Challenges of the current medicine

Krajewska-Kułak Elżbieta, Kułak Wojciech,
Łukaszuk Cecylia, Lewko Jolanta, Sarnacka Emilia

vol. 3

Challenges of the current medicine

Volume III

Medical University of Białystok
Faculty of Health Sciences

Challenges of the current medicine
Vol. 3

Edited by
Prof. Elżbieta Krajewska-Kułak MD, PhD
Prof. Wojciech Kułak MD, PhD
Cecylia Łukaszuk PhD
Jolanta Lewko PhD
Emila Sarnacka PhD

Białystok 2014

Reviewers
Prof. Irena Wrońska PhD
Prof. Kornelia Kędziora Kornatowska MD, PhD

ISBN- 978-83-89934-99-4

The first Edition
Białystok 2014

Graphic Design: Agnieszka Kułak

Printed by:
„Duchno” Piotr Duchnowski, 15–548 Białystok, Zaściańska 6

Doctors who caring for the sick, they should necessarily understand
what is man, what is life and what is health, and how the balance
and harmony of these elements sustains them.
Leonardo da Vinci

Dear Colleagues

The monograph periodical "*Challenges of the Current Medicine-Second Edition*" is a collection of works written by authors from many different medical centers.

The authors were invited to attempt to describe the difficulties of therapeutic and interdisciplinary patient care when it comes to improving the quality of life for patients. We want to discuss mourning and orphan hood tasks and consider a place of death education in medical care. For above mention consideration crucial are Saint Augustin's words. 'If *you do not come to patient's bed with love, your knowledge will be vain and your effort will be futile'.*

We hope to create an opportunity to reflections on live and passing. Death is not only regarded to ill people, but also elderly, mentally ill, dysfunctional, with genetic dysfunction, homeless and underclass people.

We want to closer medical staff duties in combating: discrimination, stigmatisation, aggression and addiction. Mother Theresa claimed that *'the biggest evil is lack of sensitiveness and brotherly love, indifference for a neighbor who is underclass, thought by exploitation, moral depravity, poverty and illness'.*

Finally, we want to discuss multicultural tasks in medicine according to Karl Rahner words '*Tolerance is to be ready to give for a different ideology representative the same intelligence and good will as itself'.* According to above mentioned, we want to consider national different perspectives on tasks such as different culture, health, illness and death, cultural aspects of certain medicine area, ethical issues on patient's cure from different culture.

We hope that all readers of this monograph will find interesting topics on 'Health Education', 'Medical Problems in Palliative Care', 'Problems of Social Medicine', 'Quality of life', and 'Threats in Workplace'.

Prof. Elżbieta Krajewska-Kułak MD, PhD
Prof. Wojciech Kułak MD, PhD
Cecylia Łukaszuk PhD
Jolanta Lewko PhD
Emilia Sarnacka PhD

Review of monograph by Prof. Irena Wrońska PhD
Challenges of the current medicine Vol. 3

The monograph *"Challenges of the current medicine"* Volume III edited by Krajewska-Kułak Elżbieta, Wojciech Kulak, Łukaszuk Cecilia, Lewko Jolanta, Emilia Sarnacka, is an interesting overview of the issues related to education and attitudes toward death and dying.

This monograph is a collective work with the participation of academics from various universities in Poland. The monograph presents knowledge of contemporary issues of multiculturalism in health care for people dying.

Information contained within this monograph accurately reflects the diversity and complexity to the problems of interdisciplinary patient care, so important in the holistic patient care.

These themes reflect well on Editors and Authors who created the monograph as an interdisciplinary platform for further reflection of the patient problems and education for health workers in all sectors.

Prof. Irena Wrońska PhD
Medical University of Lublin

Review of monograph by Prof. Kornelia Kędziora-Kornatowska MD, PhD
Challenges of the current medicine Vol. 3

The monograph *"Challenges of the current medicine"* Volume III edited by Krajewska-Kułak Elżbieta, Wojciech Kulak, Łukaszuk Cecilia, Lewko Jolanta, Emilia Sarnacka, is an interesting overview of the issues related to education and attitudes toward death and dying.

This monograph is a collective work with the participation of academics from various universities in Poland. The monograph presents knowledge of contemporary issues of Health education; Medical problems in palliative care, Problems of social medicine, Quality of life, and Threats in workplace.

Information contained within this monograph accurately reflects the diversity and complexity to the problems of interdisciplinary patient care, so important in the holistic patient care.

These themes reflect well on Editors and Authors who created the monograph as an interdisciplinary platform for further reflection of the patient problems and education for health workers in all sectors.

Prof. Kornelia Kędziora-Kornatowska MD, PhD
The Nicolaus Copernicus University in Toruń
Collegium Medicum in Bydgoszcz

MEDICAL PROBLEMS
OF
PALLIATIVE CARE

Achimowicz Bogusława[2], Jakubów Piotr[1,2], Snarska Katarzyna[3], Kulikowska Agata[3], Przegaliński Marcin[4]

Awareness of the extensive range of the problem of bedsores and its social significance in nursing practice

1 Home Domestic Care in Bialystok
2 Department of Clinical Pharmacology, Medical University of Bialystok
3 Faculty of Health Sciences, Medical University of Bialystok
4 Department of Rehabilitation, Medical University of Bialystok

Introduction

Hard-to-heal bedsores most often affect the elderly and are accompanied by a lot of diseases related to circulatory failure, prolonged immobilisation, lack of rehabilitation and malnutrition. A lack of proper care provided to patients, skin abrasion, hypoxia of places subjected to the impact of constant compression leads to the local formation of bedsore-based changes, usually with their tendency to increase [1,2]. It is accompanied by severe pain often with a large exudation of secretion with an unpleasant odour. Patients get confined at homes, isolate themselves from friends and acquaintances which ultimately lead to depression. Attempts of treatment undertaken by their families bring no intended effects; doctors very often look for causes of a lack of development of granulation in the circulatory system or local infections within wounds. As a result of damage to skin and subcutaneous tissues, blood stands over the place impacted by constant compression bringing damage to its adjacent tissues and skin [3,4]. The process of diagnosis and treatment requires a lot of knowledge and co-operation in the medical team which should consist of: a doctor who treats wounds, a nurse who attended a specialised course in the field of wound treatment, a physical therapist and psychologist.

