children express their fears in different ways. While some may scream and cry, others may have nightmares and still others may try to stay away from objects that they have fear of (Gebeke, 1994, 1).

Robinson et al., considering opinions of other investigators prepared a table showing the distribution of fear in children by age as follows:

0-6 month-olds... Loss of support, high voice tones, sudden movements.

7-12 month-olds... Foreigners, high voice tones, suddenly appearing big objects.

1 year-olds..... Separation of parents, foreigners, injury, toilet.

2 year-olds..... Big animals, dark rooms, big objects or machines, high voice tones, sudden changes in the individual's environment

3 year-olds..... Dark rooms, masks, big animals, snakes, separation from parents.

4 year-olds..... Dark rooms, sounds heard at night,

big animals, snakes, separation from parents.

5 year-olds..... Wild animals, injuries, darkness, bad people, separation from parents.

6 year-olds..... Ghosts, beasts, witches/wizards, darkness, solitude, storms, lightning.

7 year-olds..... .Darkness, beasts, storm, getting lost, child snatchers, solitude.

8 year-olds..... Darkness, people(child kidnappers, thieves, robbers), arms and guns, animals, solitude

9 year-olds..... Darkness, getting lost, nightmares, accidents or injuries, solitude.

10 year-olds..... Darkness, people, nightmares, punishment, foreigners.

11 year-olds..... Darkness, solitude, nightmares, being injured by someone, falling sick, exams, exam results

12 year-olds..... Darkness, punishment, solitude, being injured or kidnapped, exams, scores.

13 year-olds..... Guilt in general, being injured by someone, kidnapped, war in general and nuclear warfare, poor scores, exams, punishment.

14 years +..... Failure at school, personal relationships, war, exams, sex matters (pregnancy, AIDS...), solitude, family worries (Robinson III, et.al., 1991,189).

## METHOD

### *Participants*

Eighty-eight mentally retarded children aged 10-15 years and 122 children aged 7-15 years without mental retardation were included in the study. The age and gender distribution of the children with and without mentally retardation are shown in Table I.

**Table I:** Age and gender distribution of the children with and without mental retardation

| | | Female | | Male | | Total | |
|---|---|---|---|---|---|---|---|
| | | N | % | N | % | N | % |
| **With MR** | | | | | | | |
| 10-15 | 10-12 year-olds | 19 | 59.4 | 31 | 55.4 | 50 | 56.8 |
| | 13-15 year-olds | 13 | 40.6 | 25 | 44.6 | 38 | 43.2 |
| | Total | 32 | 100.0 | 56 | 100.0 | 88 | 100.0 |
| **Without MR** | | | | | | | |
| 7-15 | 7-9 year-olds | 25 | 39.7 | 19 | 32.2 | 44 | 36.1 |
| | 10-12 year-olds | 22 | 34.9 | 22 | 37.3 | 44 | 36.1 |
| | 13-15 year-olds | 16 | 25.4 | 18 | 30.5 | 34 | 27.8 |
| | Total | 63 | 100.0 | 59 | 100.0 | 122 | 100.0 |

Children constituting the mentally retarded group in the study sample were children from schools for the trainable in the central district of Ankara. The IQ of the mentally retarded children was in the range of moderate degree mental retardation group. The American Psychiatric Association, DSM IV (1994), considers moderate degree retardation as IQ of 35-40 and 50-55 (Heward, 1996). The Children Without Mental Retardation group was made up of children resident in the Ankara district center and attending public primary schools who had no handicap whatsoever.

