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Issue: Quality of Life in Providers of Health and Social Care

Original Articles

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Original Articles

Editorial

Dear readers, colleagues. I am starting my career as a medical doctor who has chosen her first job as a physician at small missionary clinic in Eldoret, Kenya. For most of us, our work is a mission in which we want to help where it is needed, we want to feel like we‘re doing something meaningful, and we try our best often to the detriment of our own needs. Doctor‘s work is usually infinite. It is not enough that we have a full-time job with multiple overtime or shifts, but also at home there are additional demands for help or advice from our friends or family.

The work in Kenya showed me this reality in it‘s extreme form, thanks which I was able to reconsider my action and priority. After work I was tired of examining many patients with difficult life issues, at home I had to be at the disposal for my husband with the children until I completely forgot about my needs and how to get back spent energy. Oftentimes, I felt like I was just giving, helping others, and noone provided the same for me. It was the first burnout not even after the first year of my work. This forced me to change my attitude towards myself. Complaining or blaiming others is not solution for this situation. I realized, that if I want to help others, first of all I need to know how to help myself to feel good, happy, healthy. So I just reserved time for myself and I did what I wanted at that moment, whether it was sleeping,doing some sport,reading a book, watching a movie or just walking in a nature. My life has moved in a better way. I am happy, I am attracting many positive situations and I have enough energy to handle occasional barriers.

I would like to remind you how important it is to take care of yourself first. I wish you to be strong enought for getting what you need to for doing this brilliant profession.

Dr. Michaela Mulera, PhD.
Clinic St. Ladislaus Strattmann in Eldoret, Kenya

Few words from the Editors-In-Chief

This journal brings authentic experiences of our social workers, doctors and teachers working for the International Scientific Group of Applied Preventive Medicine I-GAP Vienna in Austria, where we have been preparing students for the social practise over a number of years. Our goal is to create an appropriate studying programme for social workers, a programme which would help them to fully develop their knowledge, skills and qualification. The quality level in social work studying programme is increasing along with the growing demand for social workers.

Students want to grasp both: theoretical knowledge and also the practical models used in social work. And it is our obligation to present and help students understand the theory of social work as well as showing them how to use these theoretical findings in evaluating the current social situation, setting the right goals and planning their projects.

This is a multidimensional process including integration on many levels. Students must respect client's individuality, value the social work and ethics. They must be attentive to their client's problems and do their best in applying their theoretical knowledge into practice.

It is a challenge to deliver all this to our students. That is also why we have decided to start publishing our journal. We prefer to use the term 'clinical social work' rather than social work even though the second term mentioned is more common. There is some tension in the profession of a social worker coming from the incongruity about the aim of the actual social work practice. The question is whether its mission is a global change of society or an individual change within families. What we can agree on, is that our commitment is to help people reducing and solving the problems which result from their unfortunate social conditions. We believe that it is not only our professional but also ethical responsibility to provide therapeutic help to individual and families whose lives have been marked with serious social difficulties.

Finding answers and solutions to these problems should be a part of a free and independent discussion forum within this journal. We would like to encourage you – social workers, students, teachers and all who are interested, to express your opinions and ideas by publishing in our journal. Also, there is an individual category for students' projects.

In the past few years there have been a lot of talks about the language suitable for use in the field of the social work. According to Freud, a client may be understood as a patient and a therapist is to be seen as a doctor. Terminology used to describe the relationship between the two also depends on theoretical approach. Different theories use different vocabulary as you can see also on the pages of our journal.

Specialization of clinical social work programmes provides a wide range of education. We are determined to pass our knowledge to the students and train their skills so they can one day become professionals in the field of social work. Lately, we have been witnessing some crisis in the development of theories and methods used in clinical social work. All the contributions in this journal are expressing efforts to improve the current state. This issue of CWS Journal brings articles about social work, psychology and other social sciences.

Michael Olah
Peter G. Fedor-Freybergh
Edition of the journal

Ultrasound Examination in Healthcare Facilities of Refugee Camps

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Abstract:

This article depicts the usage of ultrasound imaging in field healthcare facilities of St. Elisabeth University of Healthcare and Social Work in Bratislava – in two refugee camps in Greece during a one-week period when they were staffed by a Physician experienced in and licensed for ultrasound imaging. 16.2% of patients have been indicated by the Physician to be examined by ultrasound and 15.8% of these had

abnormal findings. The majority of the examinations were indicated for pregnancy-related issues or abdominal pain. Despite this sample being too small we have clearly observed a great need for skills in obstetric ultrasound in this humanitarian project.

Introduction

Field healthcare facilities of St. Elisabeth University of Healthcare and Social Sciences in Bratislava ran in two refugee camps in Greece were one of many humanitarian projects of this university at present. This project ran since May 2016 and comprised two outpatient departments providing primary medical care similar to general practitioner for refugees in camps near towns Veroia and Alexandria in the Imathia Region of Northern Greece. These facilities were staffed by a Slovak team consisting of a Doctor (mainly with a specialty in general practice, infectious diseases or Pediatrics), a Pediatric Nurse and a Social Worker. This team employed translators from Arabic to English and was accompanied by Greek staff from KEELPNO (Hellenic Center for Disease Control & Prevention), a Nurse and a driver, and cooperated with the Greek Army in whose former barracks the refugee camps were settled. Their inhabitants were refugees mainly from Syria on their journey to Europe. They were already registered by UNHCR and waiting in the camps for up to several months to be accepted by another European country to become their final destination.

In September 2017, the facilities looked after approximately 270 refugees in Veroia Camp and 300 refugees in Alexandria Camp. 24 of them (i.e. 4.2% of inhabitants) were pregnant females. The working hours of the clinics were at that time from 10 a.m. to 1 p.m. in Veroia Camp and from 2 p.m. to 5 p.m. in Alexandria Camp. The one hour in between was for the staff to move 25 km from one camp to the other. Each camp was visited every working day, from Monday to Friday, by roughly 10 to 15 patients.

Each facility was well-equipped for the medical care it provided. This included all necessary medicines both for enteral and parenteral administration and medical equipment such as blood pressure monitors, thermometers, a blood sugar monitor, a pulse oximeter, a CRP analyzer, a hemoglobin monitor, an otoscope, an ophthalmoscope, pregnancy tests, test kits for hepatitis and HIV, a nebulizer, a 12-lead ECG, an automated external defibrillator, a stretcher and a portable ultrasound. There was an ambulance car for the referrals of more serious cases to the hospitals and transfers of patients to and from their appointments at specialists.

The ultrasound machine was a Mindray, 15“ Portable Model DP-50 equipped with a 3.5 MHz convex and a 7.5 MHz linear multi-frequency probes capable of standard B-mode including tissue harmonic imaging (THI) and standard functions like measurements in B- and M-mode, estimation of gestational age in obstetric ultrasound etc. Unfortunately, the ultrasound machine was not much used for most of the time, because the majority of the Doctors were inexperienced in ultrasound imaging.

This article describes the usage of an ultrasound machine during a one-week period from 4th to 8th September 2017 when the facilities were staffed by an Emergency Physician skilled in ultrasound imaging and licensed for abdominal ultrasound imaging.

Fig. 1: View of the clinic in Veroia refugee camp.

Fig. 2: Nurse Maria & Dr.Jan Veroia Clinic.

Material and Methods

At that time, there were 123 visits in both the camps, most of them with minor problems and injuries, e.g. a sore throat, diarrhea, backache, rashes, insect bites etc. Patients coming with complaints such as abdominal pain were examined by ultrasound as they would be in our normal European "non-field" setting. Pregnant women were coming when it became known that there was a possibility of ultrasound check-up of their pregnancy. Most of these had never been examined by ultrasound in this pregnancy on their way to Europe.

There were 20 ultrasound examinations carried out for 19 patients (i.e. 16.2% – one ultrasound exam in 6 visits) aged 3-60 years (mean 26 ± 15.1 years); 13 females aged 3-58 years (mean 26 ± 11.7 years); 6 males aged 14-60 (mean 34 ± 17.6 years) – one of them had been examined twice. The summary of indications for the ultrasound examination is shown in the graph (Fig. 3). Although the sample is too small, it can provide some general impression: the majority was represented by abdominal pains and pregnancy-related problems including common check-ups – these obstetric screenings accounted for 40% of all ultrasound examinations.

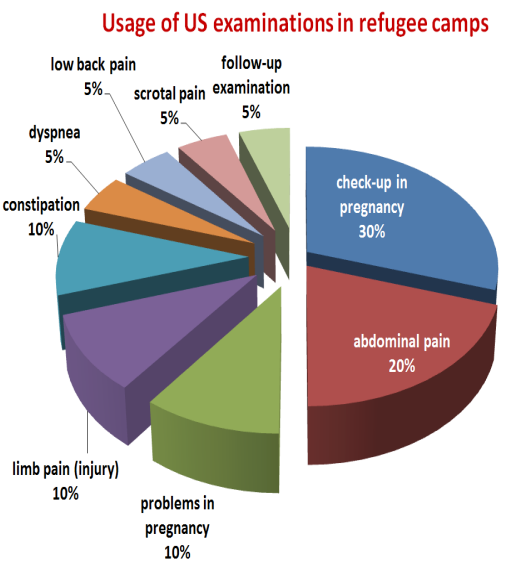

Fig. 3: Usage of ultrasound examinations in refugee camps.

The greatest need, in two fifths of the sample, was for obstetric ultrasound. Its goals were mainly to:

- confirm the pregnancy (gestational sac is visible from 3-5 weeks – first empty, then with a yolk sac and finally with an embryo from about 6 weeks),
- tell the number of embryos/fetuses,
- assess the viability of the embryo/fetus: detect cardiac action and measure the fetal heart rate using M-mode (FHR,

around 100-120 bpm at 6 weeks, up to 9 weeks it increases to 120-180 bpm) and assess fetal movements,
- estimate the gestational age (GA) using a built-in program,
- describe the insertion of a placenta (visible from 10-12 weeks and may change as the lower uterine segment grows) to rule out placenta previa or to plan Caesarian section in advance. (The incidence lowers from about 5% at 16-18 weeks to 0.5% at delivery.),
- assess the cervical length in 2nd and 3rd trimester and dilation (should be >25 mm and not prematurely dilated if there is no insufficiency).

The determination of the sex of the fetus was not a goal of such examinations but serves to assure the mother that her baby is doing well and calm her mainly in case of abdominal pains etc. The parents should be told the sex of the fetus only when there is no doubt about it and they want to know it. Although it can be determined from about 12 weeks of gestational age, this also demands a good resolution of the ultrasound machine and an experienced operator. At any time if the findings are equivocal or the examination is technically difficult, a follow-up examination should be obtained.

The rest of the examinations were mainly common abdominal ultrasounds, but it is helpful if the physician is also experienced in basic echocardiography to rule out major disorders like pericardial effusion, RV enlargement and IVC dilation as signs of possible pulmonary embolism or signs of dehydration and hypovolemic shock or cardiac failure. So called "BLUE protocol" (ruling out pneumothorax and assessing the lung tissue) can be useful in dyspneic patients. Another possible usage is to examine long bones and muscles if a fracture or muscle tear are suspected after an injury to the limb. This is quite simple and can rule out the fracture by visualization of an intact cortical surface (in several planes in order not to miss any angulation) when there are clinical doubts. This procedure can lower the number of possibly problematic referrals to hospitals for X-ray imaging. It is useful mainly for examination of diaphysis of long bones of extremities, clavicle, ribs and skull. Another aim in limb pain is to rule out deep vein thrombosis. For this application, a color doppler (color flow mapping) mode is used as a standard, but the basic examination can be carried out in B-mode as well to confirm that all the great veins are anechoic and fully compressible. Anyway, for all these purposes and other examinations of superficial tissues, a linear probe is needed. The convex probe (often of lower frequency and therefore lower resolution) with a spacer made of an infusion bag or a glove filled with water is a considerably worse alternative if the linear probe is not available.

Results

Although most of the examinations were, of course, with normal results, 3 out of these 19 patients (i.e. 15.8%) were with abnormal findings: a sludge in the gallbladder (without signs of inflammation) in abdominal pain, a liver cancer (suspected of hepatocellular carcinoma, Fig. 4) in abdominal pain and an abscess in scrotal pain (Fig. 5) that had been evacuated and another examination has been carried out during the follow-up (therefore there were 20 examinations together).

8 females have been examined because of their pregnancy. Two of them complained about abdominal pain, one about not feeling fetal movements and one was unsure if she was pregnant or not, the others came just to be checked-up. The GA has been estimated using a built-in program of the ultrasound using GS (gestational sac) or CRL

(crown-rump length) in the first trimester and BPD (bi-parietal diameter) or FL (femur length) in later pregnancies and has been 12 weeks + 0 days on average (mean 12 weeks + 1 day) – see Fig. 6-9. The fetal heart rates being measured using M-mode are shown in Fig. 10-11.

Other interesting findings were during the previous mission of first two authors at Alexandria Camp when a young female came complaining about not feeling the movements of her baby in her late pregnancy (about 6 months). The ultrasound examination revealed there were no detectable movements of the fetus, no cardiac action, and moreover, signs of decomposition of the fetus, a collapse of the skull respectively, as shown in Fig. 10. She has been referred (in overall good condition, without signs of sepsis and/or vaginal discharge etc.) to the local hospital in Veroia and then transferred to another one in Thessaloniki. Another female complaining about lower back pain has been diagnosed nephrolithiasis when several kidney stones were revealed (Fig. 11). These were cases of the previous missions in these camps and are not included in the numbers presented above. We estimate that the utilization of ultrasound examinations and the distribution of cases during previous two one-week missions were similar.

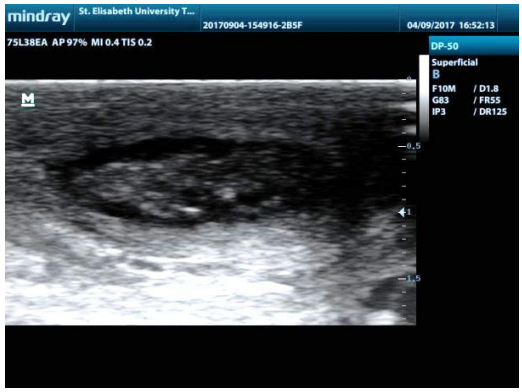

Fig. 5: scrotal abscess

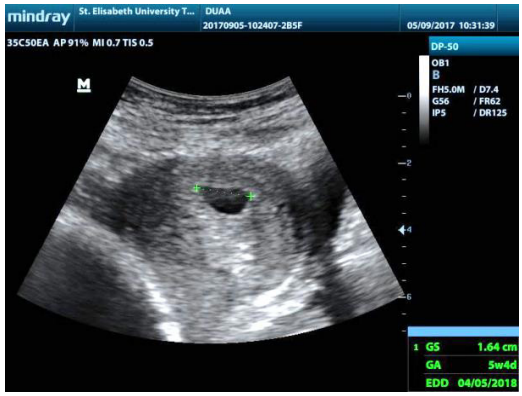

Fig. 6: estimation of GA using GS diameter

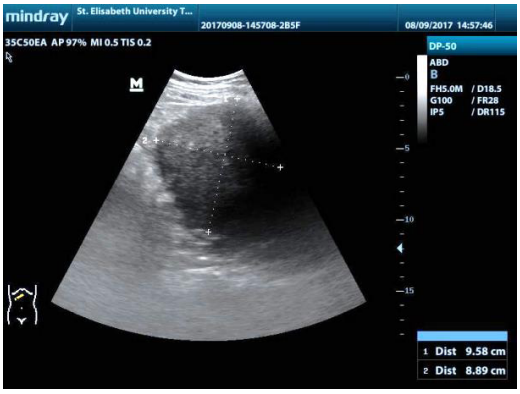

Fig. 4: liver cancer

Fig. 7: estimation of GA using GS and CRL

Fig. 8: estimation of GA using BPD

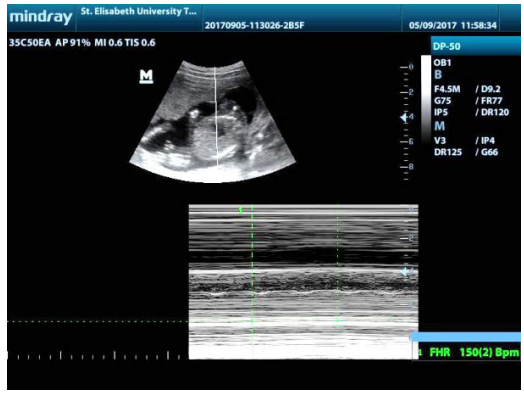

Fig. 11: estimation of FHR in fetus

Fig. 9: estimation of GA using FL

Fig. 12: collapsed skull in dead fetus

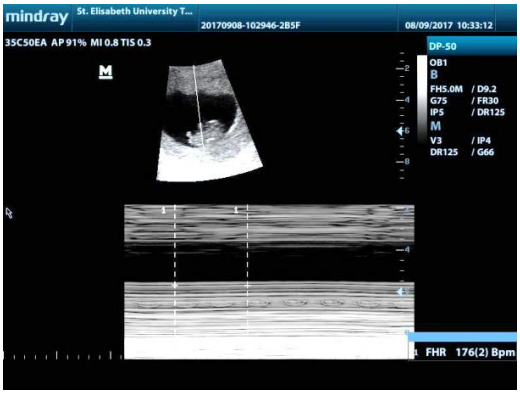

Fig. 10: estimation of FHR in embryo

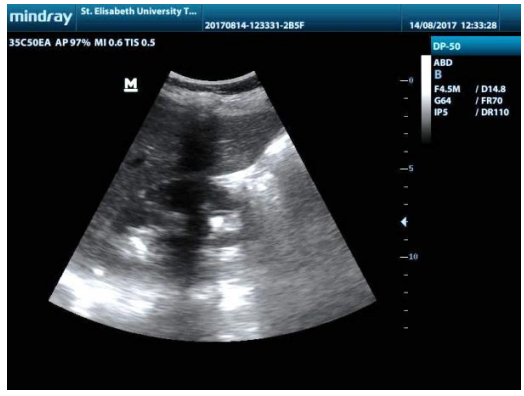

Fig. 13: nephrolithiasis in right kidney

It must be said that we haven't noticed any bigger problems when examining Muslim women. They were shyer than non-Muslim female patients we are used to and tried to undress as little as possible but cooperative. Most of the examinations were performed in the presence of their husbands who stayed there automatically but did not interfere in any way.