Bedsores occur in many branches of hospitals, nursing and care institutions (polish ZOL), nursing and medical units (polish ZPO), Nursing Homes. Increasingly, the problem has been addressed by Home Hospices and Long-term Nursing Care units providing services at patients' homes. In daily professional practise, attention is also turned to the following characteristics of a dressing: possibility to choose its form, its size adapted to a particular bedsore, resistance to friction and damage, capability to stay at a wound, ease to place and remove it, price. All the acquired knowledge allows to develop and produce various types of modern biological semi-synthetic and synthetic dressing materials to be used for the treatment of bedsores. It allows persons applying dressings to choose (attainable at the market) dressings freely and adapt them for bedsores taking into consideration the size of bedsores and their exudation.

Aim of the study

Bedsores are a complication in the treatment of a primary disease entity caused by long immobilisation, forced postural position, lack of appropriate care [5,6]. They have been a major problem in diagnostic, medical and therapeutic proceedings. The present paper attempts to assess the general knowledge of nursing staff working at various health care units in Poland

The aim of the study was to:

1. present the problem of bedsores at patients with a particular emphasis on the role of nurses in medical treatment,
2. identify risk factors in the occurrence of bedsores,
3. evaluate the preparation of nursing staff in the scope of treatment and anti-bedsores prevention,
4. identify demands for specialised courses in the treatment of bedsores.

Materials and study methods

The research was conducted at the following units: orthopaedics, surgery, neurology, internal medicine, intensive care unit at the Jedrzej Śniadecki Memorial Regional Hospital, and Home Hospice, during the qualification course in the field of long-term care and specialisation in the scope of epidemiology for nurses in Bialystok in the two years periods.

Place of work: 164 nurses took part in the survey. 13 respondents returned blank questionnaires, 1 questionnaire was filled in by an emergency medical student. Prior to the distribution of questionnaires, the nurses were asked for their approval to participate in the survey and learned about the purpose of the conducted studies.

Women made 100% of the surveyed group. The research involved qualified nurses (16.48%), specialised nurses (39.29%), nurses with a bachelor's degree in nursing (15.38%), nurses with a master's degree in nursing (15.38%).

The author's survey questionnaire was applied as a research tool. The questionnaire covered demographic issues and general nurses' knowledge about procedures in the treatment of bedsores. The questions were on: a frequency of meeting the problem of bedsores, risk assessment scales of the occurrence of bedsores, methodology of documentation of their sizes, opportunities of extra professional trainings, anti-bedsores prevention, risk factors of the occurrence of bedsores and their places, division of bedsores and methods of their treatment, applied diets, pain assessment scales and restrictions on professional practice. The survey consisted of 33 questions, 11 questions were provided with some space for extra response.

The database was set up with the help of an Excel spreadsheet. All the statistical analyses were made using the Statistica version 8 in a statistical laboratory. The results of the research were developed using descriptive statistics:

- arithmetic mean,
- standard deviation,
- percentages,
- coefficient of variation.

The statistical calculations include:

- non-parametric U test (Mann-Whitney test)
- multi-way contingency tables - tests of statistical significance of contingency variances - chi
- one-factor analysis of variance (ANOVA)
- test of statistical significance of variances (Bonferroni test)
- analysis of clusters (k-means method).

Results

The research covered nurses employed at various health care units located within the Podlaskie region. They include: Primary Health Care, Nursing Long-term Care, Home Hospice and stationary care such as: provincial hospital units, Care and Medical Units (ZOL), Nursing and Care Units (ZPO), Nursing Homes. The respondents' age and education were taken as criteria. Nurses aged 40 to 50 made 48.67% of the surveyed respondents, aged 30 to 40 were at the second place (30.67%), aged 50 to 60 made 16.67% of the total and aged to 30 constituted the smallest group.

Deepening knowledge on bedsores by nurses.

Analysing of deepening knowledge on bedsores by nurses show that over the last year 61.54% of the respondents took part in various courses / trainings / conferences on treatment of bedsores, 23.08% - within the last 2-5 years and 7.69% prior to 5 years. 7.69% of the nurses did not take part in any trainings (table 1).

Table 1. Deepening knowledge on bedsores by nurses circular and table graph. The last year participating in nurses curses was 61.54% , 23.08% - within the last 2-5 years and 7.69% prior to 5 years. 7.69% of the nurses did not take part in any trainings.

Deepening knowledge on bedsores, years trainings	Percent of nurses
No trainings	7.69
Trainings before 5 years	7.69
Trainings between 2 – 5 lat	23.08
Trainings in the last year	61.54
Sum	100.0

Hierarchy of the places of occurrence of bedsores

As the most common places of occurrence of bedsores the respondents indicated the following: lower back (0.924), heels (0.396), ischial tuberosities (0.329), trochanters (0.294), spine (0.268), elbow (0.209), ears (0.200) and head (0.191).

Ratings in the surveys were graded 1 to 8 and sorted from the most to the least relevant ones (when it comes to the risk of occurrence of bedsores).

Hence, the lowest mean indicates the highest risk.

M = mean;

1/M = risk of bedsores (mean inverse);

SD = standard deviation.

A correct definition of bedsore (decubitus)

Regardless of education, 99.33% of the respondents gave proper answers and 0.67% of the respondents did not answer at all.

Nurses' knowledge about the treatment of bedsores.

The nurses' general knowledge about the procedures and treatment of bedsores was identified. It is concluded that within the population from which the sample was taken, the highest risk of bedsores (decubitus) is related to the 3rd group factors and the lowest - to the 1st group factors.