### *Data Collection Tool*

Fears of the children included in the study sample was assessed by the "Fear Survey for Children With and Without Mental Retardation" method developed and later revised by Ramirez and Kratochwill in 1988 and 1990 ( number of fears= 0.84; total score= 0.86). This survey is a self-reported instrument that is administered individually and orally to each child. The questionnaire was in two parts. In the first part, different fear provoking objects and events and their explanations were listed from 1 to 58. Later, question numbers 59 through 60 were open ended. The children were asked about other fears not mentioned in the above list and when present what they were. As in the first part, the second part of the questionnaire was a list of fear provoking different objects and events numbered from 1 to 25. Side by side, the fear provoking events and objects in this part also had explanations attached. The second part was formed from evaluation of the answers to the previously developed question numbers 59 and 60. The confidence study of the fears questionnaire in this investigation was found to be, Cronbach alpha 0.9712.

### *Evaluation*

At the evaluation every fear provoker was read out one after the other as for example, "Did..... frighten you?" If the child gives a "no" (not afraid) answer he got zero "0" point for the question and the next question was jumped to. If the child gave a "yes, it frightens" answer, he or she was then asked "....frighten you a little or much?" If the answer was "a little" (a little afraid) he/she got "1"point, and if "much" ( very afraid) he/she got "2" points.

### *Procedure*

Both the children with and without mental retardation were asked questions individually in empty silent rooms provided by their school authorities. Before the start of the interviews each child was told to ask about the

fear being asked about in case it wasn't clear to him or her. When the question wasn't clear to the child the explanation beside the question was then given. For example: graveyards/places people are buried when they die. The same note was made before proceeding to question number 30. Answers were marked immediately.

*Data Analysis*

In the analysis the t-test, was used as the significance test for the difference between two means. Where the variance was not homogenous as determined by the Levene test, the Mann-Whitney U Test was used. The significance level for the data in the study was taken as $p<0.05$.

## FINDINGS

The most commonly observed 10 fears in the mentally retarded 10-15-year-old children group and those of the 7-15-year-old children group without mental retardation are as listed below (Table II).

Considering the general diversity of fear it was apparent that the diversity of fear amongst the MR girls and boys was higher than for boys and girls without MR.

In Table II results from the examination of the diversity of fear is shown. The most common fears observed among MR girls, was being hit at the buttocks (%59.4), girls without MR burning of the home (%96.8), whilst among boys with MR high altitude (%51.8), and among boys without MR thunder (%91.5) Examination of the fears among girls with and those without MR showed child kidnappers, getting lost, and being murdered to be among the 10 most common fears, though with different ratings. However, among boys with and without MR thunder, fire outbreak, child kidnappers and drowning were fears common to all. Examination of the most common fear provoking episodes in children with and without MR showed them to be concentrated on topics like physical dangers, animals, death, bad people, emotional derangement and physical injury (Table III).

In mentally retarded girls hitting the buttocks, shame, father shouting and to be beaten up were the fears observed that were not expressed by children from the other groups. It is noteworthy that they had fear of any attempts to punish them. Browne (1993) expressed the fact that mentally retarded children were abused physically and sexually. Parents are especially worried about the fact that mentally retarded girls are open to sexual abuse, and for that matter are seen to bring up their daughters under pressure. In this study, the observation that girls with mental retardation had fear of being punished, shows how widespread this problem is.

Table IV, shows the distribution (t test used for significance testing) of the number of fears and the severity of fear in relation to the mental status of the children in the study sample. Table V shows a comparison (Mann-Whitney U Test used for significance testing) between the mentally retarded children and those without mental retardation in terms of the number of fears and the severity of fears