Conclusion

The availability of ultrasound machine equipped with convex and linear probes and presence of a Physician capable of reliable ultrasound examination are advantageous aspects of field and other resource-limited healthcare facilities taking care of refugees who are mainly young people including pregnant females. We recommend obtaining skills and practice not only in abdominal ultrasound, vascular ultrasound and echocardiography but emphasize the need for at least basic knowledge in obstetric ultrasound.

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The Change Quality of Life Patients with Upper Limb Lymphedema after the Breast Carcinoma Surgery

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Original Article

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Abstract:

Introduction: Frequent co-morbidity of breast cancer therapy resides in lymphedema due to insufficient drainage of lymphatic fluid from the adjacent upper limb. In addition to mobility restrictions, it also adversely affects the quality of life of patients. An effective therapeutic tool is

lymphatic drainage techniques suitably supported by vascular gymnastics and limb bandaging.

Objective: In our study, we examined the effect of lymph drainage techniques on the extent of lymphedema and the subjective perception of patients‘ quality of life.

Methods and methodology: The subjective perception of the quality of life of patients was verified using a questionnaire in a defined period. Respondents were patients after the treatment of breast cancer followed by lymphedema indicating lymph drainage techniques. A total of 126 respondents were surveyed, 59 had mild lymphedema, 41 had moderate lymphedema, and 17 had lymphedema, 9 were not specified in lymphedema.

Results: Differences in female quality of life are statistically significant affected by the three stages of lymphedema severity before lymphadenopathy. ($P < 0.001$), hygiene ($p < 0.001$), food preparation ($p < 0.001$); domestic work ($p < 0.001$); shopping ($p < 0.001$). A certain trend, albeit statistically at the limit of marginal significance was also apparent in the case of walking ($p < 0.09$). The rate of improvement was directly proportional to the severity of lymphedema prior to initiation of therapy ($p < 0.001$).

Conclusion: In our study, we verified the high effectiveness of lymph drainage techniques in lymphedema therapy as well as increasing the subjective perception of patients‘ quality of life.

Conflict of interests:

The authors whose names are listed in the title of the article certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers’ bureaus; membership, employment, consultancies, or other equity interest), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

Introduction

Breast cancer affects nearly 7% of the female population in Europe, and in the US it accounts for about 30% of all women’s cancer. The occurrence of breast cancer 20 years ago was rare, the incidence increased and increased sharply after 50 years of age, directly related to menopause. (1) In addition, breast cancer continues to remain the most widespread malignancy in women, but at the same time there is a stabilized to moderately declining mortality trend for this disease. Trends in mortality decline of 20-30% were recorded in screened countries. (2,3) The Slovak Republic, with the standardized incidence of 51.6/100,000 breast cancer (which represents 2,177 cases of disease) in the last statistically closed year 2004, lists the occurrence of diseases in countries with Medium. In that year, breast cancer was the most common malignant tumor in women. Breast cancer accounts for 17.7% of all malignancies in women.

Mortality reached 19.9/100,000 women (795 cases) in the given year, with stabilization and slight decrease in standardized mortality values (4) in recent years.

Common lymphedema of the adjacent upper limb is a frequent comorbidity of the disease. This is not the painful outcome of surgery, but it significantly affects the quality of life of patients. Literary sources state that about 30% of women complain of upper limb lymphedema. In addition, lymphedema may occur several years after an operation. The main cause of this condition is the disruption of lymphatic pathways in the axilla during surgery. Secondary lymphedema has been extruded by the medical public for many years at the edge of interest due to insufficient redesign of diagnostics, especially early stage. Patients on therapy were already suffering from obsolete lymphedema, a difficult to treat stage associated with soft tissue fibrosis of the affected area. Another reason was the inability to influence the developed lymphedema by medical therapy. (5,6,7)

We divide the lymphedema according to the degree of change in 4 groups; 1) Latent at this stage is not a clinical manifestation; changes are at the cellular level; patients experience subjective difficulties in terms of burning and limb tension. 2) Reversible - it is soft on the palate; the limbs are not lifted. 3) Perennial – stiff; not limiting after the limb is lifted; fibrotic changes are also present on the limb tissue. 4) Elephantiasis - a huge limb with pronounced skin changes - thickening, wart formation - verrucosis lymphostatica; skin cracking and lymphatic leakage - chyloderma. According to the size of the limb, we divide the lymphedema into 3 groups: 1) light lymphedema - up to 2 cm; 2) moderately hard lymphedema - up to 6 cm; 3) hard lymphedema - over 6 cm. (8)

A comprehensive treatment approach to lymphedema includes massages techniques and movement therapy. Surgical treatment is reserved for lymphosarcoma and for the removal of enormous surplus skin lesions following successful conservative treatment of elephantiasis. Its disadvantage is that it violates the surface lymphatic system and thus worsens the possibilities of further conservative treatment. (5,6,7) Literary sources describe the use of the study of possibility of using hyperbaric oxygen therapy as an additive therapy in the treatment of lymphedema. (9,10,11) Hyperbaric oxygen therapy is a therapeutic approach where the patient is exposed to 100% oxygen at pressures higher than ambient (1 ATA). This leads to an increased blood oxygen level, which than can penetrate to ischemic areas more deeply than under normobaric conditions. (12,13,14,15) Our investigation was realized as a preliminary study of the project focused on the using of the hyperbaric oxygen therapy as a complementary therapy of selected diseases. Previous reports of hyperbaric oxygen therapy for breast edema led us to consider the use of hyperbaric oxygen therapy for arm lymphedema, but there is a need for further studies which should explore the effects of a greater number of hyperbaric oxygen treatments on lymphedema, with more patients.

Aim

To verify the efficacy of lymphatic drainage techniques applied in patients after breast cancer therapy in patient's perception of quality of life.

Material and Methodology

A total of 126 respondents were surveyed, 59 had Light lymphedema, 41 had a Medium lymphedema, and 17 had a Hard Lymphedema, in 9 women the extent of lymphedema was unspecified. The sample was aged 20 to 67 years old. The average age of the women was 46 years.

In our study, we used a non-standardized questionnaire that contained 12 closed questions and 3 semi-closed questions. From the closed questions was 1 dichotomous and 11 polyatomic. Between the questions was also a filtering question. Using the questionnaire, we investigated how lymphatic drainage impacts on the quality of life of patients experiencing that type of treatment. The return of the questionnaire reached 84%.

The scoring of answers in the questionnaire was in the form of ordinal data with a range of five degrees. Due to the nature of the data for individual variables (i.e., individual questions), we used nonparametric statistical tests. We used Kruskal-Wallis to compare the three subfamilies with varying degrees of lymphedema, the differences between the two pairs were tested by a subsequent Dunn Test.

In the case of pairwise testing (before and after therapy of the same individuals), we used the nonparametric pairwise Wilcoxon Test. To verify the interdependence of variables, we used the nonparametric Spearman Correlation Coefficient. The p-value of the test criterion for the statistical test used was $p < 0.05$, the differences between tested variables were considered statistically significant.

Results and Discussion

Primary results of quality of life testing before lymphatic drainage are shown in Table 1. It results from the fact that the severity of lymphedema statistically significantly restricts all activities of everyday life, with the exception of walking, which significantly affect the perception of the quality of life of the respondents. The problem of the problems in the observed life activities increased proportionally to the extent of lymphedema.

Consequently, we compared the influence of lymphatic drainage techniques on patients' quality of life. The results are shown in Table 2. For better clarity (although at the expense of mathematical and statistical suitability), the arithmetic mean of the variables monitored is given in the table for information purposes only. Table 2 shows two major findings:

- The application of lymphatic drainage technique statistically significantly reduces the subjective perception of impaired quality of life in patients (mostly $p < 0.001$, Wilcoxon Pair Test). Lower values were found only for walking not related to lymphedema of the upper limb.
- Based on the correlation coefficient, a strong positive relationship can be noted between the degree of lymphedema severity in single patients before and after lymphadenopathy. From this, a very important finding can be drawn that lymphatic drainage techniques have a beneficial effect with high constancy, since the rate of improvement is proportional to baseline lymphedema in individuals.

Table 1: Problems before lymphatic drainage.

The severity of lymphedema	Problems	n	Median	Minimum	Maximum	*p*
Light	changing clothes	59	2.00	1.00	5.00	< 0.001
Medium		41	3.00	1.00	5.00	
Hard		17	4.00	3.00	5.00	
Light	hygiene	59	2.00	1.00	4.00	< 0.001
Medium		41	2.00	1.00	5.00	
Hard		17	4.00	3.00	5.00	
Light	food preparation	59	2.00	1.00	4.00	< 0.001
Medium		41	3.00	1.00	5.00	
Hard		17	4.00	2.00	5.00	
Light	housework	59	3.00	1.00	5.00	< 0.001
Medium		41	3.00	1.00	5.00	
Hard		17	4.00	3.00	5.00	
Light	shopping	59	2.00	1.00	4.00	< 0.001
Medium		41	3.00	1.00	5.00	
Hard		17	4.00	2.00	5.00	
Light	walking	59	2.00	1.00	4.00	< 0.09
Medium		41	2.00	1.00	5.00	
Hard		17	3.00	1.00	5.00	

Legend: n - number of patients, p-value of the Kruskal-Wallis test criterion

Table 2: Testing the effect of lymphatic drainage – light lymphedema.

The severity of lymphedema	Problems	*p*	*R*	M1	M2
Light	changing clothes	< 0.001	0.69	2.37	1.71
Medium		0.002	0.63	2.66	2.20
Hard		< 0.001	0.81	4.18	3.00
Light	hygiene	< 0.001	0.66	2.15	1.61
Medium		< 0.001	0.80	2.56	2.07
Hard		< 0.001	0.42	4.18	3.24
Light	food preparation	< 0.001	0.69	2.34	1.73
Medium		< 0.001	0.73	2.73	2.12
Hard		< 0.001	0.78	4.06	3.24
Light	housework	< 0.001	0.69	2.83	2.00
Medium		< 0.001	0.77	3.12	2.39
Hard		< 0.001	0.65	4.35	3.53
Light	shopping	< 0.001	0.59	2.32	1.68
Medium		< 0.001	0.87	2.83	2.17
Hard		< 0.001	0.51	4.00	2.71

Light	walking	< 0.001	0.60	1.80	1.42
Medium		0.09	0.81	2.00	1.78
Hard		0.03	0.90	2.59	2.12

Legend: p - value of the Wilcoxon pair non-parametric test result test criterion; R - Spearmanov nonparametric sequence correlation coefficient; M1 - arithmetic mean of activities before lymph drainage; M2 - arithmetic mean of activities after lymphatic drainage

However, we must emphasize that in the case of wrong diet and long-term termination of lymphatic drainage, lymphedema is recurrent and associated pain and reduced quality of life.

Conclusion

The main goal of our study was reveal the influence of lymphatic drainage on the quality of life of patients with lymphedema on the base of identified facts. According to the quantitative research carried out in the form of a questionnaire, respondents were in all cases when the treatment of lymphedema using lymphatic drainage was receding.

Our research shows that lymphatic drainage techniques are an important therapeutic tool in the conservative treatment of lymphedema. The influence of lymphatic drainage techniques is very pronounced and, in particular, is characterized by its constant action. Thus, from the point of view of the application of lymphatic drainage techniques, the baseline condition prior to therapy is not significant, the application of the therapy decreases the rate of lymphedema and the associated subjective perception of the reduced quality of life, always substantially the same constant ratio.

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Government Price Regulation of Pharmaceuticals in Slovakia and the United States

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Original Article

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Abstract:

Health reform is a topic of significant interest to national governments. The need to assure health care access to national populations at reasonable cost compels governments to explore various means of restraining cost increases. Government price regulation, effectiveness research and cross-border re-importation are accepted practice in Slovakia, but prohibited by statute and regulation in the United States.

Introduction

Government policy-makers have many options to use when seeking to rein-in escalating health care costs. Expanding national health budgets; increasing private insurance premiums; and growing provider costs merge together to stir concern for many national leaders who worry that price and cost increases in the healthcare sector may jeopardize the overall performance of their national economies.

One glaring target for controlling a nation's health care costs is pharmaceuticals. Large national and international drug manufacturers seek to expand their product markets by selling pharmaceuticals worldwide. In many instances, those marketing efforts lead to increased levels of inter-firm competition amenable to specific price regulation tactics.

Slovakia has positioned itself to take advantage of certain progressive price regulation tools available to national governments. This ability is further enhanced by Slovakia's health economy.

> ...pharmaceuticals play an important role in Slovakia's (health) expenditure.
> Although health spending is well below the OECD average when considered as a share of GDP – 6% in Slovakia compared to 9% across the OECD in 2005 – Slovakia's pharmaceutical expenditure accounts for a relatively high portion of health spending (nearly double the OECD average share at 32% of spending) and more than 2% of the country's income. (OECD 2008, p.8)

By comparison, pharmaceutical prices are much higher in the U. S., but the nation has not taken any aggressive approach at the federal government level to stabilize pharmaceutical prices. In 2012, the OECD indicated that U. S. pharmaceutical expenditures per capita were more than double the OECD average for the same period of time (OECD 2014, p.3).

Aggressive Price Regulation

In examining Slovak pharmaceutical pricing policies, three noteworthy considerations stand out in comparison to U. S. drug pricing policy. 1) In Slovakia, the government sets retail pharmacy prices and ex-factory prices for prescription drugs sold for use in Slovak hospitals. 2) Government regulators make use of reference pricing and effectiveness research in determining the categorization of pharmaceuticals subject to such price controls. 3) The government also allows the re-importation of drugs if there is a potential price advantage (Costello, 2017). In contrast, the U. S. Government is prohibited from negotiating pharmaceutical prices and for using government – financed effectiveness research for coverage, reimbursement or treatment decisions. U. S. Federal Regulations also prohibit the re-importation of pharmaceuticals.

According to OECD, the Slovak Ministry of Health "determines the maximum retail price for reimbursed pharmaceutical products and the maximum manufacturer's price for in-hospital pharmaceutical products (OECD 2008, p.14). Slovak National Policy is also influenced by European Union Policy which allows for "re-importation" of pharmaceuticals from one EU nation to the other in order to take advantage of more favorable pricing in the exporting nation. Pharmaceuticals imported into Slovakia are ultimately regulated as to retail price, but the price threshold is determined by reference to ex-factory prices in 9 selected European Nations including "the country of manufacture, Austria, France, Germany,

Italy, Spain, the Czech Republic, Hungary and Poland. (OECD 2008, p. 14)"

Reference pricing is used to compare the prices of comparable pharmaceuticals in order to establish the pricing of a new market entrant. The referenced prices are used to justify the applicable price of the new product.

Effectiveness studies influence the decisions as to which medications will be price-regulated for reimbursement. Slovak Government Officials examine a number of effectiveness measures in making reimbursement decisions for pharmaceuticals on the "positive lists".

> A pharmaceutical is eligible to be included on the positive list, and consequently reimbursed, if there is sufficient clinical evidence of its effectiveness and capacity to save life, to cure diseases, to prevent the onset of serious health complications, to prevent deterioration of the severity of a disease or its transition to a chronic state, to serve as an active prophylaxis, or to mitigate the symptoms of disease (OECD 2008, p.17).

While U.S. Law allows private insurance companies and certain public state programs to set pricing for reimbursement of drugs, the U. S. Government itself does not set pharmaceutical prices for reimbursement purposes; prohibits by regulation the re-importation of pharmaceuticals from lower price-advantaged international markets; forbids the use of government subsidized effectiveness research for setting reimbursement levels.

The U.S. has a long history of avoiding government price setting in competitive markets. Rather, traditional economic thinking says that competitive markets, subject to the laws of supply and demand, will establish appropriate prices. However, the noted price inelasticity of many prescription medications would seem to cast some doubt on this line of economic reasoning. Nemec (2013) suggests that Slovaks may be more amenable to government efforts to establish pricing for prescription pharmaceuticals.