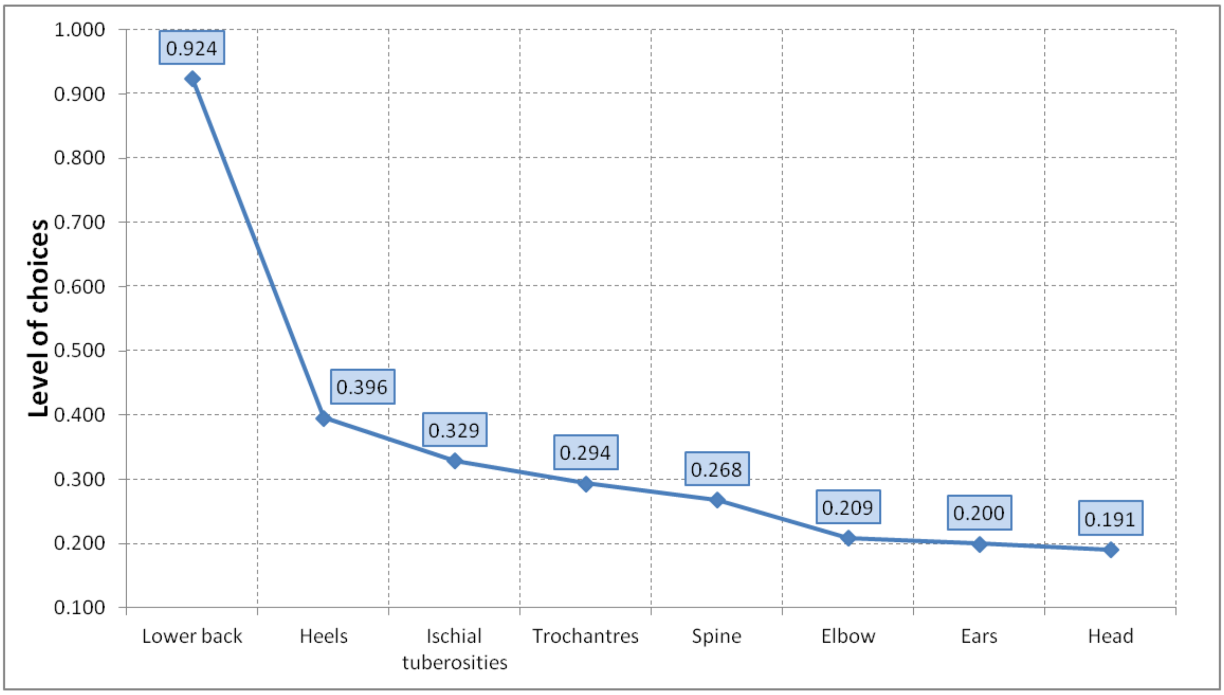


Figure 1. Places of the most frequent occurrence of bedsores (in the opinion of nurses) indicated the following: lower back (0.924), heels (0.396), ischial tuberosities (0.329), trochanters (0.294), spine (0.268), elbow (0.209), ears (0.200) and head (0.191).

The hierarchy of internal factors.

The hierarchy of internal factors favouring the development of bed sores according to the surveyed people Ratings in the surveys were graded 1 to 14 and sorted from the most to the least relevant ones (when it comes to the risk of occurrence of bedsores). Hence, the lowest mean indicates the highest risk.

The highest degree of such rating diversification referred to the following factors: "Activity" - 1 and "Kachexia" - 2. The surveyed people conformed mostly in the rating of the following factors: "Depression", "Rheumatic factors" and "Cardio factors". It is noted, however, that the degree of such rating non-conformity in all of the 14 factors was high. The conclusions based on the group can be generalised to the population of nurses. For example, in case of "Activity" factor, average rating diversification with respect to its mean value (3.078) in the group of 115 nurses who responded was equal to 3.030, which represented 98.42% of the mean level. The respondents are familiar with the new generation of dressings and know how to apply them properly. At the stage I (41.33%), stage II (30.61%), stage III (44.59%), stage IV (94.56%).

Table 2. The hierarchy of internal factors. Graph and legend in table. Hence, the lowest mean indicates the highest risk. M = mean; 1/M = risk of bedsores (mean inverse); SD = standard deviation; Wsp. zmn. = coefficient of variation The highest degree of such rating diversification referred to the following factors: "Activity" and "Kachexia".

The level of the coefficient of variation	The coefficient of variation	Factor	Ordinal
I	60.837	Depresion	14
	61.155	Rheumatology factor	13
	62.762	Cardiology factor	12
II	65.081	Incontinence /stool	11
	66.087	Gastrology facor	10
	68.920	Neurology factor	9
	69.888	Vascular factor	8
III	74.225	Tetraplegy	7
	74.414	Incontinence urine	6
	74.862	Paraplegy	5
	77.033	Constitution	4
	77.264	Obesity	3
IV	87.298	Cachexy	2
	98.417	Activity	1