**Table II:** Ten most common fears of children with and without mental retardation included in the study.

| | | | | | |
|---|---|---|---|---|---|
| **Without MR** | | | **With MR** | | |
| **Female** | Burning of the home | 96.8 | **Female** | To be whipped at the buttocks | 59.4 |
| (7-15) | Child kidnappers | 95.3 | (10-15) | Getting lost | 59.4 |
| n=63 | Fire | 93.7 | n=32 | What will happen in the future | 53.2 |
| | Lion or tiger | 93.6 | | To be beaten | 53.1 |
| | Narcotics | 90.4 | | Being made shy | 53.1 |
| | Unknown people who behave badly towards children | 90.4 | | Father shouting | 53.1 |
| | Drowning | 88.9 | | Foreigners | 53.1 |
| | Death or the Dead | 87.3 | | Thunder | 53.1 |
| | Getting lost | 87.3 | | Child kidnappers | 50.0 |
| | To be killed | 85.7 | | To be killed | 50.0 |
| **Without MR** | | | **With MR** | | |
| **Male** | Thunder | 91.5 | **Male** | High altitude | 51.8 |
| (7-15) | Narcotics | 88.2 | (10-15) | Fire outbreak | 50.0 |
| n=59 | Being leapt onto suddenly | 88.1 | n=56 | Horror films | 50.0 |
| | Fire outbreak | 86.5 | | Thunder | 50.0 |
| | Child kidnappers | 84.7 | | Getting lost | 46.5 |
| | Death or the Dead | 83.0 | | Child kidnapper | 44.7 |
| | Snakes | 79.7 | | Bees | 44.6 |
| | Getting into trouble | 79.7 | | Immunization | 44.6 |
| | Drowning | 78.0 | | Shark | 42.9 |
| | Lion or tiger | 77.9 | | Drowning | 42.9 |

**Table III:** Distribution of the fears reported to be the most severe 10 items by both the children with and without mental retardation in the study sample (intensity score).

| 10-15 Year-old Children With Mental Retardation | 7-15 Year-old Children Without Mental Retardation |
|---|---|
| *Home Burning | *Home Burning |
| *Father Shouting | *Narcotics |
| *Fire outbreak | *To be Killed |
| *High Altitude | *Child Kidnappers |
| *Getting lost | *Getting drowned |
| *Horror films | *Fire Outbreak |
| *Weapons | *Lion or Tiger |
| *Dogs | *Death or the Dead |
| *Child Kidnappers | *Snakes |
| *Being Punished | *War |

mentioned by the study sample. Examination of the relationships between the number of fears and the severity of fears and being mentally retarded or not, showed the variances to be non-homogeneous according to the Levene Test, and for this reason, the Mann-Whitney U Test was applied. From the results obtained in this study, a significant relationship was found between the number of fears and the conditions of being mentally retarded or not ($p=0.0001$; $p<0.05$). A significant relationship was also found between the severity of fear and the conditions of being mentally retarded or not ($p=0.0001$; $p<0.05$)

Table VI shows the relationship between the number of fears and the severity of fear and the gender of the mentally retarded children using t-test. Here, the arithmetic mean of the number of fears in both girls and boys was observed to be closer to one another (x girls=30.5; x boys=26.2). In like manner, the arithmetic mean of the severity of fear for both boys and girls was observed to be similar. (x girls=47.3; x boys=44.1) (no significant difference using t-test). Table VII however, examines the relationship between the number of fears and the severity of fears among children with and without mental retardation according to t-test in the study sample. By this, the difference between the fears of boys and girls was found to be significant ($p=0.008$, $p<0.05$). In terms of the severity of fear, the difference observed between boys and girls was significant ($p=0.023$, $p<0.05$).