> The approaches of all actors influencing health care reforms and trends mirror societal values of European Union members. The heritage of the Socialist period remains viable as citizens prefer to rely on "state" help rather than develop individual responsibility for their welfare (p. 196).

In the U.S., federal law prohibits the government from negotiating drug prices directly with pharmaceutical firms. The Medicare Modernization Act, which established the Medicare Pat D prescription drug benefit in 2006, established the prohibition (Feldstein 2015, p.462).

While effectiveness studies have become widely used in Slovakia and other European nations, the use of such studies, known as comparative effectiveness research (CER), is prohibited in the United States by the Patient Protection and Affordable Care Act (Obamacare), enacted in 2010. Despite the fact that the act allocated $1.1 billion for CER, the U. S. Congress prohibited the use of research information from CER for "mandating coverage, reimbursement or treatment decisions for public and private payers" (ibid p.347).

Likewise, re-importation is permitted among European Union Nations as a way of taking advantage of the most favorable pharmaceutical pricing in the EU. However, re-importation is prohibited by regulation of the U.S. Food and Drug Administration (FDA), even though the U.S. Congress had authorized it (Costello 2017, p.45). The U.S. FDA reported to Congress that it did not have the ability to assure the safety of pharmaceuticals reimported back to the United States.

Conclusion

Slovakia has utilized pharmaceutical pricing regulation, effectiveness studies, and importation from other nations as means of stabilizing pharmaceutical prices within its national borders. Of note, is the fact that the U.S. has been prohibited by federal statute and regulation from using any of these three price-restraining tools with the result that the U.S. Government reimburses public insurance beneficiaries use of these drugs at higher prices than would be the case if Slovak price regulation mechanisms were in use.

Resume

Mr. Costello is a full time faculty member in the Department of Health Administration and Human Resources at The University of Pennsylvania Scranton, U.S.A. where he also serves as Assistant Program Director for an accredited online MHA degree. Scranton's on-campus and online MHA program enrollments combine to make it the largest program in the United States. He has held faculty appointments at St. Elizabeth University in Bratislava and Trnava University, both in the Slovak Republic.

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Work-Related Factors Influencing Burnout Syndrome in Nurses

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Original Article

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Abstract:

Objective: The aim of this study was to quantify the frequency of burnout among Slovak Nurses to shed more light on the associations between the workload and burnout syndrome.
Design: cross-sectional design.

Participants and methods: A total of 770 Nurses from Slovakia participated in the study. A structured questionnaire with work-related items and Maslach Burnout Inventory were used to collect the data. Descriptive statistics, t-test, and analyses of variance (ANOVA) were calculated.

Results: Statistically significantly ($p \leq 0.05$) higher degree of burnout syndrome were identified in Nurses with longer work experience; employed on oncology departments; intensive care units; working in 8 or 12 hour shifts compared with no shifts.

Conclusion: Research results suggest that the profession of Nurses should be supported by management aimed at preventing work-related stress in Clinical Practice.

Introduction

Burnout has been defined as a specific kind of occupational stress among human service professionals, as a result of the demanding and emotionally charged relationships between caregivers and their recipients (Maslach, 2011). Clinical symptoms of burnout syndrome are nonspecific and include tiredness, headaches, eating problems, insomnia, irritability, emotional instability and rigidity in relationships with other people (Kilikova, Sramka, 2006). The level of health and social care is one of the major factors in assessing human society's development (Rakova, Kacmarova, 2014). The Nursing Profession is one of the most demanding and stressful occupations, due to the quantity and diversity of risk factors associated with the work environment and competence (Zamboriova, Stefkova, 2016). The most frequent risk factors of the burnout syndrome are excessive workload such as lack of time; shift work; type of department; organization culture (e.g. relationships among colleagues; role conflicts; etc.), not enough materials and technical equipment. The Nursing Profession is also further complicated by shift work. Working in Intensive Care Units (ICU) can originate stress in Nurses as well. The presence of *burnout syndrome* in critical care Nurses has been examined in several research studies (Panunto *et al*., 2013). Critical Care Nurses have heavy workloads, extensive responsibilities, and only limited authority. They must care for unstable patients; carry out procedures accurately; react to extremely urgent matters. Prevention of *burnout syndrome* in the individuals includes applying the Principles of Mental Hygiene (a balanced relationship between stressors and salutors, increased self-confidence, leisure time), with regard to external factors, good interpersonal relationships, social support, satisfactory working conditions, which are the most frequently factors (Maslach, 2011, Simockova, Zamboriova, 2009). The possibility is also to limit the competence of the Nurses (Beresova, 2011). Spiritual anchoring of humans in the area of living values and the environment is an important condition for healthy mental and physical development (Dirgova, Kalanin 2009). The implementation of supervising meetings can be one of the most effective tools for managing emotions related to Nursing Care (Bachrata, Kristova, 2017). ***The aim of this study*** was to quantify the frequency of burnout among Slovak Nurses and to shed more light on the associations between the work-related characteristics and *burnout syndrome* in Nurses.

Materials and Methods

This study had cross-sectional descriptive character. 770 registered Nurses completed the Maslach Burnout Inventory (MBI) questionnaire (Maslach, Jackson 1981). There were evaluated length of work experience, shift work, and type of department and type of unites (standard inpatient and intensive care), as work-related characteristics. The respondents answered the questions on-line, on the web page of the Slovak Chamber of Nurses and Midwives, and the web page of World Health Organization, Country Office in Slovakia, and on the web page http://www.who.sk. For statistical analyses, descriptive tests, t-tests, and ANOVA with LSD post hoc test were used. All analyses were performed with the Statistical Package for the Social Sciences, version 22 (SPSS, Chicago, IL, USA).

Table 1: Descriptive characteristics of burnout syndrome of the sample.

Table 1 – Descriptive characteristics of burnout syndrome of the sample		
Burnout syndrome	n	%
EE		
Low (≤ 16)	139	18.1
Middle (17 – 26)	183	23.8
High (≥ 27)	437	56.8
DP		
Low (≤ 6)	298	38.7
Middle (7 – 12)	236	30.6
High (≥ 13)	226	29.4
PA (recoded)		
Low (≤ 31)	680	88.3
Middle (32 – 38)	56	7.3
High (≥ 39)	27	0.9

Note. EE – emotional exhaustion, DP – depersonalization, PA – personal accomplishment.

Results

Demographic and workplace characteristics

The sample (n=770) consisted especially of women (97.9%). The mean age of respondents was 40.9 SD ± 8.9 years, the minimum age was 20 years and the maximum age 61 years. The average length of work experience was 21.8, SD ±9.4 years, the shortest duration of practice was 1 year and the longest one was 44 years. Nurses were from these types of departments: Internal medicine (43.1%); Surgery (36.2%); Pediatrics (8.6%); Psychiatry (3.1%); Oncology (4.7%). 74.9% of Nurses were employed on Standard Departments and 25.1% on Intensive Care Units. 43.9% worked in no shift work (fixed morning shifts); 44.8% in 8 hour shift; 11.3% in 12 hour shift.

Descriptive analysis showed middle burnout levels among 24% - 31% of Nurses on each of the subscales. High burnout levels were found among 30% - 57% of Nurses.

Length of work experience and burnout syndrome

The results show that the differences between the length of work experience and burnout syndrome is not linear. Nurses with the length of work experience between 1 – 5 years have statistically significant lower scores of burnout syndrome in EE (F= 2.439**), DP (F=1.614*) and total MBI (F=2.103*) as compared with other categories of the length of work experience.

Work shifts and burnout syndrome

With regard to shift work (Table 2), Nurses working in 8 or 12 hour shifts showed higher levels of burnout than Nurses with no shift work in the EE, DP dimension and the total burnout syndrome (MBI).

Type of department and burnout syndrome

Highly statistically significant differences were confirmed in the EE dimension and *the total burnout syndrome* (MBI) between departments (Table 2). Nurses working at Oncology Departments have the highest degree of occurrence of *burnout syndrome* in the EE dimension and in the *total burnout syndrome* (MBI) score. Based on the analysis it can be stated that higher level of *burnout syndrome* in the EE dimension and in the *total burnout syndrome* score was confirmed in Nurses working at Intensive Care Units compared with Nurses working at Standard Inpatient Departments.

Nurses and to explore the associations between work-related factors and the extent of burnout among Nurses.

Results showed a high prevalence of high level of burnout with emotional exhaustion and depersonalization of Slovak Nurses. Studies in many countries, e.g. in Spain (Canadas *et al.* 2015), in Portugal (Gama, *et al*. 2014), in Poland (Ksiazek, *et al*. 2011) or in the Czech Republic (Vevodova *et al.* 2016) found a much lower level of burnout among Nurses compared to Nurses working in Slovakia.

A study by Iglesias *et al*. (2010), showed higher risk scores for EE dimension and PA dimension in Nurses who were older than

Table 2: Burnout syndrome in relation to shift work, type of department and type of unit.

	Dimension of burnout syndrome							
	EE		DP		PA			
MBI								
Shift work	F	LSD	F	LSD	F	LSD	F	LSD
No shift work (1)	10.308***	1-2,3*	2.767	1-3*	1.102	n.s.	6.178**	1-3*
12 hour shift (2)								
8 hour shift (3)								
Type of department								
Surgery (1)								
Internal medicine (2)	5.005 ***	5-1,2,3*	1.114	n.s.	1.676	3-1,4*	3.528**	5-1,2,4*
Pediatrics (3)								
Psychiatric(4)								
Oncology (5)								
Type of unit								
Intensive Care Unit	14.786***	n.s.	2.653	n.s.	0.056	n.s.	6.994***	n.s.
Standard Departments								

*Note. EE – emotional exhaustion, DP – depersonalization, PA – personal accomplishment, MBI – Maslach Burnout Inventory.; LSD – post Hoc tests; * $p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq 0.001$, n. s. not significant.*

Discussion and Conclusion

The aim of this study was to assess prevalence of burnout syndrome in Slovak

30 years, which is also in line with a study by Xie *et al.* (2011). In a study by Franca *et al.* (2012) a direct link was found between older professionals and burnout. In our sample, more detailed analysis of the categories

of the years of work experience confirmed a statistically significant differences in the EE, DP dimension and in the total MBI. The lowest level of EE, DP and MBI total score was identified on Nurses with length of service of 1-5 years. Burnout rate increased with length of service but not completely linearly. In accordance with our results, many authors (Gama, *et al*. 2014; Franca *et al.* 2012; Slezáková, *et al* 2016; Vargas *et al.* 2014), found out that the degree of *burnout syndrome* increased with the length of work experience. We found out that shift work has an influence on the occurrence of *burnout syndrome*, and we can state that Nurses working in three 8 hours´ shifts or two 12 hours´ shifts have a higher degree of *burnout syndrome* in the EE, DP dimension and in the total score MBI than Nurses working in fixed morning shift, which indicates that work in one shift in a medical facility is the least risk work in relation to the occurrence of *burnout syndrome*.

In the study by Xie *et al*. (2011), shift work was reported to be a risk factor, since statistical significance was confirmed in the EE and DP dimensions too. It is also in line with a study by Canadas *et al*. (2015). In our study, the Oncology Nurses had significantly higher scores of *burnout syndrome* in the EE, dimension as compared with the Internal, Surgery and Pediatric Departments, and a higher total score MBI as compared with Internal and Surgery Departments. Blanchard *et al.* (2010), confirmed the presence of a high score of *burnout* syndrome in the EE, DP dimensions in 340 medical workers working at oncology departments, which is in line with the results of our research. A high total score of burnout *syndrome* in Nurses working at the Oncology Department was found by Ksiazek *et al.* (2011) too. Working in Intensive Care Units in our sample of Nurses was associated with a higher prevalence of *burnout syndrome* in EE and in the total score MBI compared to Nurses working in standard units. Similar to our findings are the results of study by Canadas *et al*., (2015) or meta-analytic study by Vargas *et al.* (2014) who found that specificities of work at Intensive Care Units and Emergency are significant factors influencing the occurrence of burnout syndrome.

The primary objective of the work was to define the personal and workplace factors that seem to be responsible for the formation of burnout. Nurses showed a high degree of *burnout syndrome* in the EE dimension and in the DP. Risk factors related to increased occurrence of *burnout syndrome* included shift work; length of work experience; work at Oncology Departments and Intensive Care Units. Combination of both person and organization directed interventions seems to be an appropriate solution to reduce *burnout syndrome* in Slovak Nurses, especially in older professional Nurses who worked at Oncology Departments and Intensive Care Units and as regards shift work, in Nurses who work in two or three shift work.

Conflict of Interest

The authors whose names are listed in the title of the article certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, or other equity interest), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

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Managing Chronic Diseases in the Slovak Republic: Futures Perspectives and Challenges

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Original Article

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Abstract:

With populations continuing to age and costs for their care expected to increase, it has become more important than ever for healthcare professionals to acknowledge the need to be proactive instead of reactive with regard to chronic care. Like many other countries in Central and Eastern Europe, healthcare facilities in the Slovak Republic are better equipped for acute care rather than chronic illnesses. There is a need to

adopt a chronic care model in the Slovak Republic and update a set of clinical guidelines to streamline the diagnosis and treatment of chronic illnesses. Updating organizational structure and procedures relating to chronic care management will allow healthcare professionals to save costs; develop patient centered care; educate the public on preventative methods. Creating a plan that centers on preventative and personalized medicine will help future generations in the Slovak Republic and hopefully reduce the prevalence of chronic diseases.

Introduction

The Slovak Republic's healthcare system makes health insurance affordable for its citizens. People who earn more pay more, and those who earn less pay less. This approach allows over 98% of the population to be covered by health insurance, which translates into the majority of the population being healthy. However, approximately 22% of the population suffers from common diseases, such as: cardiovascular diseases, diabetes, respiratory diseases, psychiatric diseases, infectious diseases and cancer (Kapalla, 2010). Countries around the world are seeing a similar trend of an increasing prevalence of chronic diseases. Chronic illnesses currently affect over 1/3 of the European population and account for poor health and restricted activity. This translates into about 70-80% of European healthcare costs being spent on chronic care (Legido-Quigley, 2013). With this in mind, the Slovak Republic has an opportunity to implement new chronic care management techniques, such as predictive, preventative, and personalized medicine as well as the chronic care model.

The Slovak Republic is facing an aging population and a very low birth rate. The average age has increased to 39.6 years in 2013, which is 5.5 years more than 20 years ago. This pace of a rising life expectancy in the Slovak Republic is relatively slow, however it can be dangerous in conjunction with a birthrate of only 1.3 babies per mother. (Minarechova_2015) This aging population could lead to an increased need for chronic disease management. In addition to the increase in average population age, lifestyle choices can have a large impact on population health and chronic illnesses. In the Slovak Republic, "41% of the population smoke regularly or occasionally, and the consumption of the alcoholic drinks was 106.31 per inhabitant in the year 2008" (Kapalla, 2010 p.560). These choices can have a lasting impact on one's health and could lead to increased healthcare costs due to the treatment associated with chronic diseases.

Chronic Care Conditions

In 2011, there were 51,903 deaths in the Slovak Republic, and about half of these deaths were caused by chronic conditions (Loucka, 2014). The majority of the mortality in the Slovak Republic is associated with the following diseases: diseases of the circulatory system (53.4%); neoplasms (22.6%); diseases of the respiratory system (6.0%); diseases of the digestive system (5.6%) (Kapalla, 2010). These causes of death are related to the prevalence of chronic illnesses and the risks associated with them.

Place of death also plays an important role in the discussion of chronic illnesses. The majority of the population in the Slovak Republic would prefer to die at home. However, only 23% of Slovakians die at

home and 62% of Slovakians suffering from chronic conditions die in the hospital (Loucka, 2014). Citizens in the Netherlands experience a much different proportion of end of life settings, where only about 30% of deaths relating to chronic conditions occur at the hospital. This can be due to a variety of factors, such as their developed nursing home care system. Overall, these statistics affirm that the majority of the population in the Slovak Republic is not having the end-of-life care they prefer. Investigating the place of death allows researchers to examine end of life policy and determine if patients are receiving the highest quality of care. Adjusting policies relating to home hospice care and other end of life settings would allow more Slovakians to die in their preferred setting.

Currently, the Slovak Republic does not offer many long-term care solutions. There are no nursing homes available to the public, and "care homes for older people or local variations of nursing homes usually do not have a physician on the staff and many GPs do not have enough experience with symptom management at the end of life" (Loucka, 2014). This lack of long-term care options can make taking care of those suffering from chronic illnesses difficult. Due to this, the responsibility of caring for someone diagnosed with a chronic disease often falls upon the family members: "These diseases by their nature are not easily cured and require long-term medical care. As a result, patients and their families need to adapt their lives in order to manage the disease" (Legido-Quigley, 2013). Providing constant care can result in direct and indirect costs such as pharmaceutical expenses and potential loss of income, respectively. Overall, these costs can put strain on a household's budget. To help avoid these costs, healthcare professionals should provide education on preventative measures that should be taken to avoid being diagnosed with a chronic disease. This education should include promoting a healthy lifestyle, living conditions, and nutrition. Applying these recommendations to people's everyday lives can make a substantial difference in preventing chronic diseases.