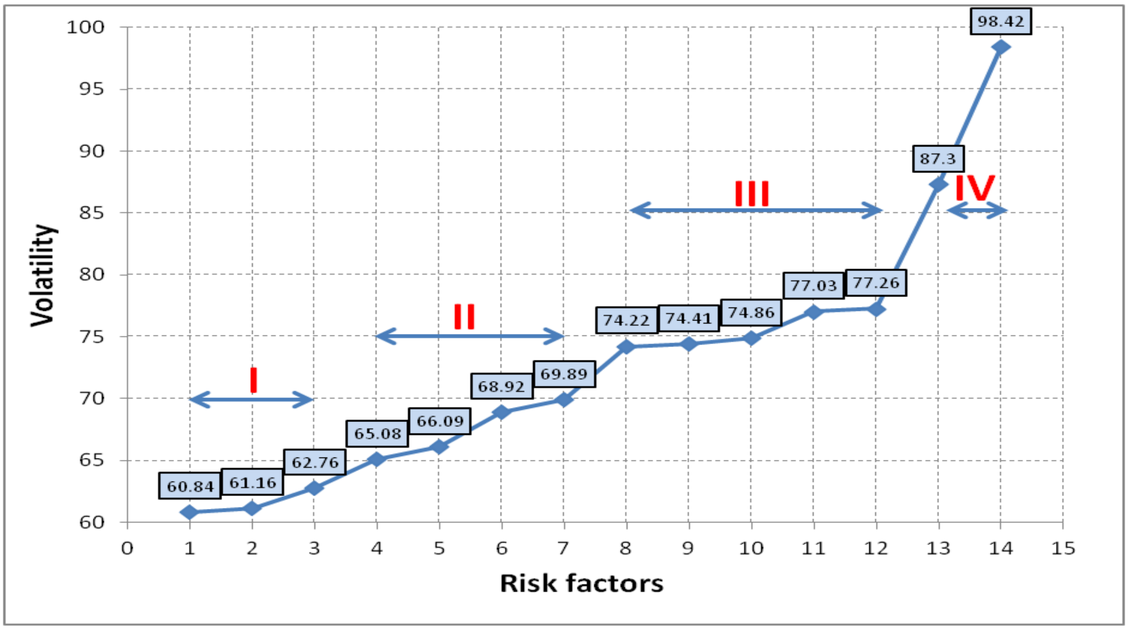
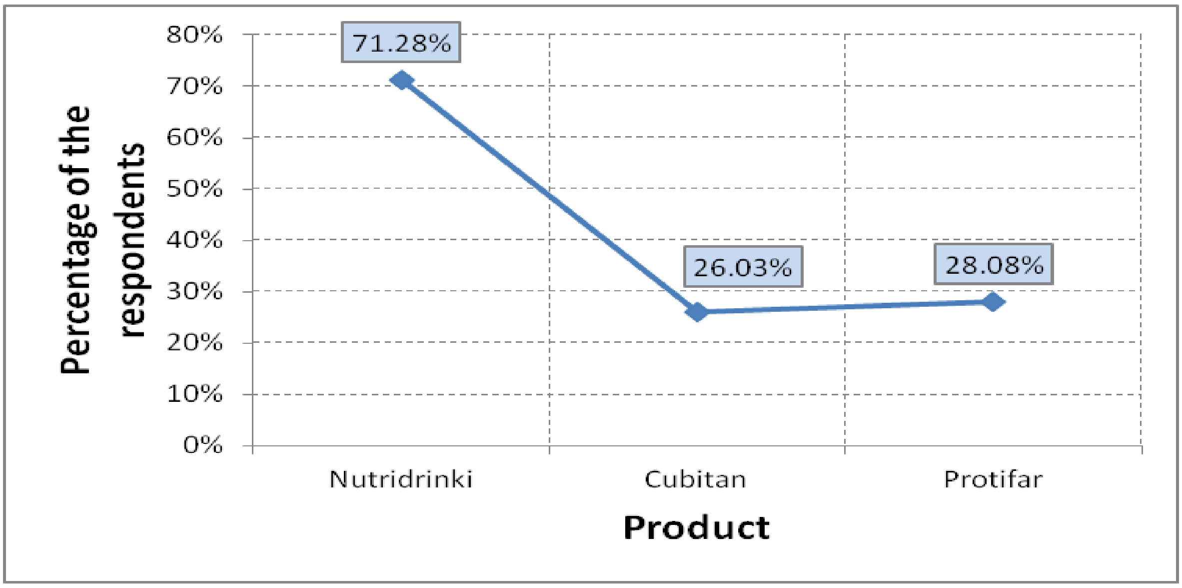


Figure 2. The hierarchy of internal factors as above in the graph show. Graph and legend in show in the Fig. 1. Hence, the lowest mean indicates the highest risk. M = mean; 1/M = risk of bedsores (mean inverse); SD = standard deviation; Wsp. zmn. = coefficient of variation The highest degree of such rating diversification referred to the following factors: "Activity" and "Kachexia".

Application of products supporting the treatment of bedsores

Nurses who apply high-protein, high-calorie diets in the treatment of bedsores recommend enrichment with Nutridrinki (71.23%), Cubitan (26.03%), Protifar (28.08).



Product	N	Percent
Nutridrink	104	71.23
Cubitan	38	26.03
Protifar	41	28.08

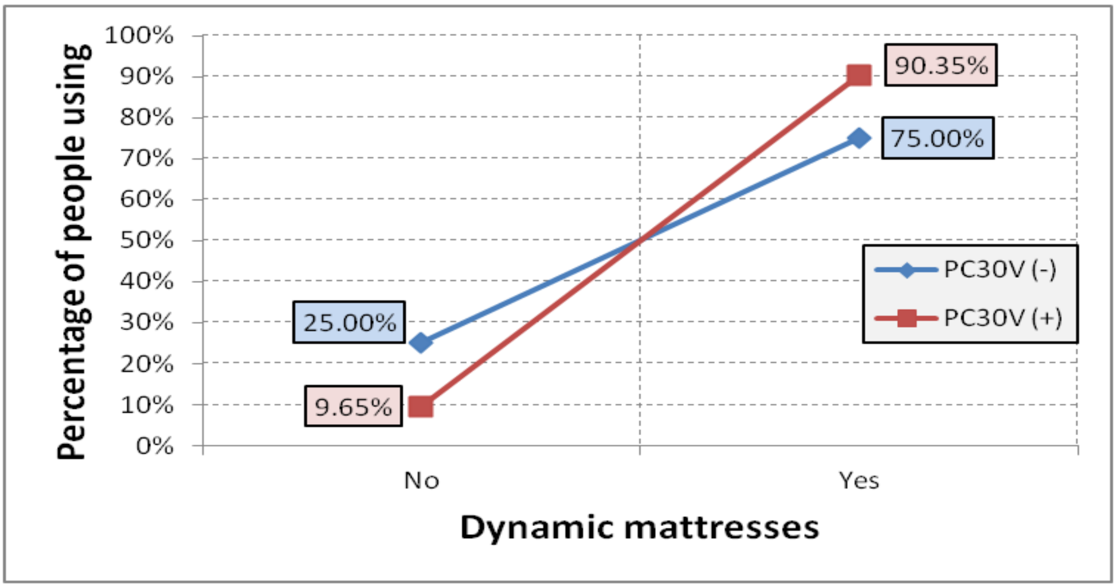
Figure 3. The graph show total number of products supporting the treatment of bedsores in the investigated population. The nutridink product is the most widely used.