## DISCUSSION

Some investigators support the notion that mentally retarded children express their emotional reactions far later in life than normal children. Cicchetti and Sroufe (1976, 1978), conducted a longitudinal study on the development of laughter and smiling in babies with Down's Syndrome. They found that children with Down's Syndrome had a delayed laughing reaction but had the same series of reactions to stimulants as normal babies (Ganiban, et.al.,1993, 43). In a study on children with more than one handicap Gallagher, Jens and O'Donnell (1983), found a significant relationship between the mental age and smiling behaviour (Ganiban, et.al., 1993, 44). Cicchetti and Sroufe (1978), in their study on babies with Down's Syndrome used the Bayley and Uzgiris-Hunt scoring system. In this study, babies with Down's syndrome who showed fear and expressed their sorrow at earlier stages were found to have intelligence scores higher than the others (Ganiban, et.al.,1993, 44). Bauer also mentioned the relationship between fears and mental development of children (Robinson III, et.al,1991, 191). However, some investigators defended the notion that mentally retarded children compared to those with normal development can have more fears. Children also think that success in life can raise their self esteem which in turn may also affect their perception of fear. According to investigators a child with high self-confidence thinks that he is able to control his environment and hence has little to fear. For example when such a child is left alone in the dark he/she thinks he can bring back light and therefore fears little. However, for the mentally retarded child as he/she grows to understand the handicap and gets to feel that his failure is linked to that handicap, then he/ she loses self confidence and gets worried about not being able to control his environment. This could then lead to an increase in his /her fears. According to Rotter and Robinson (1987), the child is able to develop appropriate strategies towards fear provoking events or objects depending on level of mental development, and this may lead to a decrease in his fears (RobinsonIII, et.al, 1991, 193). In a study on children with normal development and those in need of special education, Deverensky found the mentally retarded children to have more frequent and more severe fears than the normally developing children (Deverensky, 1979). In the same way, Zelfa also found that mentally retarded children show more frequent and severe fears than normally developing members of their agegroups (Zelfa, 1988, 2595).

In both groups, children with and without mental retardation, "burning of the home" is the most common fear at first glance (Table III). Apart from this though, with differences in

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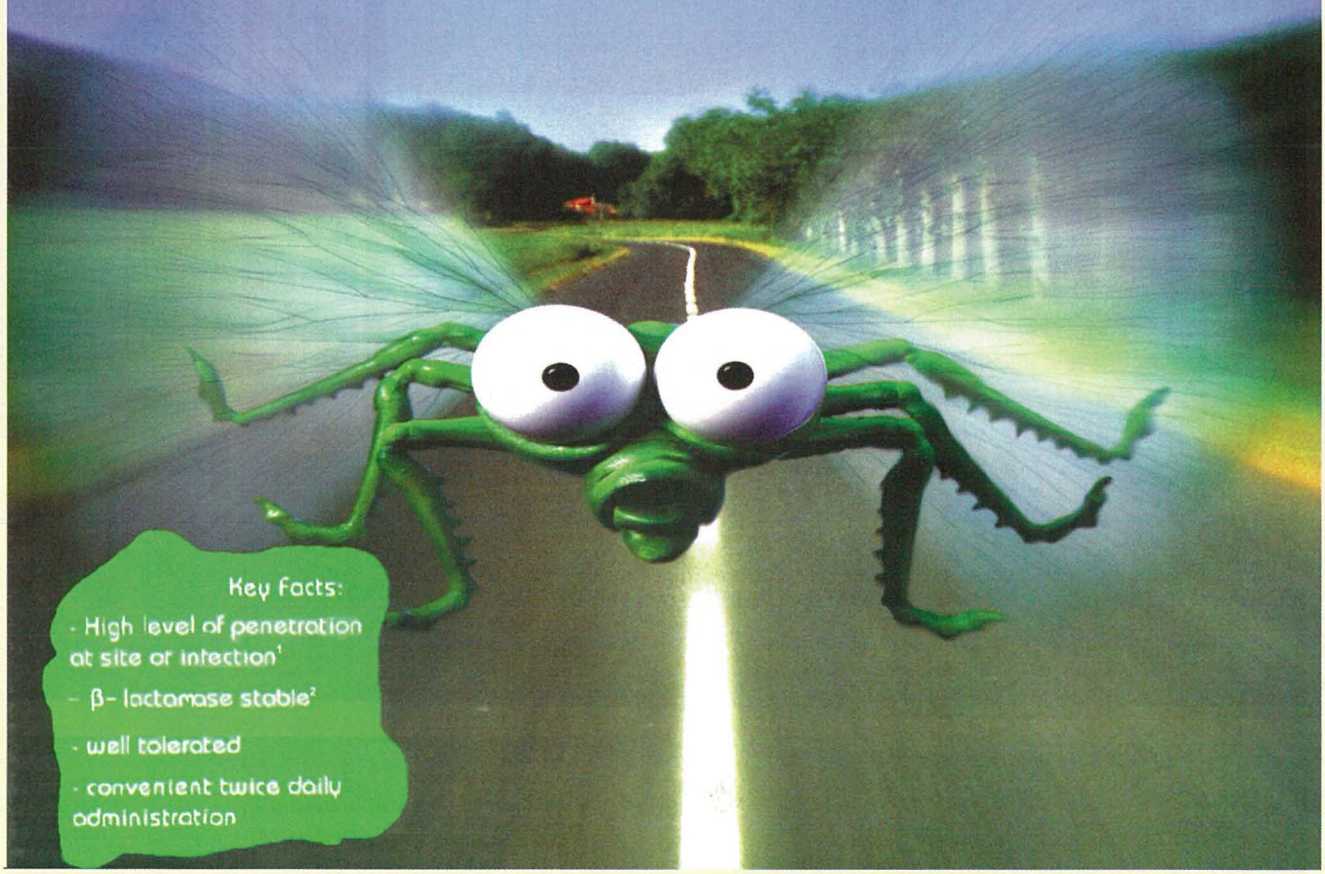