Acute care beds dominate the hospital infrastructure in the Slovak Republic: "Across Europe and increasingly the rest of the world, the economic costs of chronic illness dwarf the costs of acute illnesses, both for the healthcare system and for other stakeholders" (Gemmill, 2008). With this in mind, the Slovak Republic should focus on improving access to chronic care and long-term beds instead of acute care. "In 2007, there were 26,546 acute beds, 4,450 psychiatric beds and 4,403 long-term beds in Slovakia" (Szalay, 2011). This reliance on acute care is not conducive to the treatment of chronic illnesses. Due to this, health officials implemented a bed reduction plan to adjust the structure of both inpatient and outpatient providers. This plan resulted in acute beds being reduced and 6,000 beds being eliminated or transformed into chronic care beds. In addition, "three acute care hospitals were closed and several others transformed into almost exclusively chronic (long-term) care facilities" (Szalay, 2011). All of these measures have made treatment for chronic illnesses more accessible. However, there are still opportunities for improvement with regard to limiting the reliance on acute care. "Even though the number of acute beds has steadily declined, it was still among the highest in Europe in 2008" (Szalay, 2011). Health officials should continue to implement an acute bed reduction plan and work towards improving the accessibility to long-term care for their patients.

Clinical Guidelines

According to the World Health Organization, the Slovak Republic does not currently have an official basis for the development

of clinical guidelines on chronic conditions. "The Institute of Preventive Medicine, with the support of the Slovakian Ministry of Health, was active in the field of clinical guidelines some years ago, producing the handbooks for diagnostic and therapeutic guidelines, including the most important and frequent chronic conditions" (Legido-Quigley, 2013). Unfortunately, these handbooks were last updated in 2002 and do not reflect current practices. Due to this, the Slovak Republic has an opportunity to create new guidelines and best practices in relation to chronic conditions. Developing national guidelines will help improve the delivery and quality of care given to patients. In addition, regulating strategies to improve care for chronically ill patients and coordinating all actors involved will ensure better patient health outcomes and effectiveness. The engagement of stakeholders is also critical when developing new clinical guidelines. "Depending on the context stakeholders can include representatives of professional organizations, service providers, the pharmaceutical industry and funding bodies; patients, their families and carers and patient representatives or organizations; academics or other experts; and other members of civil society" (Legido-Quigley, 2013). Promoting transparency with these stakeholders will help ensure the success and acceptance of the new guidelines.

Constructing updated guidelines relating to chronic disease management does not mean professionals should disregard the need for prevention. It is important for Physicians to be prepared when treating patients with chronic diseases. However, it is even more important for them to educate their patients on prevention techniques. To promote healthcare cost savings and healthier lifestyle choices, Physicians should implement a predictive, preventative, and personalized medicine (PPPM) strategy (Sadkovsky *et al.,* 2014). Predictive techniques require Physicians to conduct regular check-ups and screenings with their patients to try and foresee a medical complication in an apparently healthy person. Public health officials can also engage in predictive techniques by "monitoring the quality of the tap water, water reservoirs, concentration of the pollens in the air, nutrition and the food safety" (Kapalla, 2010). Predictive measures can help reduce overall healthcare spending by eliminating the potential costs associated with the treatment of chronic illnesses. In addition, they foster a strong doctor-patient relationship and promote constant communication.

Preventive Care and Management Strategies

Prevention programs are also used in chronic care management. These programs should focus on educating the public and healthcare professionals on "a healthy lifestyle, healthcare, healthy nutrition, reduction of the damages due to alcohol, drugs and tobacco products, prevention of injuries, healthy family, healthy working conditions, healthy living conditions, reduction of the incidence of the infectious diseases, reduction of the incidence of the non-infectious diseases, and physical activity" (Kapalla, 2010). These objectives work towards improving public health and the health of each individual citizen. Prevention education is a low-cost solution for reducing the prevalence of chronic illnesses. Healthcare providers should focus on promoting these programs to improve quality of care and ensure future cost savings.

The last strategy Physicians in the Slovak Republic would benefit from is personalized medicine. It is important for healthcare professionals to understand that "a patient does not care about the population statistics; the patient cares about the health of him- or herself and the health of

the close relatives" (Kapalla, 2010). Due to this, Physicians need to focus on the personalized aspect of Medicine. An example of a personalized approach is the prescription of a drug with respect to the patient's metabolism and possible interactions with other drugs. Understanding a patient's family history and preferences will improve patient safety and satisfaction and help to ensure coordinated patient-centered care.

of stakeholders: "Collaborative, integrated, and people-centered care provision is a way forward for sustainable and efficient care systems" (Nagyova, 2013). Focusing on this approach will ensure chronic disease patients are receiving the highest quality of care. In addition, a chronic care model can help lower healthcare costs and lessen the burden of chronic care management on patients and families.

Table 1: Essential Factors of Chronic Care Management.

Factor	Details
Community resources	Provider organizations need to be linked with community-based resources, e.g. senior centers, patient education classes, and self-help groups.
Healthcare organization	The culture, organizations, and mechanisms of the healthcare and provider organizations must promote safe and high quality care. For instance, provider reimbursement is an important influence on providers' incentives to improve chronic care.
Self-management support	Most patients can be taught to manage chronic illness through diet, exercise, self-measurement of conditions (e.g. glucometers), and proper medication use, and education can help patients routinely assess problems and accomplishments.
Decision support	The daily use of evidence-based guidelines is key, and providers can be supported through physician education and daily reminders.
Delivery system redesign	Delivery systems for chronic care must be separated from acute care by using planned visits and case management of high-risk patients. This redesign also involves creating practice teams with a clear division of labor.
Clinical information systems	Electronic systems provide data for better management of chronic illness through: (i) reminder systems to help primary care teams comply with practice guidelines, (ii) feedback for physicians on performance measures (e.g. lipid levels), and (iii) data registries for planning individual patient care and conducting population-based care.

Source: Adapted from Gemmill, 2008

With regard to chronic care management, the Slovak Republic would benefit from adapting a chronic care model. A chronic care model aims to foster systemic change and focus on those who have the disease, yet also includes preventive strategies for those who do not. This model utilizes six factors in chronic illness management, which are described in Table 1. Management of chronic illnesses requires a long-term approach and active involvement from a range

Conclusions

The Slovak Republic has an opportunity to change how chronic illnesses are being diagnosed and treated. In particular, they would benefit from increasing long-term care options; reducing the reliance on acute care; updating clinical guidelines on chronic diseases; utilizing a PPPM strategy; implementing a chronic care model. These strategies aim to encourage strong

Doctor-patient relationships and continuity and coordination throughout the healthcare system. In addition, it is important to educate Physicians and patients on the importance of prevention, with regard to public health and lifestyle choices. Applying these changes is expected to result in more interventions, increased patient safety, and overall improvements in population health.

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Psychological Burden Experienced by Polish and Slovak Nurses Working at Chemotherapy Units

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Abstract:

This study included 234 Nurses employed at chemotherapy units: 165 from Poland; 69 from Slovakia. The participants were examined with previously validated versions of Meister Questionnaire. In the assessed

dimensions of mental load, *Monotony* and *Unspecific Load* (reaction to stress) differentiate the Nurses working at chemotherapy units in Slovakia and Poland. The working conditions of Nurses providing care to oncologic patients treated with chemotherapy both in Slovakia and Poland are connected with a burden which is the result of time pressure and excessive responsibility. Assessment of the mental load can be used to improve the organization of Nurses' work creating safe working conditions in both studied countries, taking into consideration the mobility of the workforce in the European Union.

Introduction

One of the important components of a work-related burden is mental load - defined as a subjective reaction of an employee caused by the interaction of a group of individual, technical, organizational and social factors in the work environment (1,2). In the analyzed sources, the problem becomes a more frequent reason for conducting studies in different occupation groups, however not in the group of Oncology Nurses caring for patients undergoing chemotherapy (3,4). Providing Nursing care in the course of chemotherapy is characterized by a certain peculiarity, which on the one hand requires interdisciplinary knowledge; diagnostic abilities; knowing what decision to make; and on the other hand becomes the source of mental load. The burden is caused by the level of involvement and the close relationship with the patients and their families, which is the result of repetitive treatments and regular hospitalizations at the ward. Consequently, this situation may lead to professional burnout and mental overload, and lowered satisfaction with life (2,3,5). One of the methods of assessing mental load is subjective assessment with the use of self-description scales. However, due to a lack of a standardized tool, this method is rarely used. Moreover, there are no international studies which would allow to compare the phenomenon of mental load experienced by Nurses. Therefore, the present study was aimed at verifying whether Nurses working in a country other than Poland are also exposed to the same mental load. For comparison we used a group of Nurses working at a chemotherapy unit in Slovakia, assuming that the study population is similar to the Polish one in terms of demographics and socio-cultural conditions, and the organization of the workplace.

Methods

The study included 234 Nurses, among them 165 from Poland and 69 from Slovakia. To provide equal sample size, 69 participants were randomly chosen from the Polish group. Therefore, eventually the data from a total of 138 Nurses (69 from each country) were included in a multivariate analysis of variance. Polish Nurses were employed at chemotherapy units for 11.77±7.65 years on average and their mean age was 43.07±7.99 years. The group included 25 Nurses living in rural areas and 44 city- and town-dwellers. Mean age of Slovak Nurses and mean duration of their employment at chemotherapy units were similar as for Polish group (42.51±7.32 years and 10.25±6.2 years). a total of 29 Slovak Nurses lived in rural areas and 40 in towns/cities.

The study was based on a diagnostic survey with previously validated versions of Meister Questionnaire (1,3,6). Slovak Nurses were surveyed with the version approved by the Slovak Ministry of Health (7), and Polish Nurses with the version adapted by

Debska *et al.* (8). Both versions were previously shown to be characterized by acceptable accuracy and internal consistency rates (Cronbach Alpha >0.77) (1,3). Meister Questionnaire allows to determine three dimensions (subscales) of mental load: *Overload*, *Monotony* (monotonous load) and *Unspecific Load* (interpreted as unspecific response to stress). Each subscale included a number of specific items: *Time Pressure; Great Responsibility; Problems and Conflicts* for the *Overload* subscale, *Low Satisfaction*, *Dull Work* and *Monotony* for the *Monotony* subscale, and *Nervousness*; *Oversaturation; Fatigue; Long-lasting Load* for the *Unspecific Load* subscale. Median values for all these dimensions were compared with respective critical normalized values proposed by Zidkova (3,6).

Statistical characteristics of the analyzed variables were presented as arithmetic means, standard errors of the mean, medians, standard deviations, minimum and maximum values. Normal distribution of the analyzed variables was verified with Kolmogorov-Smirnov Test. Then, mixed-design analysis of variance (ANOVA) was conducted, with nationality as a between-group factor and the scores for Meister Questionnaire as a within-group factor. The Bonferroni Correction was applied to multiple comparisons. Eta^2 values were calculated to determine the effect of nationality on the analyzed parameters and intragroup differences in the scores for specific dimensions. The results of all the tests were considered statistically significant whenever their p-value were lower than 0.05.

Results

In Slovak respondents, median values exceeded their critical values for all but two items of Meister Questionnaire: *Low Satisfaction* and *Dull Work*. In the case of Polish participants, median values for five statements exceeded their critical values. Both in Polish and Slovak group, the most problematic items turned out to be *Time Pressure*, *Great Responsibility*, *Problems and Conflicts*, *Fatigue* and *Long-lasting Load* (Table 1).

Table 1: Descriptive statistics for the individual items of Meister Questionnaire in Polish and Slovak Nurses.

Item	Poland			Slovakia			Critical value[1]
	Mean	Median	SD	Mean	Median	SD	
Time Pressure	4.04	4.00$^+$	1.08	3.62	4.00$^+$	1.02	3.00
Low Satisfaction	2.21	2.00	1.06	2.38	2.00	1.02	2.00
Great Responsibility	4.06	4.00$^+$	1.01	3.16	4.00$^+$	1.20	2.00
Dull Work	1.74	1.00	0.96	2.01	2.00	0.98	2.00
Problems and Conflicts	2.37	2.00$^+$	1.22	3.24	4.00$^+$	1.39	1.00
Monotony	1.75	1.00	1.00	2.38	2.00$^+$	1.13	1.00
Nervousness	2.78	2.00	1.22	2.90	3.00$^+$	1.25	2.00
Oversaturation	2.07	2.00	1.15	3.03	3.00$^+$	1.31	2.00
Fatigue	3.22	4.00$^+$	1.28	3.55	4.00$^+$	1.23	3.00
Long-lasting Load	3.70	4.00$^+$	1.18	3.42	4.00$^+$	1.24	3.00

[1]According to Zidkova [3, 7]; $^+$ denotes exceeded critical limit

Statistical analysis revealed significant differences between Polish and Slovak group in terms of the analyzed subscales. and achieved the lowest scores on *Monotony* scale ($F_{2,135}$=64.59, p<0,001). The results are summarized in Table 2.

Table 2: Descriptive statistics for the subscales of Meister Questionnaire in Polish and Slovak Nurses.

Subscale	Group	Mean	SD
Overload	Poland	3.49	0.77
	Slovakia	3.33	0.78
Monotony	Poland	1.90	0.78
	Slovakia	2.26	0.78
Unspecific Load	Poland	2.94	0.97
	Slovakia	3.23	0.93

Slovak respondents scored significantly higher than Polish ones on *Monotony* ($F_{1,136}$=7.34, p<0.01) and *Unspecific Load* scales ($F_{1,136}$=3.09, p<0.01). Further analysis documented significant subscale-to-subscale differences within both Polish and Slovak groups. Polish respondents were shown to score the highest on *Overload* subscale, followed by *Unspecific Load* and *Monotony* subscales ($F_{2,135}$=117.99, p<0.001). In turn, Slovak participants scored the highest on both *Overload* and *Unspecific Load* scales

In order to determine the effect of the group (Polish vs. Slovak) on the analyzed scores, respective Eta^2 values were calculated. The most prominent intergroup differences were documented in the case of *Monotony* scale, followed by *Unspecific Load* and *Overload* subscale. Furthermore, the analysis of Eta^2 values showed that the subscale-to-subscale differences in among Polish respondents were significantly more evident than among Slovak participants (Figs. 1-3).

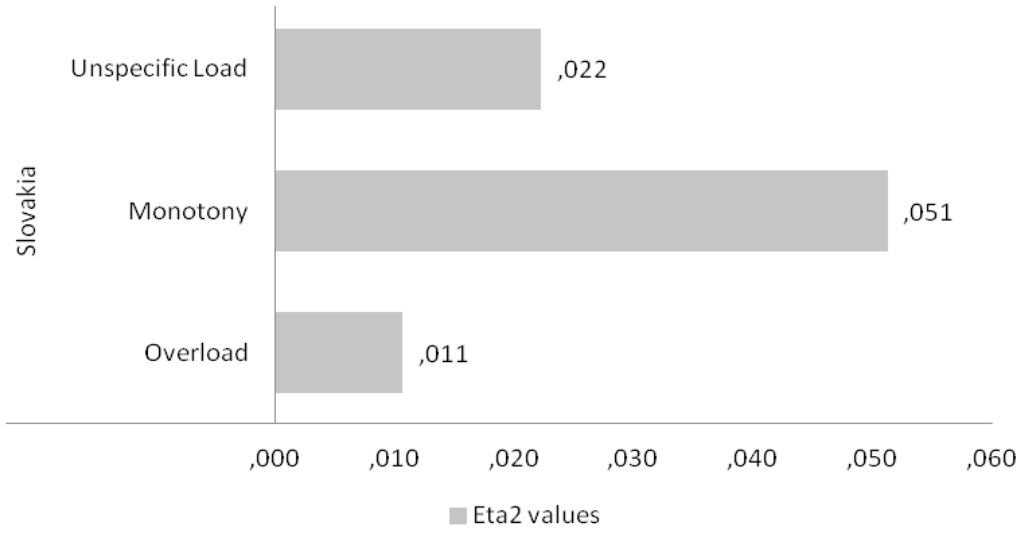

Fig. 1: Eta^2 values for the subscales of Meister Questionnaire in Polish Nurses.