Correlation between the application of PC30V by nurses and the use of dynamic mattresses

Correlation between the application of PC30V by nurses and the use of dynamic mattresses show that, nurses much more frequently apply PC30V and also use dynamic mattresses in relation to nurses who do not use PC30V (Figure 4).

Correlation between education and needs to participate in extra trainings.

Correlation between education and needs to participate in extra trainings in the treatment of bedsores show that nurses, regardless of their level of education, recognise the need to improve their knowledge and wish to benefit from extra trainings. distribution is equal in the four groups (Fig.5).



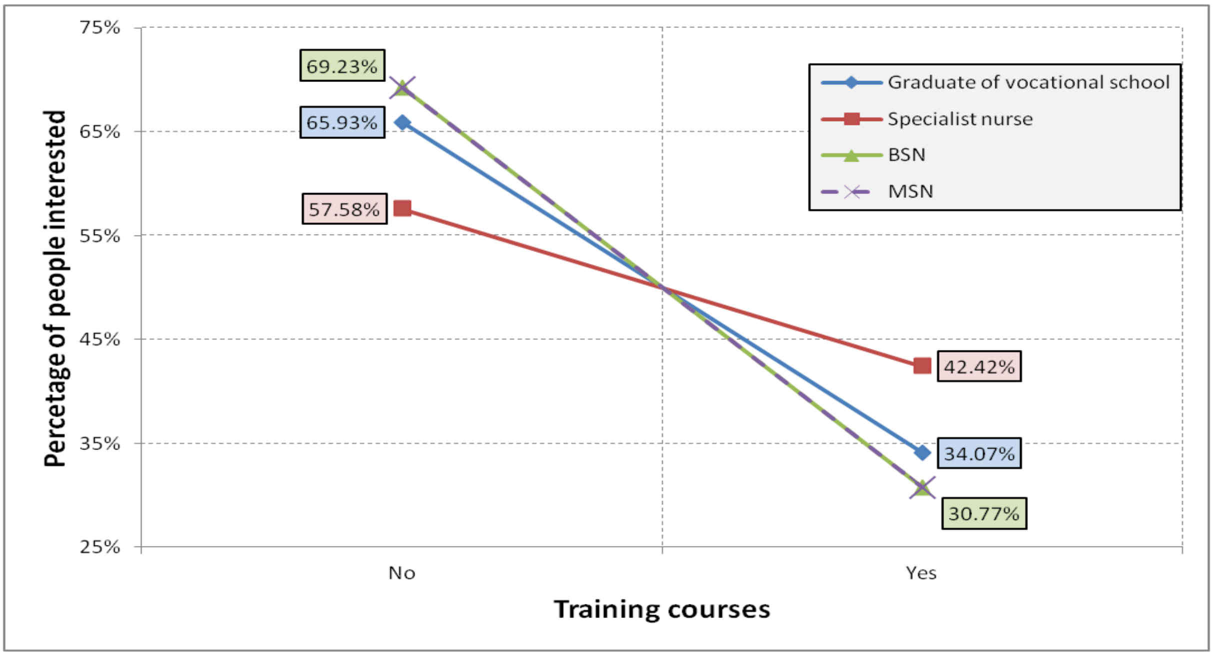
PC30V	Dynamic mattresses		Sum
	Not apply	Apply	
No	9	27	36
%	25.00%	75.00%	
Yes	11	103	114
%	9.65%	90.35%	
Sum	20	130	150

Figure 3. Application of PC30V by nurses in relation to nurses using dynamic mattresses.

Obstacles which are most often encountered by nurses in professional practice

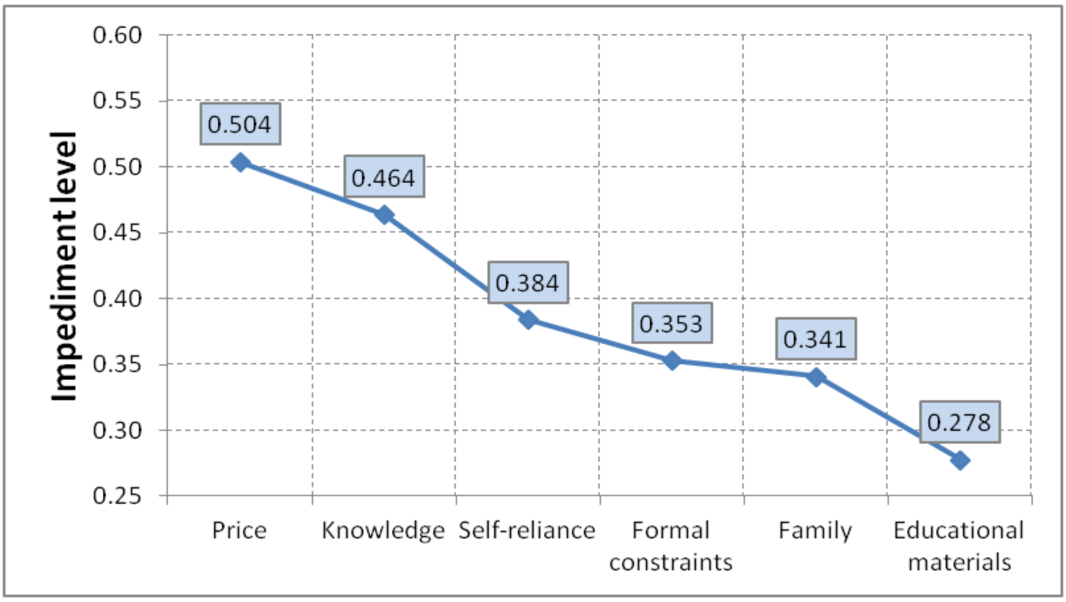
Constraints faced by nurses performing patient care were assessed: The following was subjected to assessment: a dressing price (0.504), a lack of knowledge / experience (0.464), constraint / poor tolerance of independence in nursing practice (0.384), formal / organisational constraint (0.353), a lack of understanding of the needs of a family in nursing practice (0.341), a lack of appropriate educational materials (0.278). All the ratings in the surveys were graded 1 to 6 and they were sorted from the most to the least relevant ones.