**Abbreviated Prescribing Information** **Uses** Zinnat is indicated for infections of upper and lower respiratory tract, skin and soft tissue. **Presentations** White tablets containing 125 mg, 250 mg and 500 mg cefuroxime axetil, suspension containing 125 mg cefuroxime axetil per 5 ml. **Dosage** *Adults:* Most infections - 250 mg twice daily. Lower respiratory tract infection - 250 mg twice daily. Pneumonia - 500 mg twice daily. Urinary tract infection - 125 mg twice daily. Pyelonephritis - 250 mg twice daily. Uncomplicated gonorrhoea - 1 g single dose. *Children*: Most infections - 125 mg twice daily. Otitis media - 3 months to 2 years 125 mg twice daily, 2 years to 12 years 250 mg twice daily. Tablets should not be chewed or crushed and therefore are not suitable for children under five years of age. Zinnat should be taken after food for optimum absorption. **Contra-indications** Hypersensitivity to cephalosporin antibiotics. **Precautions** Zinnat may, in general, be given to patients who are hypersensitive to penicillins, although cross-reactions have been reported with some cephalosporins and special care indicated in patients who have experienced anaphylactic reaction to penicillin. Cefuroxime axetil should be administered with caution during early months of pregnancy. **Side effects** Gastrointestinal disturbances including diarrhoea, nausea and vomiting had been reported, these are generally mild and transient in nature. As with all broad spectrum antibiotics, there have been rare reports of pseudomembranous colitis. Rarely, hypersensitivity reactions, eosinophilia and transient increase of hepatic enzyme levels have been noted. **Package quantities** All strengths of tablets are supplied in foil strips in packs of 10. Suspension is supplied in bottles containing 50 ml and 100 ml.


**References:**

1. Perry CM & Brogden RN. Drugs 1996; 52(1): 125-158.
2. ZINNAT Approved Product Information.



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Table IV: The distribution of children with and without mental retardation in sample according to the t-test of the relation between number of fears and intensity of fears.

| | Number | Mean Number Of Fears | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| **Number of fears** | | | | |
| With MR | 88 | 27.7727 | 21.6108 | 2.3037 |
| Without MR | 122 | 41.9016 | 14.1237 | 1.2787 |
| **Severity of fears** | | | | |
| With MR | 88 | 45.3068 | 36.5341 | 3.8946 |
| Without MR | 122 | 64.5984 | 25.9251 | 2.3471 |

Table V: The distribution of children with and without mental retardation in the sample in relation to the number of fears and intensity of fears (Significance test: Mann-Whitney U).