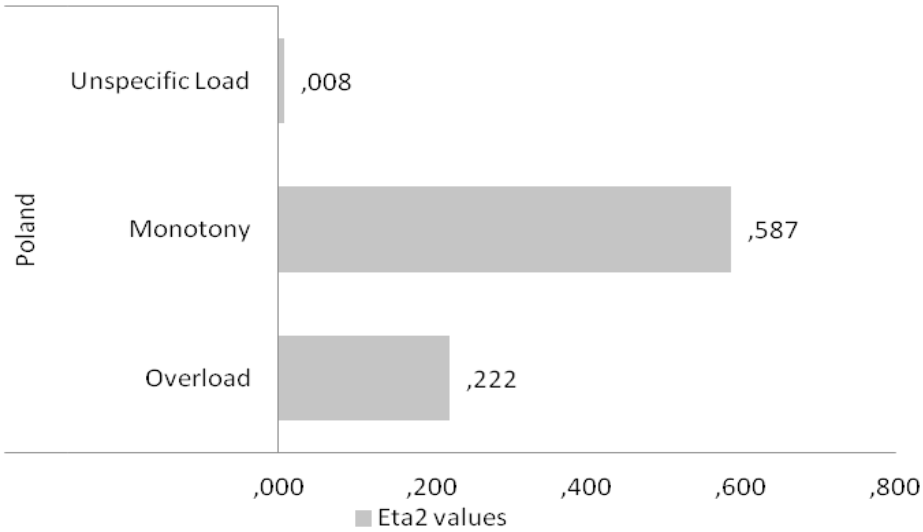

Fig. 2: Eta^2 values for the subscales of Meister Questionnaire in Slovak Nurses.

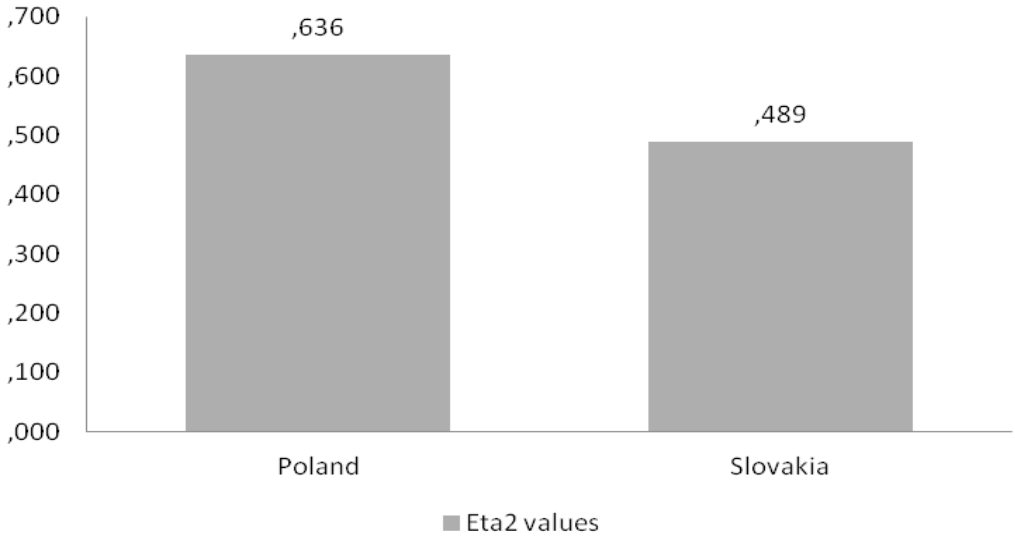

Fig. 3: Comparison of cumulative Eta^2 values for Polish and Slovak Nurses.

Discussion

Using a standardized Questionnaire to assess current mental load allows the researcher to perform international comparisons after its prior adaptation into a relevant language. Prerequisites for such research are met by the Meister Questionnaire which was used as a screening method for assessing psychological burden in research conducted in the Czech Republic and in Slovakia (3,6,8,9,10,11). In Poland, in studies by Debska *et al.* (12) the aforementioned research tool was used when analyzing a group of Nurses working at different units (Intensive Care, Surgical, Internal Diseases,

Primary Care, Oncology). In all the studied groups, the second level of mental load, corresponding to overload, was found. In the same studies, the authors also documented the relationship between mental load and occupational burnout.

Zidkova (6) conducted research in the Czech Republic, using the Meister Questionnaire to assess the mental load experienced in different job positions on a large study group of 1,832 subjects including 1,300 women. None of the scores reached respective critical values. However, assessing groups of employees in the same occupation, she observed that critical values were exceeded for *Overload* in the case of Doctors and Nurses, and for the *Unspecific Load* (reaction to stress) in the group of Scrub-Nurses. In another Czech study, Mazgutova *et al.* (4) showed that work-related mental load in Nurses is recorded highest in terminal care units, in comparison with internal diseases or emergency wards. Moreover, in a group of 168 Oncology Nurses additional burden and stress was caused by excessive Administration as shown in a study by Zalesakova et al. (10).

Previous Polish studies did not show unambiguously that the specialization (place of work) was the factor differentiating the level of load. The results were inconclusive. In the study by Debska *et al.*, the levels of mental load documented for Oncology Nurses did not differ from those recorded for Nurses working at other units. Another study showed that Nurses working at the Intensive Care Unit reported significantly lower levels of mental load than those working at the Surgical Ward (13). It is noteworthy that in both studies work experience was the differentiating factor for mental load, especially for the *Overload* and *Monotony* subscales – the longer the work experience, the higher the scores for the two dimensions. Zalesakova *et al*. also reported differences in mental load depending on work experience in Oncology Nurses. The least overburdened were the Nurses with shorter experience working at a chemotherapy unit, and the most overburdened were those working there longer (10).

An analysis of the available sources shows that the greatest work-related burden reported by Nurses employed at hospital wards was mainly associated with *Time Pressure* and *Great Responsibility* (13). In Social Care Facilities burden was caused by tiring work, rush, fatigue, too many duties (14). A study by Oginska and Zuralska (15), conducted on a group of Neurology Nurses, showed that most of the participants were overburdened with duties and experienced fatigue. Similar results were reported by Gurkova *et al.* (11), who documented that critical values were exceeded for *Time Pressure*, *Great Responsibility*, *Fatigue* and *Long-lasting Load*. Another study conducted among Polish Nurses working in an in-patient medical care showed that 72.6% of the respondents were exposed to stress at the workplace, despite the fact that most of them reported job-satisfaction (16).

Our present study provided similar results, since in both groups (Polish and Slovak), the greatest burden at work turned out to be associated with *Time Pressure*, *Great Responsibility*, *Fatigue* and *Long-lasting Load*; *Problems and Conflicts* were additionally reported in the Slovak group. The respondents scored highest in *Overload* and lowest in *Monotony*. The results for the studied groups differed significantly for *Monotony* and *Unspecific Load*, with the Slovak group scoring higher than the Polish one. With great caution we could assume that nationality may have been the differentiating factor in these subscales, seeing as, as can be surmised from the available sources and previous Czech, Slovak and Polish studies, the differentiating factor was rather place of work, age, and work experience in a given specialization. And regardless of the country

of the study, the results were similar, which proves that Nurses have similar problems connected with the workplace. However, due to a lack of unambiguous results, it seems significant to find the factors affecting the level of work-related mental load in Nurses working in different language areas and different organization and social settings.

Conclusions

In the assessed dimensions of mental load, *Monotony* and *Unspecific Load* (reaction to stress) differentiate the Nurses working at Chemotherapy Units in Slovakia and Poland.

The working conditions of Nurses providing care to Oncologic patients treated with chemotherapy both in Slovakia and Poland are connected with burden, which is the result of time pressure and excessive responsibility.

The assessment of mental load can be used to improve the organization of a Nurse's work, creating safe working conditions in both studied countries, taking into consideration the mobility of the workforce in the European Union.

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Processes for Nursing Occupation as a Tool for Mobility of Nursing Workers

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Original Article

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Abstract:

Introduction. The International Council of Nurses has had an important role in enforcing of the regulation of the occupation of the Nurse. The Council established 11 basic principles of regulation based on their importance. The aim is to present the implementation of the International Council of Nurses in Slovakia and their intentions and to

characterize the forms and methods of regulations of this occupation. This work also aims to analyze the legislative base of the process and refer to the importance of self-regulatory mechanisms. Our intention is to familiarize the reader with creation; development; maintenance of mandatory registration of Nurses in Slovakia.

Results. Concessions, registration, certification and accreditation of people or programs are the mechanisms of regulation. Regulation of the Nurses' occupation in Slovakia takes place in the form of self-regulation or statutory regulation. The basic tool of self-regulation is the Ethical Codex, which defines the responsibility of Nurses towards people – patients and also towards practice, profession, co-workers and society. A Nurse takes on the moral commitment that she/he will observe the values and fulfil the moral responsibilities expressed in the Codex. Codex as a self-regulatory mechanism expresses the aims and values of the nursing occupation. In practice, this means that the Nurse binds herself/himself to support health, prevent diseases, recover and maintain health and ease the suffering. Statutory regulation is set by legal norms and has a form of state registration, it is governed by the government and as realized by the Slovak Chamber of Nurses and Midwives. The tool for statutory regulation is obligatory registration. Based on Law no. 578/2004 of the Codex of Healthcare Providers, Healthcare Workers and State Organizations in Healthcare - § 62 section 1 – Registration is the entry of a Nurse to Register and issuing a confirmation of Registration. It is important in national and international context. In a national context, it defines who and under what conditions are eligible to work as a Nurse. In international context, it conditions the ability to find employment on the international labor market. Registration is mandatory in Slovakia since 2004.

Introduction

Regulation - Latin origin - means a controlled intervention that guides the unrestrained course or maintains the values of the regulated quantity. The International Council of Nurses (ICN) participates on the course of regulating healthcare professions. Margrett M. Styles was assigned by ICN to undertake a study in the years 1983-1984 in order to provide evidence of the need to regulate the profession. Styles collected, organized and evaluated nursing data in each country. She has developed directives to approve the ICN's official position and to support Member States in assessing and developing their regulatory system. ICN proposed the first principles, principles of professional regulation. The recommendations were approved in 1985 by the Council of National Representatives of ICN (Hanzlikova, 2011).

The core. ICN formulated regulatory objectives as follows:

- define the profession and its members;
- define the scope;
- set educational standards;
- set ethical standards and standards of professional competence;

- create a system of responsibilities;
- create verification (screening) procedures.

How is a profession defined and who is a professional? In the years 1987-1992, ICN realized an international project in more than 80 countries. The aim of the project was to ensure that ICN's objectives for regulatory regulation were put into practice. The result of ICN's activities was that in 1992 the World Health Organization (WHO) identified five regulated health professions (Physician, Dentist, Pharmacist, Nurse and Midwife). *By adopting a WHO resolution, nursing has become one of the regulated professions. It was determined that a Nurse is a Nurse practicing nursing and is registered in the Register of Nurses.* A Nurse is a person - a professional who carries out the set of activities related to the provision of nursing care on the condition that he/she has acquired professional competence for practicing the profession (Act 311/2002 Coll.).

What is the scope of the Nurse in Slovakia? The scope of the Registered Nurse is in implementation of practical activities **a)** in the provision of nursing care, **b)** in nursing education, **c)** in the management and provision of primary, secondary and subsequent nursing care by the nursing process. A Nurse works to the extent that she/he knows how to identify deficits in the patient's needs; design and realize procedures to meet those needs; maintain nursing documentation; evaluate nursing care results. It follows that a Nurse acts in a nursing practice that is standardized; means cooperation with other members of the multidisciplinary team involved in the planning, provision and evaluation of nursing care.

Training standards are set in the training for the profession. This third principle of ICN in Slovakia is implemented in such way that the legislation establishes the criteria of professional competence in the Nurse's profession. In accordance with the Government Regulation of the Slovak Republic no. 296/2010 Coll., the *professional qualification for the performance of professional work activities*, a Nurse acquires by obtaining the higher education degree in the study of a qualified General Nurse (lasting at least three years), higher education of the first degree in the bachelor study program in the field of study of Nursing (lasting at least 4,600 hours of which *theoretical* teaching represents at least 1/3 of the lessons and *practical* at least ½ lessons) or higher education of the 2nd Degree in the Master's Degree Program in Nursing. The professional qualification for the performance of certified work activities is obtained through certification training in certified work activities. The education standard defines that theoretical teaching of students is the part of the lessons to acquire the knowledge and professional skills necessary for organizing, planning, providing and evaluating comprehensive nursing care. It is carried out at colleges, universities and is run by pedagogical staff who are professionally qualified to perform professional work in the Nurse's profession. *Theoretical lessons* must be balanced with practical lessons. *Practical lessons* are a part of student education on the basis of which they acquire the skills to plan, provide and evaluate nursing care in direct contact with a healthy or ill person or community. They learn practical skills to lead and organize nursing care, including the education of the person, family or community. Teaching is done in hospitals and other healthcare institutions, under supervision of professional staff who are professionally qualified to practice professional nursing activities. Students are involved in providing health- care. These conditions are created to learn how to assume responsibility for nursing care.

The objective of establishing ethical standards was implemented by ICN by adopting

a Nurse Ethical Code. The International Code of Ethics for Nursing was adopted by ICN in 1953 and revised in 1969, 1973, 1989, 2006 (Novotny, Novotna, Rybarova, 2017). The Code emphasizes professional behavior that is consistent with ethical principles. This means that if one becomes the Nurse, she/ he takes a moral commitment to respect the values and fulfil the moral obligations expressed in the Code. Plevova and colleagues (2011) believe that Nurses manage their own profession by respecting the Principles of the Code of Ethics. Slovak Nursing and Nurses have their own Code of Ethics, which is published as Annex to Act No. 311/2002 Coll. about the Nurse's profession, about the position of the Midwife, about the Nursing Commission and the Nursing Assistants.

The Code of Ethics defines four basic responsibilities of the Nurse:

- promoting health;
- preventing illness;
- recovering and maintaining health;
- relieving suffering.

At the same time, it establishes four characters - principles that correct the standards of behavior.

The "Nurses and People Principle" states that the professional responsibility of a Nurse is to provide the required care. Providing nursing care, Nurses promote environmental protection; respect human rights; values; customs; religious convictions of a person, family, and community.

The "Nurses and Practice Principle" states that Nurses have a personal responsibility of nursing practice and maintain professional competence through lifelong education. A Nurse in nursing care is responsible for the safety of care, care for dignity and respect for patients' rights.

The "Nurse and Profession Principle" states that a Nurse takes on professional responsibility to implement professional roles in clinical practice; management; research in the education process.

The "Nurses and Co-workers Principle" assumes building and maintaining positive interpersonal relationships in clinical practice. The Code of Ethics expresses the objectives and values of the person - a Nurse who performs the profession.

Standards of professional competence are defined as follows: a Nurse who has acquired professional competence in the performance of professional work activities is authorized to carry out the professional work associated with the provision of nursing care. A Nurse who has acquired professional competence to perform specialized work activities is authorized to perform it independently within the scope of an accredited specialization study program. A similar standard of professional liability also applies to the performance of certified work activities.

The system of professional responsibility is determined by competencies. The currently applicable regulation classifies a Nurse's competences into three groups: 1) The highest number of competencies represents competence - the work done by the Nurse alone; 2) consists of activities which she/he carries out on its own but on the basis of a Doctor's orders; 3) includes the lowest number of performances that the Nurse performs in cooperation with the Doctor eventually under the authority of the Doctor.

The verification of a Nurse's professional competencies performed by the Slovak Chamber of Nurses and Midwives (SCHNaM). The initial review is carried out when a nursing graduate of the study program decides for practice. Nurse appointment can be performed after Registration in the Register maintained by SCHNaM. The Chamber will issue a Registration Certificate and assign a Registration # within 10 days of delivery of the application and other documents. Entry into the Register is

evidence of the first professional competence check. The person will communicate the data necessary for Registration no later than three months from the start of a Nurse's Medical Profession to the competent employer. Further verification of professional competences is accomplished by fulfilling the statutory duty to continuing education. A Nurse is required to constantly educate and complement her knowledge through various methods and forms.

The Chamber examines the state of nursing competence in five-year assessment cycles. For activities of continuing education, Nurses are allocated credits. In a five-year cycle, a Nurse is required to receive 100 credits (in measurable and undetectable component). The activities of continuing education are included: for example, active participation in one impact education activity at the local, district, regional level in the role of being a main author or co-author; in a panel discussion; a poster presentation. In addition, attendance of a Nurse on Internship at an accredited workplace; lecturing; in a mentoring process in the educational process. Credits can be obtained for publishing at home or abroad.

It follows from the above, that regulation can be performed *as* ***self-regulation or statutory regulation. Self-regulation*** takes place as a process of managing a Nurse's own behavior in the spirit of the Code of Ethics. ***Statutory regulation*** is established by legal norms. The Government of the Slovak Republic has issued (as stated in the text) legal norms for Regulation of Education, implementation of nursing practice and adjustment of working conditions.

The stronger instrument of statutory regulation ***is the higher-featured registration.*** ICN already characterized registration in 1969 as follows: "*For registration, we consider the process of documenting and maintaining records of individuals who have complied with nursing practice requirements"* (Hanzlikova, 2011). This method maintains ***regulatory control of practice*** that protect the public and guarantee professional care. It is important in the National and International context. It fulfills the role of a list of Qualified Nurses in the national context. In the International context, it plays a role in the field of globalization, the issue of applying to the International Labor Market. According to the opinion of Kutnohorska (2010) registration is the motivation of Nurses to education, which allows them to move more freely on the labor market within the European Union. The Register is the information source about of the number, composition, education of Nurses in active nursing profession. A registered Nurse may ask the Chamber to issue the License. The License is the abbreviated appellation for the rights and obligations accruing from the License Agreement.