Within the surveyed group, the highest rating conformity refers to the following two (relatively least significant) obstacles: a lack of understanding of the need to educate a family and no appropriate educational materials. "Price" is the major obstacle - in this respect the nurses are moderately diverse in their opinions. "A lack of knowledge / experience" is located relatively high (at the second place) among the obstacles. However, the degree of such opinion differentiation in this scope is very high (Fig.6).



	Extra nurse trainings		
Nurses:	**No**	**Yes**	**Total**
Graduate of vocational school	60	31	91
%	65.93%	34.07%	
Specialist nurse	19	14	33
%	57.58%	42.42%	
Bachelor of science in nursing, BSN	9	4	13
%	69.23%	30.77%	
Master of science in nursing, MSN	9	4	13
%	69.23%	30.77%	
Total	97	53	150

Figure 5. Correlation between education and needs to participate in specialised courses in the treatment of bedsores. figure top to down legend, Diplom- Graduate of vocational school, Specialista- Specialist nurse, Licencjat- Bachelor of nurse BA, magister- Master of nurse, MD.



	N	1/M	M	SD	coefficient of variation
dressing price	130	0.504	1.985	1.352	68.15
a lack of knowledge	103	0.464	2.155	2.028	94.09
formal / organisational constraint	117	0.384	2.607	1.666	63.90
constraint of independence in nursing practice	95	0.353	2.832	2.014	71.13
a lack of understanding of the needs of a family	115	0.341	2.930	1.514	51.68
lack of appropriate educational materials	104	0.278	3.596	1.978	55.01

Figure. 6. Coefficient variation of formal and informal constraints in nursing practice

DISCUSSION

Nurses in their own professional practice very often faced with the problem of difficult to heal wounds in different locations on the patient [7, 8]. During each visit, the nurse assesses the risk of developing pressure sores. In the literature, we find about 20 scales the risk of developing pressure ulcers in daily practice is the most popular scale of Norton [9,10]. The consequence of the development of pressure sores and problems in their treatment gave rise to the need to create an integrated system of prevention and registration. The important part is to identify patients at risk for developing pressure sores and cover them Surfaces intensive care, according to the guidelines of the European and world standards in prevention and treatment of difficult to heal wounds [11,12]. The best-known method of identifying patients that are at risk for a point scoring system to evaluate the risk of developing pressure ulcers, made on the basis of scales assessing the presence and intensity of the impact of various etiological factors. In our study we assessed that in nursing practice using a variety of tools for risk assessment, taking into account various factors. Each newly admitted patient is evaluated on the basis of the scale, which suggests that the degree of threat of RRO. This allows you to take individualized care to patients [13].

The literature mentions a rock Waterlow, Braden, and Douglas scale by Dutch Consensus Prevention of Bedsores (CBO). These scales are used in various departments of our hospitals, and nursing and care institutions, nursing and medical, nursing homes based on standards developed [5,8,14]

As with other authors, the most common site of pressure ulcers are the sacrum area, secretaries larger area of the femur, heel, ankle side of the lower limbs, the neighborhood ischial tumors. Depending on the medical facility, the type of diseases in which treated and the age of patients are given a variety of statistical data on the incidence of pressure ulcers. "According to Smith, data from the years 1980 - 1994, at the nursing homes bedsores covered 17-35% prior to the adoption, in the residence built in 7 - 23% boarder in a nursing home. In the UK, the incidence of pressure ulcers ranges from 14.4% to 22.8% ", the U.S. rate is about 4% with respect to the problem of pressure ulcers Hallet concerns of patients lying in home care who are under the care of family physicians and clinics district [2,15]. The patients in the terminal stages of cancer by De Connona, who conducted the study at the Hospice of St. Christopher in London said that the problem of pressure ulcers concerns 14% of hospitalized patients. In the years 1994 - 1996 in the Department of Palliative Care in Poznan conducted research and found the problem of pressure ulcers in 21% of patients [15,16].

The scale of the problem which leads therapeutic for each occurrence of pressure ulcers is related to the lack of highly specialized equipment, the lack of qualified medical staff, poor organization of work, small agents under contract with the National Health Fund. Achieving good results in the treatment of pressure ulcers requires a lot of time on training and take active part in specialist courses, and conferences in the field of treatment of difficult to heal wounds [9].

In the course of the conducted studies the following conclusions have been put forward:

1. The problem of treatment of bedsores by the surveyed nurses is well known. The best results were obtained on ICU units, Home Hospice and Long-term Care Unit. The worst at neurology, Primary Health Care (POZ), Care and Medical (ZOL), Nursing and Care (ZPO) units.
2. The most relevant risk factors favouring the formation of bedsores in the group of the surveyed nurses are as follows: no physical activity, wasting syndrome (cachexia) followed by obesity, body type, paraplegia, incontinence and other factors associated with chronic diseases.
3. The preparation of nursing staff is satisfactory especially in specialised centres such as hospices, intensive care units. However, gaps in trainings and failure to widen knowledge by Primary Health Care (POZ), neurology, Care and Medical (ZOL) and Nursing and Care (ZPO) units were indicated.
4. The appropriate organisation of provision of medical services and the application of modern methods of treatment are both equally important.
5. The education of patients and their families is also important in the process of wound healing and crucial in the prevention of recurrences and primary prophylactics.
6. Extensive trainings of medical staff (as well as patients and their caregivers) in the scope of appropriate application of modern methods of therapy would improve its effectiveness and reduce the global costs of treatment.
7. The organisation of specialised courses in the field of prevention and treatment of nard-to-heal wounds is needed and recommended.