| | Number | Mean Rank | Sum of Ranks | u | p |
|---|---|---|---|---|---|
| **Number of fear** | | | | | |
| With MR | 88 | 78.57 | 6914.00 | 2998.0 | 0.0001 p<0.05 |
| Without MR | 122 | 124.93 | 15241.00 | | significant |
| Total | 210 | | | | |
| **Severity of fear** | | | | | |
| With MR | 88 | 83.60 | 7356.50 | 3440.5 | 0.0001 p<0.05 |
| Without MR | 122 | 121.30 | 14798.50 | | significant |
| Total | 210 | | | | |

Table VI: The distribution of children with mental retardation in relation to the sex of children and the number of fears and intensity of fears.

| (With MR) Gender | No. | Mean No. Of Fears | Std. Deviation | Std. Error Mean | t | p |
|---|---|---|---|---|---|---|
| **No. of fear** | | | | | | |
| Female | 32 | 30.4688 | 22.5517 | 3.9866 | 0.884 | 0.379 p>0.05 |
| Male | 56 | 26.2321 | 21.1058 | 2.8204 | | nonsignificant |
| **Severity of fear** | | | | | | |
| Female | 32 | 47.3438 | 33.6439 | 5.9475 | 0.540 | 0.695 p>0.05 |
| Male | 56 | 44.1429 | 38.3346 | 5.1227 | | nonsignificant |

Table VII: The distribution of children without mental retardation in the sample according to the sex of children and the number of fears and intensity of fears.

| (Without MR) Gender | No. | Mean No. of Fears | Std. Deviation | Std. Error Mean | t | p |
|---|---|---|---|---|---|---|
| **No. of fear** | | | | | | |
| Female | 63 | 45.1587 | 13.8450 | 1.7443 | 2.70 | 0.008 p<0.05 |
| Male | 59 | 38.4237 | 13.6902 | 1.7823 | | significant |
| **Severity of fear** | | | | | | |
| Female | 63 | 69.7302 | 26.6653 | 3.3595 | 2.299 | 0.023 p<0.05 |
| Male | 59 | 59.1186 | 24.1440 | 3.1453 | | significant |

the ratings, "fire outbreak" and "child kidnappers" also occupy important places. In a study in which 5-15 year-old 400 school children expressed their fears, Jersild, Markey and Jersild (1933), some of the pioneers of fear studies classified fear into 18 categories and presented it in the form of a list (Draper and James, 1985).

*Wounds-injuries and physical dangers, *Animals, *Bad people, thieves, etc., *Supernatural events, secrets, mysterious events, *Darkness, solitude, abnormal sights, malformations, *Nightmares and ghosts, *Harassment, being accused, failure, *Losing things belonging to one's self, *Sickness, being wounded, death of a close relative, *losing a parent or close relative, *other people being wounded, quarrels-fighting *stunning events and noises, *frightening noises, stories, movements, *Terrifying events, *Some people and objects *Marriage, *Nothing, *No idea.

According to Graziano (1978) fear in children starts when the child is exposed to a fear provoking event; this can be internal ie, something from inside or from the external ie, something from the environment. In some situations both entities may prevail. (Smith,et.al.,1990). In the development of the above fears parents and the environment are thought to be effective. The conditions mentioned above are conditions likely to create danger results for the child, his family or environment. For this reason, children are likely to be warned by their parents frequently. From time to time the media can also arouse these fears in children. With the effect of the media children can become afraid of conditions like war, terorism, supernatural events and natural disasters which in actual fact are not encountered by the child.

Fear of being beaten, punished, hit on the buttocks, going to the dentist, and being immunised may be learned fears. Previous experience of the children plays a role in identifying the potential objects/conditions of fear by the child. They may fear pain producing events like being beaten up, visiting the dentist by recollecting their past encounters with such states. In other words, children learn to fear these provoking situations or objects.