According to the *Law on Healthcare Providers*, following licenses: ***a license to practice self-employed practice of medicine; to practice a medical profession; to perform the duties of a professional representative in the Nurse's*** **profession**. For licensing, a Nurse has to meet the following requirements of the law:

- full competency to perform legal acts;
- health competence;
- professional competence;
- integrity;
- credibility;
- registration.

The conditions for issuing the license must be fulfilled throughout the validity period of the license (Botikova et al., 2009).

Regulatory Control of Titles is also Part of the Regulation Issue

Regulatory control of titles allows the person to use a professional title. The aim is to inform patients about nursing qualifications.

The title Nurse is only allowed to be used by Nursing Professionals. The use of professional titles is regulated by Regulation of the Government of the Slovak Republic no. 12/2008 Coll. Statute of uses of professional titles and their abbreviations, which are linked to the professional competence for the exercise of the Medical Profession provides that: - the professional title "Nurse" is used by a person who is professionally competent to perform nursing professional activities. If a Nurse has received higher professional education at a secondary Medical School, sh/hee has the right to use the abbreviation the dipl. n. (dipl.s.), which is used after the name and surname of the user, followed by a comma.

Conslusion

Finally, it can be stated that a ***regulated profession*** is also considered to be a profession for which the legislation defines:

- a particular professional title;
- the conditions for obtaining the qualification;
- the conditions for the exercise of the profession;
- activities reserved to this profession (Kilikova, 2017).

Processes for regulating healthcare professions are compatible with regulatory processes in other countries of the European Union. The content of this activity respects directives of the Council of Europe and the Union's legislative framework.

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Prenatal Care in Uganda and the Czech Republic

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Original Article

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Abstract:

Objective: The objective was to determine whether the Czech and Ugandan women are familiar with the concept of prenatal counseling; if they visit prenatal clinic; what kind of tests are conducted during the prenatal counseling; whether their health throughout pregnancy is monitored by a Health Professional.

Background: Prenatal care in the Czech Republic and in Uganda differ from each other. A Midwife plays an important role in the care of pregnant women in Uganda. In the Czech Republic a pregnant woman undergoes a higher number of tests compared to Uganda.
Methods: Respondents were selected by purposive sampling. There were two homogeneous sets of respondents from the Czech Republic and Uganda - women with children under the age of 2. A non-standardized questionnaire in Czech and English language was created, with the level of significance of 5%.
Results: The knowledge level of the term prenatal clinic is higher in the Czech Republic than in Uganda. 80 Czech respondents (100%) underwent ultrasound examination during pregnancy. It was only 22 respondents (27.5%) in Uganda. Cardiotocographic examination in Uganda does not take place in the Czech Republic is extended, it completed a total of 70 (87.5%) respondents. Health status of Ugandan respondents monitors in 75.6% (51 respondents) Midwife, the Czech Republic all 80 (100.0%) of the respondents is monitored by a Doctor.
Conclusions: The results can be applied in legislation changes and improvements in education.

Introduction

Pregnancy is a physiological period and throughout history, it has been interspersed with various theories, attitudes and procedures. The topical issue in our society is an approach to a pregnancy and a labor as to physiological processes. For a woman, pregnancy and labor are enriching conditions and do not mean a pathology or illness. It is therefore necessary to treat them as natural life phases or natural phenomena.

Prenatal care means not only health monitoring during pregnancy but also an offer of courses and other activities which a woman can do during her pregnancy. Theoretical, exercise and mixed courses are offered to pregnant women in the Czech Republic. (Roztocil, 2008, p. 57)

Prenatal counseling is understood as a pregnant woman seeing a Healthcare Professional, in the Czech Republic mostly a Gynecologist and an Obstetrician. The Czech Gynecological and Obstetrician Society recommends that women with normal pregnancy undergo prenatal counseling once every four weeks until the 36th week of gestation (including) and once a week from 37th week of gestation to the due date. The Czech Gynecological and Obstetrician Society also recommends a complex prenatal examination be performed by the end of 12th week of gestation at the latest. Within each visit of prenatal counseling a detailed collection of anamnesis data; external examination measuring weight gain; blood pressure and pulse; chemical analysis of urine; if appropriate a bimanual vaginal examination to state the cervix score are carried out. The detection of fetus vitality signs is carried out from 24th week of gestation onward. Among irregular examinations in particular week of gestation also belong detailed blood sampling; birth defects screening; ultrasonography screening; vaginal swabs; Cardiotocographic; etc. (Lubusky, 2007)

As regards the frequency of visits in prenatal counseling, pregnant women in the

Czech Republic follow recommendations by the Czech Gynecological and Obstetrician Society. Some of them also search for independent Midwives.

Dish (2007) states that about 94% of Ugandan pregnant women have four prenatal counseling visits during their pregnancy, most often between 10th-16th, than between 20th - 24th, 28th - 32nd and in 36th week of gestation. Prenatal counseling is managed by Midwives and it is performed in hospitals or health care centers – health units.

In prenatal counseling a thorough collection of anamnesis data in pregnant women is carried out. Vaginal examination is carried out on demand and it is aimed to searching of abnormalities and infections – syphilis, candida albicans, etc. Size of pelvis is measured between the 36th and 42nd week of gestation. This measuring is done to all *primiparas* and all *multiparas* whose previous children were born weighing more than 3 kilograms. (Fraser *et al*., 2009, p. 247)

Blood pressure and heartbeat is measured during every visit in prenatal counseling. Body height and weight are recorded within the first visit. The weight gain is watched in the course of the entire pregnancy. All the data are recorded into a maternity certificate. Urine and blood examinations are carried out on demand. (Henderson, Macdoland, 2004, p. 248)

Instrumental methods of examination are not widespread in Uganda. Some women undergo ECG during their pregnancy but this is available only in healthcare centers in the capital Kampala. Ultrasonography screening and cardiotocography are not part of routine examinations. (Henderson, Macdoland, 2004, p. 254)

In the second and third trimester, prophylaxis is done against most frequent local diseases such as infection, malnutrition, malaria and pre-eclampsia.

One of the most important African topics of education is hygiene. There is a lack of drinking water in Uganda. In prenatal counseling Midwives counsel pregnant women about appropriate diet during pregnancy; danger of natural (medicine men's) medicine; basic diseases in pregnancy; importance of labor in hospital environment; malaria and anemia prophylaxes; parenthood planning; signals of labor initialization; correct breastfeeding and importance of exercising and relaxation. They also educate women in childcare and about sexually transmitted diseases.

The principal objective of this work was to compare a level of prenatal care in the Czech Republic and Uganda. Several sub-aims were set through which it was possible to meet the main aim.

Sub-aims: To ascertain whether:

- the respondents know what the term "prenatal counseling" means.
- the respondents visit/visited prenatal counseling.
- the respondents' health condition was monitored during their pregnancy.
- ultrasonography examination is done in the Czech Republic and in Uganda.
- cardiotocography examination is done in the Czech Republic and in Uganda.

Sample and research methodology

A standardized questionnaire in English and Czech languages was created. It consisted of 21 items, topics covering prenatal care, labor and postnatal period with socio-demographic data. The linguistic validity was carried out with respect to a bilingual version of the instrument. In the introduction to the questionnaire, the respondents were presented with research objectives and informed about how the data would be used. Within the scope of a pilot study a content and construct validity of research instrument was made. The software Microsoft Word 2007 and Microsoft Excel 2007 were

used. For statistical processing the χ^2 test (Chi-squared Test) was used; calculation was with Microsoft Excel 2007 and open source OpenEpi 2.3.1.

The collected data were recorded into contingency tables and consequently generated tables and graphs of particular measuring values. We worked at a significance level of 5%. The research survey took place in locations where the author acted as a volunteer – Midwife, in *Holy Innocents Children's Hospital* Mbarara and *Uganda Martyrs Ibanda Hospital*, districts Mbarara (Mbarara, Tsigye) and Isingiro (Ibanda, Kanyonza, Ruhimbo, Mabona, Rwengiri, Rwembwa). All stated workplaces and locations acknowledged the survey and agreed with the research being carried out.

The research survey in the Czech Republic was realized in healthcare providers at selected Medical Doctors' offices, who were acknowledged with a research survey in advance and agreed with it. Research was held: in office of General Practitioner for children and adolescents MUDr. Jana Spackova in Ostrava-Poruba, General Practitioner for children and adolescents MUDr. Vera Chvatalova in Valasske Mezirici and in the Pediatric Department of the Hospital in Valasske Mezirici. The selection of healthcare providers and General Practitioners was realized on the basis of a pilot study after which we learned that it was optimal to opt for women respondents who had already given birth, visited a General Practitioner or were in hospital with a child under two years of age at that time – this seemed to be an adequate period because women were able to remember the course of prenatal care and childbirth itself. Data collection took place in both countries ranging from June to September 2010.

The research survey was carried out in two sets of respondents. They were women with children under two years of age living in the Czech Republic and Uganda. A return rate of questionnaires was 88.9% in the Czech Republic and 100% in Uganda. A 100% return rate in Uganda was because of the language barrier; we had to address a particular woman and translate and fill in a complete questionnaire to the local African language in cooperation with an interpreter because not all the respondents could speak English. It is possible to describe the cooperation with an interpreter as a potential limit of study because of possible tending to distortion of research survey results. In total, 160 questionnaires were evaluated, 80 from the Czech Republic and 80 from Uganda.

Results

We focused on women's awareness in the area of pregnancy, labor and childcare. Mother was reported as the information source about pregnancy, labor and childcare by 10 respondents (12.5%); a Midwife by 45 respondents (56.3%); a Medical Doctor by 29 respondents (36.3%). Three respondents stated another information source – a sister, a husband or a friend. It was found that in the Czech Republic mother was given as the information source about pregnancy, labor and childcare by 34 respondents (42.5%) and the same number stated a Midwife as their information source. For 48 respondents (60.0%) a Medical Doctor was an information source about pregnancy, labor and childcare; 24 respondents (30.0%) stated other information sources - a friend, specialized literature and the Internet.

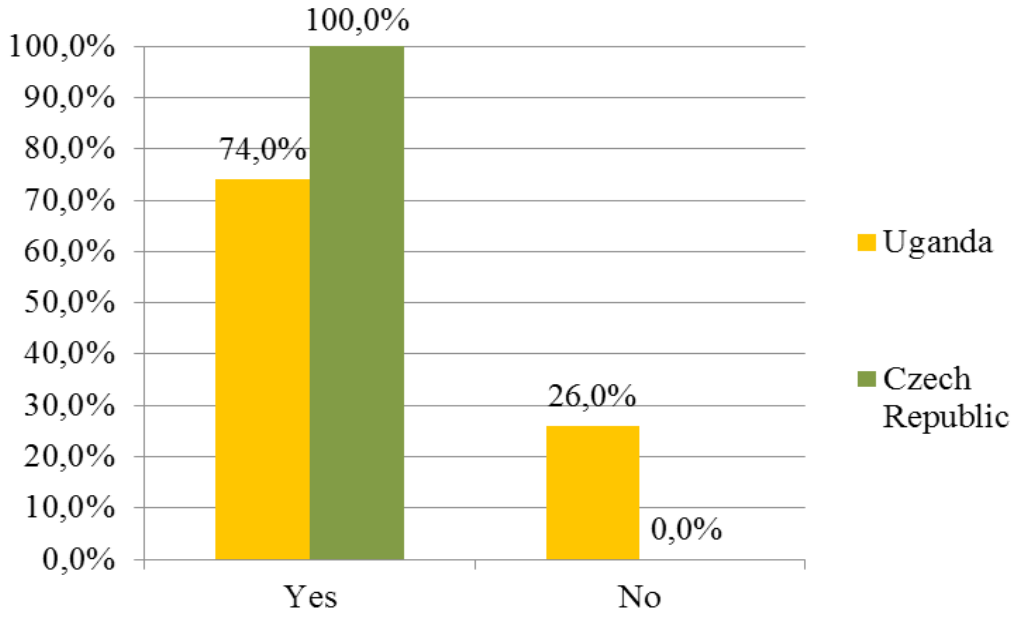
Our objective was to ascertain if respondents know what prenatal counseling is and whether they had received it. 64 (81.0%) Ugandan respondents stated they knew what prenatal counseling was; 15 (19.0%) respondents did not know. In the Czech Republic, the results show that except for one respondent all the 79 respondents knew what prenatal counseling was. Statistically

significant difference in response rate p=0, 0002, p < 0.01 was confirmed.

Graph No. 1 shows percentage of respondents from Uganda and the Czech Republic in a visit rate of prenatal counseling. In this item was result of Chi-squared Test p = 0.0002, statistically significant difference in response (p < 0.01) was found.

units (healthcare centers with low quality of healthcare) or during field shift of Midwives.

Nowadays, the ultrasound examination is being done for a pregnant Czech woman several times during the pregnancy. This was confirmed in the survey showing that all the 80 respondents (100.0%) from the Czech Republic underwent an ultrasound



Graph No. 1: Antenatal clinic attendance.

The health condition in pregnancy was checked in Uganda in 78 respondents (97.0%). In the Czech Republic all the 80 respondents (100.0%) underwent a medical check of pregnancy in prenatal counseling.

In Uganda, 17 respondents (21.8%) were present in prenatal counseling (in hospitals) for medical check-up of their pregnancy. The health condition of 59 respondents (75.6%) was checked by a Midwife and in 2 respondents (2.6%) by their mothers. Examination by a Midwife was carried out in the course of random meeting in Health

examination during their pregnancy. The result of Chi-squared Test p= 1.4510 shows there no statistically significant difference in respond rate (p > 0.01) was found. There were only 22 respondents (27.5%) who underwent an ultrasound screening in Uganda; CTG examination is not carried out there. The reason that none of the addressed respondents underwent this examination is very simple – lack of financial resources for the instruments. No statistically significant difference in response rate (p > 0.01), p=6.7338 was found. (Chart No. 1)

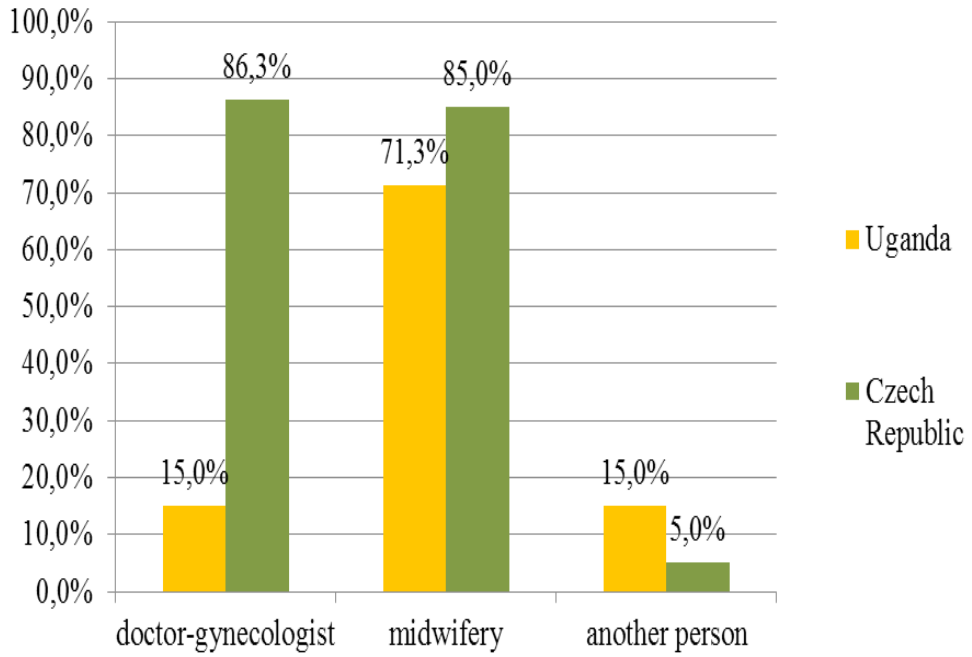
Chart No. 1: Cardiotocographic examination by the respondents in pregnancy.

	Uganda		Czech Republic	
Answer	Relative	Absolute	Relative	Absolute
Yes	0	0.0%	70	87.5%
No	80	100.0%	10	12.5%

In our research survey, we were interested in who assisted women in the course of labor itself. The respondents were allowed to give more answers. The results from the Czech Republic and Uganda are shown in the Graph No. 2. Other person was stated by Ugandan respondents in 12 cases (15.0%), out of which a husband assisted to 1 respondent (8.3%), mother-in-law to 1 respondent (8.3%) a neighbor to 1 respondent (8.3%), 3 respondents (25.0%) reported the assistance of TBA (traditional birth assistant) and mother in 4 respondents (33.3%). 2 respondents (16.7%) stated they delivered on their own. The other person, namely a husband, was reported by 4 respondents (5.0%) in the Czech Republic.