These demands are possible to meet only in specialised treatment centres dealing with chronic wounds. The golden standard procedure in such centres should be to "pull out" the role and importance of specialised nursing staff in medical and nursing care "from the background to the front". The overall aim of the system activities should be to locate such centres appropriately.

References

1. Grodzki T., Kocemby J., Skalska A.: Geriatria z elementami gerontologii ogólnej. Wyd. Via Medica. Gdańsk, 2007,.
2. Gryglewski A.: Odleżyny profilaktyka i leczenie. Farmaceutyczny przegląd naukowy, 2007, 11-12, 2-8.

3. Hać S., Wild T., Stefaniak T., Kobiela J., Gruca Z., Śledziński Z.: Komputerowy system oceny gojenia ran przewlekłych (WHAT). Zakażenia, 2008, 3, 99- 102.
4. Kowalik A., Fabia A., Zelek A.: Leczenie odleżyn. Mag. Pielęg. Poł.. 2004, 11, 26-27.
5. Kowalik A., Fabia A., Zelek A.: Przeciwdziałanie odleżynom. Mag. Pielęg. Poł.,. 2005, 1-2,37-38.
6. Madhuri Redd, Sudeep S. Gill, Sunila R. Kalkar, Wei Wu, Peter J. Anderson, Paula A. Rochon, Treatment of Pressure Ulcers, JAMA. 2008, 300, 2647-2662.
7. Owłasiuk A., Taranta E., Sadowska E.: Infekcje w odleżynie. Mag. Pielęg. Poł.. 2005, 12, 36-38.
8. Materiały szkoleniowe: Zasady Dobrej Praktyki: wysięk a rola opatrunków w prawidłowym gojeniu ran- schemat opracowany przez Światową Unię Towarzystw Leczenia Ran. Białystok, 05.06.2008.
9. Rosińczuk- Tonderys J., Uchmanowicz I., Arendarczyk M.: Profilaktyka i leczenie odleżyn. Wyd. Continuo. Wrocław, 2005.
10. Dalkowska A., Gaworska- Krzemińska A., Krzemiński M.: Roszczenia pacjentów- konsekwencje cywilnoprawne ran powikłanych. Zakażenia, 2007, 3, 80- 84.
11. Rutkowska B., Koper A.: Profilaktyka odleżynowa. Mag. Pielęg. Poł.. 2004, 4, 20.
12. Sopata M., Głowacka A., Tomaszewska.: Odleżyny- profilaktyka i nowoczesne metody leczenia zachowawczego (cz.1). Zakażenia, 2008, 4, 89 – 94.
13. Sosnowski S., Janicka E.: Odleżyny zapobieganie i leczenie (cz.1, cz 2). Mag. Pielęg. Poł., 2005, 10,18-20.
14. Szewczyk M.,T. i WSP.: Narzędzia oceny ryzyka rozwoju odleżyn. Przewodnik Lekarza, 2005,1, 92-97.
15. Szociński J.: Leczenie ran przewlekłych. Puls Medyczny 2009, 01, 34-35.
16. Wieczorkowska – Tobis K., Talarska D.: Geriatria i pielęgniarstwo geriatryczne. Wyd. PZWL, Warszawa, 2008, 283-289.

Chmiel Izabela[1,2], Czekaj Janusz[1,2], Kliś-Kalinowska Anna[1,2]

An assessment of patient satisfaction with nursing care in the Department of Palliative Care ZOL in Krakow

1. Faculty of Health Sciences of the Jagiellonian University Medical College in Krakow
2. Care and Treatment Center in Krakow

Introduction

One of the most important aspects of palliative care is to provide patients with the best comprehensive care at the highest possible standards, and thus ensure the highest achievable quality of life for these patients. These goals may be implemented by a process of continuous monitoring and assessment of the care provided, however the validity of the currently used tools for the evaluation of patient life quality is, in the case of palliative care, questioned by a number of researchers. The majority of authors recommend a different approach – research on **satisfaction with care** [1-5].

The concept of **satisfaction** is inseparably related to the feeling of contentment. Most authors consider it a resultant of expectations and the obtained effects of certain actions, where apparently a simple relationship occurs: the greater the discrepancy between them, the lower satisfaction [1-6].

Modern medicine relies on a partnership between patients, their families, and the interdisciplinary medical team in charge of these patients. This model of care helps avoid unnecessary conflicts, create a positive sympathetic atmosphere, and respects patient autonomy.

Terminally ill patients expect much more from medical personnel than just performing their duties “in accordance with good practices.” Patients hope to receive support and wish to be treated cordially and respectfully. They also need help with their suffering as well as wish to be provided with an environment that suits their individual needs and creates the appropriate atmosphere. These are patient-specific expectations and it may even be said that they are of a personal nature. Patient satisfaction with the care provided is determined by meeting these expectations. If they are met or exceeded, the level of satisfaction will be high.

Therefore, patient satisfaction is an indicator of the difference between each individual’s needs and the degree of their fulfillment in a given real situation [3,4,6].

Aim

The aim of the study was to determine the degree of patient satisfaction with palliative nursing care and factors affecting this satisfaction.

Materials and methods

The study was conducted between January 9 and May 18, 2012 in the Department of Palliative Care at a Care and Treatment Center (ZOL) in Krakow, 267 Wielicka Street. The Chief Executive of ZOL and the Manager of the Palliative Medicine Clinic with the Department of Palliative Care gave their consent to conduct the study. The study included 55 patients who had given their oral consent to participate in the study. The subjects were informed about the possibility to withdraw at any stage of the research.

Two research methods, a reference literature review and a diagnostic survey, were used in the study. The literature review involved an analysis of conference reports, articles published in professional literature, magazines and websites on the subject of palliative care and patient support and satisfaction, with particular emphasis on the relationship between the patient and medical personnel.

A 42-question questionnaire was used as a research technique in the diagnostic survey. Both open-ended and closed-ended questions were used. Some of the questions were multiple-choice. The questionnaire consisted of three parts: the first part included our own questionnaire, the second and the third parts included standardized questionnaires: Multidimensional Scale of Perceived Social Support (MSPSS) and Care Satisfaction Questionnaire (CSQ) [7-10].