According to the results of studies conducted, children with mental retardation experience less numbers and less severe fears than children without mental retardation. When the levels of mental development in the children included in the mentally retarded group of the study sample was compared in the Ramirez and Kratochwill (1997) sampling study, it was seen that the average IQ of the children was 67 (interval 50-81) , in the trainable level group (mild retardation). The children in our study sample could be thought of as not developed enough to perceive the fear provoking items asked in the questionnaire because they were from the trainable category (Moderately retarded). This also seems to confirm the relationship between mental development and expression of emotional reactions defended in the studies by Cicchetti and Sroufe (1976, 1978), Ganiban et al., (1993), Gallagher, Jens and O'Donnell (1983), Cicchetti and Sroufe (1978) and Bauer.

Several investigators like Croake (1969), Croake and Knox (1973), Orton (1982), Davidson (1985) in their studies conducted found girls to fear more than boys do (Smith, et.al., 1990,154). In a study by Ramirez and Kratochwill, in terms of the number and severity of fear, children with mental retardation and girls without mental retardation were found to have more fears than normal boys. (Ramirez ve Kratochwill, 1997, 89).

In studies by Bauer,1976; Houston, Fox and Forbes, 1984; Lapouse and Monk, 1959; and Ollendick et al., 1985; Pratt(1945) fear was found to be more prevalent in girls. While some investigators are of the advocate that this lies in the fact that girls readily express their fear, others are in of the view that this lies in families treating their children differently based on gender differences. Thus, according to these investigators families tend to accept fears of their daughters more easily than those of their sons. (Kendall and Ronan, 1990).

The difference between boys and girls without mental retardation was not found to be significant in the study conducted. Because the intelligence level of the children in the study sample was within the educatable levels and the number of fear episodes and its severity was not yet apparent in these children no significant difference due to gender could be observed.

In our country, mothers and fathers of children with mental retardation usually behave in a restrictive manner with their children. They don't believe that their children can take care of themselves and live independently. Therefore the children with mental retardation can not improve their self-esteem. Because of this the children with mental retardation have more frequent and more severe fears than the normally developing children.

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# Slovenian Journal of Public Health

Igor Svab

The monthly review »Zdravstveno varstvo«, for more than four decades presenting the basic publication on the domain of public health in Slovenia, is entering the year 2003 with a new editorial board and new goals. The main ones are to update the review and to increase its professional reputation. The basic concept remains the same: the review deals with the public health domain and primary health care. It stimulates the contributions regarding public health problems and public health development, especially in the area of Central and South-Eastern Europe.

Contributions were divided in two basic categories, and include editorials, review and research articles and short reports. Other contributions include professional reports, letters to the editor and news. These changes required changed and more detailed instructions for authors.

The only criterion for the publication will be professionalism. Special attention was devoted to a better review procedure, considering the criteria used in all the reputable journals. At least two independent experts will assess all the contributions and their opinion will decide whether to publish them or not. Most prominent experts from home and abroad will be invited to collaborate.

It has been decided that after the New Year, the journal will be published in the Slovene and English language simultaneously. Thus the Slovene terminology will still be cultivated, while at the same time foreign authors could publish their contributions, so that the experts who are not proficient in Slovene could read them. This means that readers will find articles in Slovene and English in the same issue. A good abstract in English will be provided for each Slovenian article, and a good abstract in Slovene for each English article.

So after the New Year, the journal will have a Slovene as well an English title. The title in English »Slovenian Journal of Public Health« is not a verbatim translation of the Slovene version, but it elucidates the domain, covered by the journal, in the best way.

The journal will be available on the internet which is becoming an ever more powerful medium in professional literature. Thus we will try to reach as broad a circle of expert readers interested in the domain of public health as possible.

These changes will - hopefully - improve the professional level of the journal and contribute to the domain of public health in Slovenia. We wish that our present readers would keep reading our review also in the future and that we will attract new ones. The success of our efforts will be reflected by the reactions of our readers. They are always the most critical and righteous arbiters.