Discussion

Except for one, all the respondents (99.0%) from the Czech Republic knew what prenatal counseling was. In Uganda, this term is familiar to 81.0% and unknown for 19.0%. The reason for different results of research surveys in Uganda and the Czech Republic could be insufficient and poor health awareness of Ugandan women during their pregnancy. It is connected to the woman's age and her maturity. Research of Grant and Hallman (2006) in South Africa revealed that at the age of 18 more than 30% of adolescent women have given birth at least once. Pregnancy poses one of the most serious cause of interrupting school attendance, namely at the



Graph No. 2: Assistance of labor.

high-school level. This means that in many cases for teenage mothers the child birth results in study termination. (Grant, Hallman, 2006, p. 3) The research showed there are factors which influence whether a teenage mother is able to continue in her education after giving birth. Most of the factors depend on the girls' ability to control logistics, finances and education with mother care. (Kaufman, Wet & Stadler, 2001)

We learned from results of research surveys in the Czech Republic and Uganda that 100.0% of Czech respondents visited prenatal counseling. There were 74.0% Ugandan respondents who visited prenatal counseling and 26.0% who did not. There could be several reasons for these different results: poor awareness on prenatal counseling importance in Uganda; poor access to a healthcare center providing prenatal counseling in Uganda along with its remoteness. Globally, if we look at the prenatal care in Uganda it is necessary to note that the percentage of women visiting prenatal counseling is progressively increasing. UNICEF, *State of the World's Children, Child info and Demographic and Health Survey* constantly informs the general public about these results. (UNICEF 2016)

We were interested if a health condition was checked in all respondents. In all the respondents in the Czech Republic checks were carried out in prenatal counseling. In 2 Ugandan respondents their health condition was not checked at all, however 21.8% respondents visited prenatal counseling. While in the Czech Republic the prenatal counseling is carried out by a Medical Doctor, in Uganda it is done by a Midwife. Research survey results indicate that the activities and competency of Midwives are far wider in Uganda than in the Czech Republic. Prenatal counseling is often done only by a student of Midwifery degree program.

The Czech Republic differs from Uganda in the development of instrumental methods of examination. Only 27.5% respondents in Uganda underwent ultrasound examination in their pregnancy. Cardiotocography is not available in Uganda; therefore no respondent undertook this examination during pregnancy. It was reported that in the Czech Republic 12.5% of respondents did not undergo cardiotocography. The reason why not all the Czech respondents undertook this examination, although the CTG equipment is available in every Czech prenatal care, can lie in the women's approach to this examination, their opinion, lifestyle and also the week of gestation.

Conclusion

Knowledge of prenatal counseling is wider in the Czech Republic than in Uganda. Similar results were discovered regarding visits of prenatal counseling. More Czech women visited prenatal counseling than Uganda women. The frequency of ultrasound examination was higher in the Czech Republic. CTG was not available for any Uganda respondent. In all Czech respondents their health condition was monitored by a Medical Doctor; in Uganda respondents' health condition was monitored by a Midwife._

Follow-up research surveys should focus more intensively on the profession of a Midwife. The competencies of Midwives in Uganda are far greater than in the Czech Republic. Information gained in the research can be used in praxis, above all as a motivation for tighter cooperation between both countries. In many parts of Uganda, the study programs of Midwifery are supported by the European Union and therefore a potential cooperation should not pose an issue.

It should be noted that despite the survey, results look more positive more for the Czech setting, the quality of prenatal care in Uganda is on the increase and is gradually improving, as has been confirmed in studies carried out by UNICEF.

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The Opinions of Persons with Hearing Impairment on the Help of Assistive Devices – Hearing Aids

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Original Article

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Abstract:

Introduction: The article deals with reviews and ratings of people with hearing impairments, measuring the effectiveness of hearing aids in facilitating communication with the surrounding world of hearing majority. It outlines the importance of assistive aids based on the partial

results of the research that relates to the elimination of communication barriers of people with hearing disability.

Methodology and materials: The article presents partial results of the research for which a custom questionnaire was designed, according to a model of the *International Classification of Functioning, Disability and Health* - ICF. This classification, as opposed to ICD-10, takes into account the consequences of the diagnosis in the social environment. It monitors not only the state of health but also individual differences of the impact of hearing impairment on the quality of life. The research explores the importance of using a hearing aid in communication, compares the quality of speech recognition with and without using the assistive aid. Also, it focuses on the ability to talk with more people, and to what extent people with hearing impairment have difficulty listening to lectures or radio without a hearing aid.

Discussion: Based on the results, we concluded that hearing aids cannot restore the hearing ability as we know it in hearing people. Therefore, the assumption of the hearing majority that hearing-impaired people need no further intervention after being given a hearing aid, is incorrect. Generally, it cannot be argued that hearing aids are really providing effective support in elimination communication barriers in persons with high hearing loss.

Conclusion: People with high hearing loss do not usually use hearing aids as they are no longer helpful to them, and people, whom we refer to as "hard of hearing", do not suffer from hearing loss at the level that the criteria of the Social Welfare Law would recognize as eligible for allowance for higher quality hearing aids.

Introduction

The World Health Organization (WHO) reports that there is one child with complete hearing loss and 3 - 6 with hearing impairment in 1,000 newborn babies. The WHO also points out that the number of people with hearing disabilities in the world is growing (Tarcsiova, Hovorkova 2002). According to Slowik (2007) a person receives 60% of the information from the environment both in a targeted and involuntary manner. Beno (2014) in his publications broadly categorizes the implications of a hearing disability in terms of a communication barrier which brings along other problems. According Cernanova (2012) who is a Psychiatric Clinical Practitioner and deals with mental disorders due to hearing impairment, hearing disorder due to adverse impact on communication and thus on the interaction with the environment, causes many negative psychological and social effects. According to a study published by K. Tambs (2004) to which Cernanova (2012) refers, hearing-impaired people compared to general population suffer from higher levels of psychological distress; lower levels of social functioning; less common social activities; more relationship problems with family, friends and at work; greater emotional problems; increased anxiety; depression; phobias; and higher levels of interpersonal sensitivity and hostility.

The common majority population assumes that the problems of the hearing impaired can be resolved by wearing a hearing aid which today is one of the best-known audio-prosthetic device. But in fact, hearing aids cannot restore hearing ability as it is known by hearing people. Therefore, the assumption that the hearing-impaired need no further intervention after being given a hearing aid, is incorrect. Groma (2009) points out that the acquired disorder needs much more than mere allocation and set-up of a hearing aid. He also mentions rehabilitation and especially adaptation. He further states that "the problem of adaptation to hearing loss is underestimated in our circumstances." However, any state aid to those with hearing impairments whose hearing loss is less than 80% according to Fowler is also underestimated.

In our article, we describe selected results of research focused on the social policy of the state towards people with hearing impairments which maps the views of respondents to questions about the possibility of eliminating barriers in the field of communication. The questions in the research were prepared by a model of the *International Classification of Functioning, Disability and Health* (ICF). This classification is part of a set of classifications of the World Health Organization and is intended to measure and assess the degree of disability, medical fitness assessment, or for example, to identify specific educational needs. It is a multipurpose classification that serves different disciplines and sectors. Unlike the ICD-10 classification which only establishes a clinical diagnosis the ICF describes the more complex situation of people in terms of their health and their functional capabilities.

Methodology and Materials

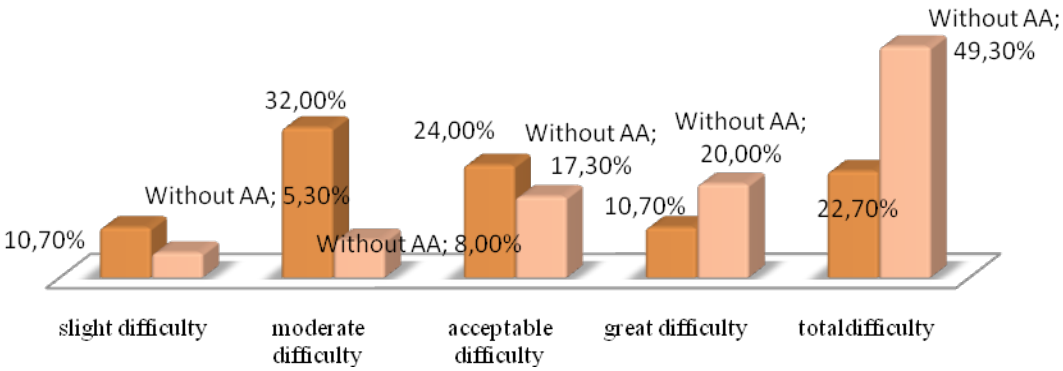
We have also applied the model of functional disabilities and health capabilities in our research. We have created a custom questionnaire with questions and alternative options/responses that correspond to the original ICF questions. We have focused on those that are specific to communication and social assistance. 76 respondents (aged 24 and 72, mean age 44.21) who have a hearing disability participated in the survey so far. The respondents included 46 (61%) women and 29 (39%) men. Hearing loss reported by respondents ranged from 60% to 100% according to Fowler (Annex in Slovak Act 447/2008 Coll). When asked what assistive devices they use, most of them mentioned a hearing aid and only two the cochlear implant. That is why in our research we have also focused on the benefits of or the barriers in using this most common assistive device - the hearing aid.

The current market for assistive aids offers a great choice. From inexpensive in commercially focused sales to high-quality and expensive equipment from recognized companies. Hearing-impaired people choose them based on the type and nature of their own disability. In addition to the different types and shapes of these devices, their functions are particularly important. Currently, digital programmable devices are produced, but cheaper analog devices are still available on the market. The difference between them lies in the fact that digital devices are equipped with a chip that can detect whether the sound comes from the noise of environment or speech. They can suppress noise and adjust speech so that the sound is pure, amplified and minimally distorted.

Multi-channel devices can be tuned more precisely to individual frequencies, ensuring even better reception for people with different degrees of hearing loss. There are different settings for perceptual (sensorineural) types of disorder and for conductive types of disorder. Such a device can amplify the weakest sounds the most,

the moderate ones less, and do not amplify too loud sounds at all. This is a great advantage over older devices that used to amplify all kinds of sounds equally. Today, there is no significant justification for using the older type of hearing aids by people with the sensorineural hearing impairment who have a greater problem with decryption of phonemes as well as volume. Hearing aids that are currently available as partly reimbursed by the insurance company are mostly cheaper analog devices and expensive programmable devices are less available for people with hearing impairment and therefore do not contribute to the elimination of communication barriers as it is generally expected.

Figure 1: Difficulty of listening / use of assistive aids (N = 75).



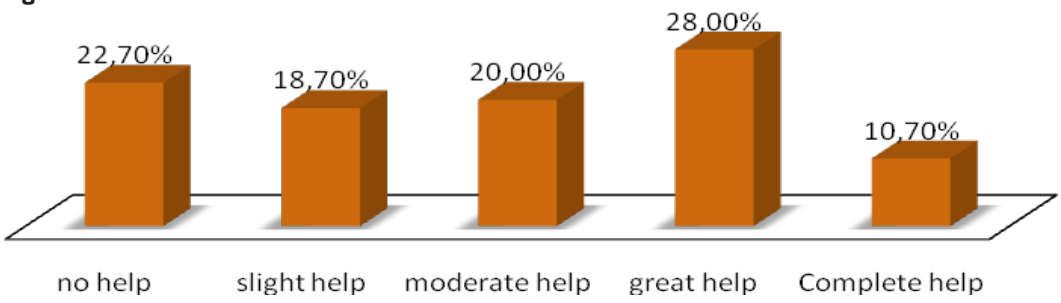
Source: Authors' own research

Results and Discussion

Figure 1 shows the answers of respondents to a question about the difficulty of listening to radio, music or lectures **with and without using** assistive device (CD), i.e. the hearing aid. If we overlook the mean option of an alternative response which is often chosen by indecisive respondents the answers of respondents have not suggested that the hearing aid would be of significant help to them. Total difficulties without the assistive device were reported by almost half of the respondents (49.30%). Even with the use of the device, total difficulties were still reported by 22.70% of the respondents. Based on the answers, we assume that the part of the respondents who experience great and total difficulties will move to the category of mild and moderate difficulty when using the device. This confirms the incorrect assumption of the hearing majority that once the hearing aid is in place, the affected person can hear well again.

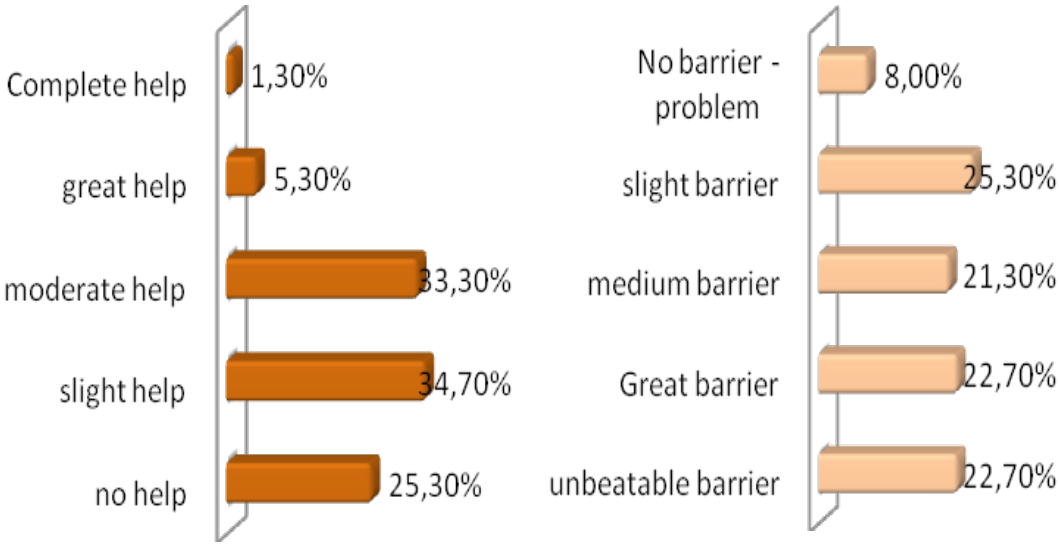
Figure 2 shows the answers of respondents to the question on the extent of help provided by a hearing aid. 41.4% of respondents said that the help is poor. More than half of them (22%) said that the hearing aids "do not help at all". Positive-oriented responses offered a percentage of 38.70%. We can conclude that most respondents also confirmed the opinion of the previously mentioned author, Groma (2009), who says that "the mere allocation of the aid is not enough".

Figure 2: Use of assistive devices.



Source: Authors' own research

Figure 3: Help or hindrance of the table for determining the criteria of social assistance.



Source: Authors' own research

Figure 3 illustrates the views of hearing-impaired people to the tables of Act 447/2008 Coll. on financial benefits to compensate severe disability.

It turns out that most respondents consider these tables to be a barrier, or ill means of effective assistance. In addition to the questionnaires, we also investigated why the respondents chose their answer, and we learned that some people chose the label of "unbeatable barrier" because they could not get the status of a citizen with severe disabilities or could not obtain approval for a better hearing aid; others understood it as a serious hurdle in the government's officially proclaimed effort to eliminate communication barriers. There were also comments on the obsolescence of categorization according to Fowler (introduced before World War II).

The table in Act 447/2008 Coll. provides the categorization of hearing impairment, or hearing loss according to Fowler. These

criteria are used to assess the degree of disability and to award certain social benefits or advantages. In connection with hearing aids, it also concerns the possible state aid in buying or servicing hearing aids. According to set criteria, people referred to as hard of hearing are often not eligible to apply for state aid. Generally speaking, they are not "deaf enough". The criteria do not reflect whether it concerns a teacher, lawyer, farmer or a truck driver. They only deal with reduced working capacity. However, in the professions where every word is concerned, for example, the limit of hearing loss of 60-65% means a significant negative impact on communication. On the other hand, a forest worker with such a hearing impairment would not significantly suffer from reduced working capacity at all. But a teacher would. However, this law does not account for it. Article 7 of Law 447/2008 Coll. states that "impaired communication ability is limited ability to communicate due to impairment or loss of body functions, sensory functions or mental functions." Although the law states that compromised communication abilities are compensated, compensation is provided only to persons with severe disabilities, namely those with 50% degree of functional disorder or more. The above-mentioned table considers 50% degree of functional disorder to be a severe hearing loss with a minimum loss of 80% according to Fowler (practical deafness of more than 85% according to Fowler and complete deafness of 100% is considered as a degree of functional disorder of 70% and 80%).

Conclusion

Based on our preliminary research results, we can reasonably believe that, in the opinion of the respondents, there is room for many options to improve the social policy of the state for citizens with hearing disabilities in the context of eliminating communication barriers. It is important to recognize our finding that people whose hearing is impaired and who do not use sign language to communicate are more likely to rely on high-quality hearing aids than those who use sign language to communicate. However, we have not confirmed this statistically, so we can present this knowledge only as an assumption that will need to be verified by further research. It turns out that the economically weaker people cannot afford the multi-channel devices and, at the same time, are not eligible for state assistance - compensation under Act 447/2008 Coll. And deaf people who prefer to communicate using the sign language, often do not use the hearing aids at all. Although they have a greater chance of getting governmental support, their hearing loss is so great that the use of a hearing aid is of no great importance for them in terms of communication.

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Bioethical Challenges at the Beginning of 21st Century in Education of Healthcare Professionals

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Original Article

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Abstract:

This paper is analyzing selected contemporary bioethical challenges within healthcare delivery. The main challenge for contemporary Health Professionals is to develop critical thinking and apply a holistic

approach for persons in various phases of their daily professional performance. The authors introduce the interdisciplinary concept of education in bioethical problems at FM CU in Bratislava. Intersectional education in the humanities in undergraduate training for Healthcare Professionals allows optimization of professional skills for the graduates, following the "*Humanization of Medicine*" as a longitudinal trend.

Introduction

The main challenge for contemporary Physicians, Nurses and other Healthcare Professionals is to apply a holistic approach to persons in any phases of their daily professional performance. Fast technological development opens the doors to depersonalization or dehumanization of Medical or Nursing Care especially for those who are most vulnerable. There are patients who are near the end of life; terminally ill with oncologic, neurodegenerative or other life-limiting diseases; but also chronically ill or handicapped individuals, pregnant women, prenatal and postnatal children, people of older age, etc. (Kosticova, 2015).

Rapid developments in the Medical field in the last century have revolutionized Medical and Nursing Practice. Life expectancy has been prolonged; many infectious diseases have been eliminated; genetic defects can be detected *in utero* or *in vitro*; organs and cells can be transplanted; human reproduction can be controlled; pain can be relieved. Besides all these developments, Physicians and Nurses in many developed countries are facing many challenges in the practice of their professions.

An ethical decision is not just about providing the best clinical outcome for the patient but involves a search for coherent solutions in situations where different people's interests or priorities conflict. It is often as concerned with the process through which a decision is reached as with the decision itself taking into account ethical standards, law and quasi law (Sommerville, 2016).

Medicine Together with Nursing and an Holistic Approach to the Sick

The anatomy of the "old" Medicine and Healthcare was within the autonomy of healing. In the tradition of Hippocrates and Judeo-Christian values of European Healthcare and Medicine, the Doctor (Physician) was a Healer, nothing more but nothing less. The ethical imperative for them pledged to do no harm to their patients as they sought to do only good. With the eclipsing of paternalism by autonomy of a patient, the authority and ethical responsibility of the Physician or Nurse has changed and the duties of beneficence have become more apparent and necessary (Mojzesova et al., 2015).

The "new Medicine": a "winning Medicine" concentrates on cellular and subcellular level of human body. It uses biotechnologies for the improvement of human health, but also omits holistic approaches to the incurable human; to the terminally ill; to the unborn; to all who need help, protection, support or rescue. Medicine and Healthcare was transformed from individual art to institutionalized application of specialized technology.

However, disease is an attack on the whole person. Unfortunately, depersonalization and subsequently dehumanization are constant "treatment" in contemporary technologically oriented Healthcare (Pellegrino, 1980). The holistic approach requires to respect a human person in four dimensions (levels) of her/him: 1) somatic (bodily), 2)

psychic, 3) spiritual and 4) social. (Trizuljakova, 2016, Kosticova, 2015). Holistic Medicine Practitioners are sure that the whole person is made up of interdependent parts and if one part is not working properly, all the other parts will be affected. In this way, if people have imbalances (physical, emotional, or spiritual) in their lives, these can negatively affect their overall health.

The Bioethical Challenges for Education of Healthcare Professionals

One also can see the relativization and weakening of traditional moral values in contemporary Healthcare. It is important to consider new biomedical technologies with concern for many ethical dilemmas in medically assisted human reproduction; human fertility regulation; regenerative Medicine; creation of hybrids or chimeras; contemporary science and high technologies. Medicine without tight connection with ethics is comparable with plant without water. Undergraduate students should be educated with attention on humanitarian subjects, not only on preclinical or clinical ones.

The moral integrity of Healthcare Professionals should be strengthened by permanent ethical and bioethical education and training. The basic questions in the teaching process in general are: Why? What? How? The basic premise is that the learning or teaching process must be selective and integrative. The challenge is to provide sound education in the art of Medicine; in the art of healing; in an art of treatment; in the art of listening to the sick; in the art of communication with patients, their relatives, and with colleagues.

Education in human values and ethics seems as a guarantee for entering into the 21st century, as new and new moral dilemmas are still emerging and "ready-to-use answers" are not available. It is optimal when undergraduate education of future Health Professionals has an intersectional character.

The Example of Intersectional Education at Fm Cu in Bratislava

Teaching of an obligatory subject *Medical Ethics* at the Faculty of Medicine within Comenius University in Bratislava, capital of Slovakia, is part of intersectional concept of undergraduate education of future Medical Doctors. Semi-compulsory subjects like "Introduction to Medical Law" and "Communication Skills" need to be included in this concept, too. In these subjects Teachers concentrate on holistic approaches to human beings in health and disease. The content of topics is oriented on subjects of Healthcare interests – on the human individual; on the dignity of human person from ethical point of view; on the necessity of respecting human dignity according to selected international or national legislation; the doctrine of informed consent etc..

Human dignity is considered guaranteed and a starting point for all human rights. A correct understanding and respect for human dignity becomes a protection for human life during its ontogenesis from fertilization to the natural death. Medical students as future Health Professionals are led to critical thinking, so they participate on open discussions, debates and polemics about selected bioethical topics; about ethical dilemmas in connection with the beginnings of human life (prenatal diagnostics, preimplantation genetic diagnostics, new technological possibilities within in vitro fertilization laboratory methods, research with participation of early human embryos); or with end of human life issues (about palliative care vs. euthanasia). Topics include rights of patients; truth telling and hope for those who suffer; belong to limitations both of a patient and of professional autonomy of Healthcare Professionals are explained to students not only from an

ethical point of view, but from legal, too. Communication skills are considered as one of the instruments of a Health Professional.

Conclusion

The optimal relationships between Healthcare Professionals and their patients are based on excellence in actual scientific knowledge and erudition, practical skills and optimal ethical attitudes. Modern society often ignores or refuses basic human values. The bioethical challenges for contemporary education of Healthcare Professionals are based on respect for all human beings during their ontogenesis from the beginning to the end of their lives becomes an aim of the Profession. Clinical reasoning is a complex matter, thus, education of Health Professionals should be designed as intersectional among subjects within the curricula.

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Healthcare of Workers in the Vitkovice Ironworks as Part of the Workload of Social Workers in Industrial Companies in 1954

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Abstract:

Objective: This paper aims to describe the healthcare of workers, including institutions and their provided Social Services, to define the role of a Social Worker and to identify the methods of Social Work used in the company Slobodníková Vitkovice Ironworks in the former Czechoslovakia.

Design: Historical research.
Participants: Archival materials of Vitkovice Ironworks and available relevant literary sources on the topic covering the period between 1876 - 1954.
Methods: A combination of research methods: (1) Hermeneutic-classificatory Content Analysis according to Plichtová (1996), (2) Thematic Analysis according to Catherine Kohler Riessman (2008) following Michael Foucault's Genealogical Method.
Results: The workers' health at Vitkovice Ironworks was one of the priority areas of the Social Care System in the company. Since 1945 the position of Social Workers has existed under the Social Care Department and their job description also included addressing the health issues of the workers.
Conclusion: The result is the discovery, in the considered time, that the health care of workers was an integral part of the corporate social policy of the Vitkovice Ironworks, in which professionally educated Social Workers participated with their specific methods.

Introduction

Vitkovice Ironworks have been described as one of the largest metallurgical enterprises in the Austro-Hungarian Empire, which earned its fame for its social activities geared towards supporting their employees. Jemelka *et al.* (2015) expands the description of the ironworks so that they are viewed as an iconic example of a European factory town. In historical literature, pithy development of social policy dates back to the assumption of the ironworks by a new director P. Kupelwieser in 1876. However, analysis of Social Work in this company is missing from the professional literature. Well-developed professional Social Work was identified in the company after World War II, yet because of the overwhelming amount of archival material, the analysis has been limited to the year 1954. Healthcare for workers was implementation of professional Social Work.

Research Methodology

In accordance with its hermeneutic background, our methodology is based on historic research. The selected research design corresponds to the concept of social and economic history, exploring the transformation of social institutions, communities and structures. Research methods include a hermeneutic- classificatory content analysis according to Plichtová (1996) and a thematic analysis according to Riessman (2008), which is applied to the gathered findings.

Definition of Social Work in Bohemia and Moravia

Social Work in the Czech historical context is perceived mainly as a professional activity carried out based on specific methods in various areas of Social Careand with theoretical support of its own findings as well as findings provided by other disciplines. At the Congress of Social and Health Work in the Czechoslovak Republic in 1928, Bláha defined Social Work as a specialized activity that seeks to remove or compensate social problems (Klíma, 1931). Social Work has also found its application in the care of

workers in factories in the form of general measures and organization of Social Care Services such as provision of canteen meals, healthcare and other services. The topic of Social Services in the industry emerged in 1928 as an official professional section of the International Conference in Paris where there were, amidst the keynote speakers, Marie Krakesova, Helena Radlinska and others (Kotek, 1928).

Introduction to the History of the Vitkovice Ironworks and their Social Care System

The Social Care System for the employees of the Vitkovice Ironworks was considered a structured form of assistance under the Austro-Hungarian Empire. Activities with a social focus included the construction of hospitals and healthcare facilities, day nurseries, kindergartens, orphanages and retirement homes, meal canteens and cafeterias and others, as well as the construction of the so-called Nove Vitkovice *(New Vitkovice).* Thanks to its social program, in many ways the ironworks became a pioneering company in the field of advanced business methods not only in the Czech lands, but also in the Habsburg Empire (Sevecek, 2009). The Ironworks needed a stable base for its workers, therefore it cared for the social, health and educational conditions of its employees and their family members. Kupelwieser understood the link between the general well-being of his employees and their families and the quality of the workforce, reflected in the end results of the company (Matej, Korbelarova, Leva, 1992). At the beginning of the 20th Century, the Social CareSystem was created that contained a number of benefits which it provided to the ironworks employees. Social benefits had a positive effect on the living standard of workers, encouraging their involvement in their work for the company.

Institutions and Provided Social Services

Since 1919, the management of the ironworks had regularly submitted a summary report - with statistics on health and social facilities set up by individual plants in favor of the workers - to the District Care for Youth in Moravska Ostrava. The report included a description and statistical data from the following facilities: Charitable trust for raising funds for the VHHT orphanage; Shelter for convalescents; Counseling Services for patients with skin and sexually-transmitted diseases; Counseling Services for infants; Counselling services for patients with tuberculosis, Children's homes, a Charitable trust for an old people's home founded by Vilem Gutmann; as well as Homes for apprentices (Archive of VHHT 11, inv. no. 1610, ref. no. 302). The Social Care System was gradually expanding through the establishment of some new Social Care Facilities. Great attention was paid to their employees' health. Despite the positively described social policy implemented by Vitkovice Ironworks, the workers were often out sick or suffered from work injuries. The company hospital had been functioning since 1840. Both the high accident and sickness rate among steelworkers forced the management of the company to establish the Knappschaftspital (a hospital for ill workers) in one of the residential buildings. This hospital was the first in-patient facility, not only in the Ostrava region, but also across the Austrian Empire (Matejcek, Vytiska, 1978). In the period between WWI and WWII, the hospital was equipped with the latest amenities and a well-organized rescue service. At the same time, a hospital for patients with contagious diseases; a shelter for convalescents; a resort for summer and winter holidays in the Beskydy mountains were set up for office workers. Spacious workers' washrooms in all plants; office worker spa with a large indoor swimming pool as well as a summer swimming pool also served for health

purposes. Sports were possible in a large sports house with two outdoor fields to play football; several tennis courts; and a track for cyclists (Archive of VHHT 11, inv. no. 1610, ref. no. 302).

Application of Social Work in the Healthcare of Workers

Based on primary documents, the Social Worker position existed and was established in Vitkovice Ironworks in 1945 in connection with the defined content of Social Careand the job description of a Social Worker. The terms – Social Worker and Social and Health Worker – are used as synonyms and vary in the texts, which corresponds to the concept of Social Work in the designated area. The Director Dr. Herain was assigned the implementation of Social Policy in 1937, being put in charge of the following facilities: an insurance company for sick workers; a retirement fund institution; a care providing institution; a company hospital; the professional preparation of apprentices. Inspector Langfort, with six other employees, was in charge of the Department of Social Care. After 1945, the name of the Social Care Department continued to change in quick succession, as well as its inclusion in the trade unions of the ironworks. The Department had gone through various appellations, such as the Social Care Department; Social Group; Personnel Care Department; Social Section up to the final designation Social Department in the Employment Department. In 1949, the ironworks had a Functional Economic and Social Department whose activities were divided into individual departments which also included the Healthcare Sector (a company hospital; 8 company outpatient clinics; 4 health rescue stations; a Social Care Department (the management of charitable trusts and foundations; care for employees and their families; a day nursery and a home with a kindergarten for the children of mothers employed in the national enterprise; recreational care company; Social Care and Occupational Hygiene Charity Services; social research as well as statistics and planning. The Social Care Department managed and administered various funds of employees, foundations and a network of company Social Workers in different workplaces of the enterprise (Archive of Vitkovice 1946-1954, inv. no. 898, ref. no. 153).

Social Work Methods Used at the Vitkovice Ironworks

Social Workers were mainly engaged in individual casework, however, they also delivered educational lectures in the social and medical field and promoted them through radio broadcasts and the press. The topics of the lectures included general hygiene, pregnancy, childcare, and sexually transmitted diseases. Social Workers tried to persuade, especially young workers, to attend cooking classes, sewing and educational courses. Archive materials prove further professional activities as part of the Social Worker's job description – the social investigation of families - the so-called bureaucratic intervention and promotion (Archive of Vitkovice 1946-1954, inv. no. 1070, ref. no. 167). Vocational schools were also those that responded to the need for professionally trained Social Workers to work in factories. In 1947, under the Vocational School for Female Occupations in Ostrava, the first grade of a future four-year Social and Health Care School and the 2nd Grade of the School for Training of Social Workers were established. The report of final graduation examinations shows that the female students completed their 2nd Year of Mandatory Practice at the Vitkovice Ironworks in the area of Factory Care. Thematically selected graduation questions were "Organisation of Social Policy in the Nationalized

Enterprises," "Care for Workers in the People's Democracy" or "Housing Care and Catering of Workers" (Archive of Ostrava, Higher Medical School in Vitkovice, file no. 6, inv. no. 125).

Conclusion

The nature of metallurgical production required continuous attendance by workers without any interruption. Suspension of production (burnout of the furnaces) would mean great financial losses for the owners of the ironworks. Therefore it was necessary to keep workers on their jobs. One of the options was social benefits, such as providing housing, stable income, healthcare and education for their children. In its early days, assistance provided by the Vitkovice Ironworks was focused on support in case of the incapacity to work due to sickness or injury. For this purpose, a fraternal fund, which consisted of a treasury for the sick workers as well as a care providing facility, was founded. Unfortunately, the fraternal fund ceased to exist in 1895. After that, as its successor, a health insurance company replaced it, referring to the legislative requirement and the general care providing institution that managed several social funds. A retirement fund institution had already started in the 1840s. Financial security for old age was also linked to the worker's qualification. Only the guards, foremen and lower rank officials were granted a pension from the retirement fund. A retirement treasury was founded for other employees. An integral part of social activities were those made by Healthcare Workers, which included provision of meals, construction of a hospital, professional counseling centers and a shelter for convalescents. In 1927, the ironworks management set up a workshop for employees who, due to injury in the ironworks, had become "disabled." After WWII, the workshops were used to retrain healthy employees for new jobs, which were more in demand. Today, we would call this a form of retraining. In the period in which Paul Kupelwieser served in the position of the Director General, Healthcare focused on the functioning and development of a hospital; in the area of childcare, emphasis was placed on the establishment and functioning of a children's shelter, an orphanage and a day nursery, as well as the establishment of primary schools. Meal catering was centered on the opening of a market place, grocery shops and canteens directly in the plant. After 1900, Healthcare also began to expand into other areas. Specific counseling centers were opened, and employees, following their illnesses, were allowed to remain in convalescence. Institutionalized elderly care was established. Education expanded to the apprenticeship level, and employees were served meals in canteens. After the retirement of Director Kupelwieser, Social Care was expanded to include care for the elderly, people with disabilities, care for apprentices; the supply of Healthcare Services also expanded, etc. Besides the above-mentioned activities of a social nature, which were maintained even after 1945, the actual Social Work activities of the Social Care Department, functions and role of Social Workers, including the possibility of their training and involvement in Vitkovice Ironworks in social research, continue to newly emerge. The ironworks ran several facilities, which, amongst others, included several kindergartens and a shelter for children. Archive material from 1937 states that the kindergartens and the shelter were supervised by two inspectors. In 1945, that is eight years later, the documents are already more specific about this topic. The shelter was managed by a company Social Worker who supervised socio-medical aspects of the company-run nurseries. From this it can be concluded - provided that in 1937 there was already a Social Care

Department in place – that the aforementioned Inspectors could be Social Workers. It was not an inspection in the strict sense, but the performance of Social Work. The utilized methods of Social Work particularly include individual casework in the form of counseling and also contemporary literary sources mention the method of official intervention in a family. Unfortunately, this method is not further specified. In addition, Social Workers used to deliver educational lectures in the social and medical field and promoted Social Work through radio broadcasts and the press.

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