**PAIN - 'The Fifth Vital Sign'**

The clinical management of pain is a problem that continuously confronts the physician, yet there are wide gaps in our knowledge concerning the structure and physiology of pain-temperature pathways.

*The little studied condition called Thalamic Pain Syndrome (TPS).*

In clinical management - "pain" is probably the most difficult problem that confronts the Primary Care Physician. And yet there are wide gaps in our knowledge of TPS. From the aspect of Neurophysiology, the Thalamus sends almost constant pain signals to the body. The peripheral receptors for pain are presumably bare terminals of a branching network of fine nerve fibers.

The perception of pain sensations are recognized as: just pain (sharp, pricking), and others as slow (burning). Although pain is invisible and it can only be measured by the sufferer, the idea that it's all in the mind is purely hogwash - and dangerous. Chronic pain has been shown to weaken the "immune system," impair healing, and disturb sleep patterns; all while increasing depression, anxiety, and social isolation. It invariably leads to more pain. "It's the classic vicious cycle."

"The more depressed and debilitated one becomes because of pain, the less able he or she is to seek help."

Penny Cowan; The founder of the "American Chronic Pain Associatuion" (1980) knows only too well the despair that accompanies chronic pain."I'm 53, but I know what it's like to be 80." Twenty seven years ago, she reported the tremendous headaches and neck pain to her family doctor.

The doctor at first thought she might have an aneurysm, multiple sclerosis, even went as to include leukemia. After a battery of tests came up negative, he then suggested that she is simply depressed. Meanwhile the debilitating pain spread to her joints - when she started seeing other doctors. None of them could find anything. The test would come back negative and they'd tell me, "well, you're just going to have to live with it."

What they failed to understand was that severe chronic pain takes total control of your life. The guilt and powerlessness you feel when they tell you it must be in your head, is as bad as the pain itself. This is not unique. After six years, she was diagnosed with "fibromyalgia syndrome" - pain in the muscles, tendons, and ligaments for which no cause has been identified.

"The first and most basic thing chronic pain sufferers want from their doctor is simply - to be believed."

It's the asking about the nature of the pain, treat it and then follow up to make sure the treatment is effective for the patient. But the acknowledging of pain ultimately is not as important as treating it.

In a survey of 108 women with gyneclogic cancer for example; it was found that fear was the predominant psychosocial consequence of having cancer. Specified fears were: fear of pain (63 percent), dying (56 percent), losing control of their lives (48 percent), and becoming totally dependent (46 percent) on pain killers.

*Most importantly however, do not stigmatize the pain sufferer.*

The treatment of pain is not a medical issue but a moral imperative. Consider pain as the: "Fifth Vital Sign" (in addition to pulse, blood pressure, temperature and respiratory rate).

"..... in the privacy of the examining room, I was accorded the great privilege of talking about me, my feelings and aches and pains and what's happening here and there and down here, and the doctor was not so bored to hear about it."

*J.Mifsud - Navarro*

**The Middle East Journal of Medicine**

The Middle East Journal of Medicine (MEJFM) is a new peer-reviewed journal to meet the needs of scientists, practitioners, policymakers, and the patients and communities that serve in the Middle-East. The Journal will begin publication, online, in spring, 2003. The frequency will be initially once every 4 months for one year then once every three months followed by once every two months.

The Mission of the Journal will be to promote family medicine in the Middle East. The journal will publish original clinical and educational research of interest to primary care specialities, practicing clinicians, residents and others involoved in primary care and community medicine education. The journal also publishes special articles and commentaries about the fundamental concepts of medical education, as well as book reviews and international reports. It will foster the basic and applied sciences of primary care practice.

The aim of the journal will be to provide academically sound, clinically practical information for family and general physicians, in addition to the promotion of the specialty of family medicine in the Middle-East Region.

*A.Abyad*
*(Editor)*


Correspondence and contributions to this journal are to be sent to:
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