Our own questionnaire was designed to provide socio-demographic characteristics of the study group, obtain medical data (diagnosis, complaints/symptoms), and identify patient expectations regarding the clinic.

The Multidimensional Scale of Perceived Social Support had 12 questions. Patients completed it by assigning scores to statements in accordance with the following scoring key: 1 – strongly disagree, 7 – strongly agree.

Based on the patients’ ratings, a mean score was calculated, which was assigned to a particular statement and thus determined its position (in terms of relevance) [7,8,9].

The Care Satisfaction Questionnaire had 12 questions, to which the following answers could be given: Yes; Probably Yes; Not sure; Probably No; No.

In order to facilitate a clear comparison of individual factors affecting overall satisfaction, each of these factors was assigned a numeric value in accordance with the enclosed key. The maximum score was +110 points, and the minimum was –110.

This method of interpretation allowed to show the extent to which the patients were less or more satisfied with different aspects of care [10,11].

An Excel spreadsheet was prepared for questionnaire data compilation.

Study group characteristics

1. **Socio-demographic data**

The study on satisfaction with nursing care included 55 patients, 30 female (54.5%) and 25 male (45.5%). Mean age in this group was nearly 68.5 years. Females, mean age 69.8 years, were the older part of the group (mean age of males was 66.7 years). A 40-year old woman was the youngest, whereas a 92-year old woman was the oldest participant in the study. Eighteen patients, i.e. one-third of the subjects (32.7%), were aged 61-70 years.

A total of 34 (61.8%) participants were married. There were twelve widows and only 5 widowers. Three women were unmarried and one woman was divorced.

Most of the subjects had vocational (25 patients, 45.5%) and secondary (17 patients, 30.9%) education. Six participants (10.9%) reported elementary education and seven participants (12.7%) had higher education.

The vast majority of patients (40 individuals, 72.7%) performed physical work, and only 14 (25.5%) were white-collar workers. One woman (1.8%) had never worked.

Mean duration of work experience was 37 years. The youngest woman participating in the study worked for the shortest period of time (13 years), whereas the longest was 61 years (an 85-year old man). The largest group was 26 (48.1%) patients with a duration of work experience of 31-40 years; the second largest group (41-50 years) had 13 (24.1%) patients. Ten (18.5%) patients worked 21-30 years, three (5.6%) patients worked less than 20 years, and one person (1.9%) worked 51-60 years.

Two subjects (3.6%) were still professionally active at the time of the study, one person was receiving welfare, and the other participants received retirement pensions (27 individuals, 50.0%) or disability pensions (24 individuals, 44.4%). More than half of the respondents (31 individuals, 55.4%) reported help from the family, and 17 (30.4%) respondents reported carer's allowance as additional sources of income. Two participants were provided with social benefits, and one person relied on their own savings. Five individuals did not have any additional income. In most cases (30 participants, 54.5%), total family income was higher than 1200 PLN, seventeen (30.9%) patients reported an income of 801-1200 PLN, and eight (14.5%) reported an income of 401-800 PLN.

The majority of patients (48 individuals, 87.3%) lived with their families, one (1.8%) participant lived with a carer, and six (10.9%) on their own.

2. Medical data

The vast majority of patients (45, 81.8%) were diagnosed with cancer. The remaining 18.2% were diagnosed with third-degree decubitus ulcers, acute cardiovascular and renal failure.

Thirty-nine (70.9%) subjects suffered from one ailment, and twelve (21.8%) from two. Four (7.3%) patients had three or more ailments.

Among the subjects, the most common nursing care issues included: pain (45 cases, 81.8%), limited self-care due to the progress of disease (33, 60.0%), weakness (32, 58.2%), as well as decubitus ulcers and changing dressings (30, 54.5%). Nursing issues were related to lack of appetite in 26 (47.3%) patients, dyspnea in 19 (34.5%) cases, immobilization in 18 (32.7%), and nausea or vomiting in 16 (29.1%). Depressed mood associated with disease progression resulted in nursing problems in 14 (25.5%) patients, constipation occurred in 13 (23.6%), and dry mouth in 12 (21.8%). Lymphoedema was observed in 5 (9.1%) patients, problems related to glycemia, blood pressure and heart rate measurements as well as with injection administration occurred in 33 (60.0%) cases. There was also one patient who had to attend a dialysis center three times a week to undergo the procedure.

3. Expectations

More than two-thirds of the subjects, i.e. 37 (67.3%) patients, stated that they were familiar with the range of services provided by the center, and 18 (32.7%) declared partial familiarity. There were no individuals among the subjects who were unfamiliar with the range of services provided by the center.

Patients' expectations with regard to the services provided were mostly associated with appropriate care (40; 72.7%), improvement in general well-being (37; 67.3%), and control over ailments (33; 60.0%). Eighteen (32.7%) patients expected a full recovery, and 16 (29.1%) patients hoped to receive assistance in their daily activities. One-fourth of the participants, i.e. 14 (25.5%), responded that their expectations from the personnel were associated with the need to stay among people. Three (5.5%) participants expected assistance in housework; one person (1.8%) needed assistance doing injections. Only one person (1.8%) did not have any expectations from the nursing care center.

And one person (1.8%) stated that the services offered by the center were not punctual. The remaining 54 participants (98.2%) were satisfied with both promptness and punctuality.

Nearly all respondents, i.e. 54 patients (98.2%), expressed their willingness to recommend the center to their acquaintances. One person (1.8%) who gave a different response explained that "she/he was provided with the services for a too short a period of time to decide.” The most frequently (33 participants; 60%) repeated arguments in favor of recommending the center were good organization and the availability of the personnel. Kindness, understanding and attentiveness were mentioned by 27 (49.1) respondents, while expertise and professionalism by 16 (29.1%). Convenient access and location were important to 6 (10.9%) patients.

Results

Multidimensional Scale of Perceived Social Support

In this part of the questionnaire, the respondents were asked to score how they agreed with the given statements (Figure 1).

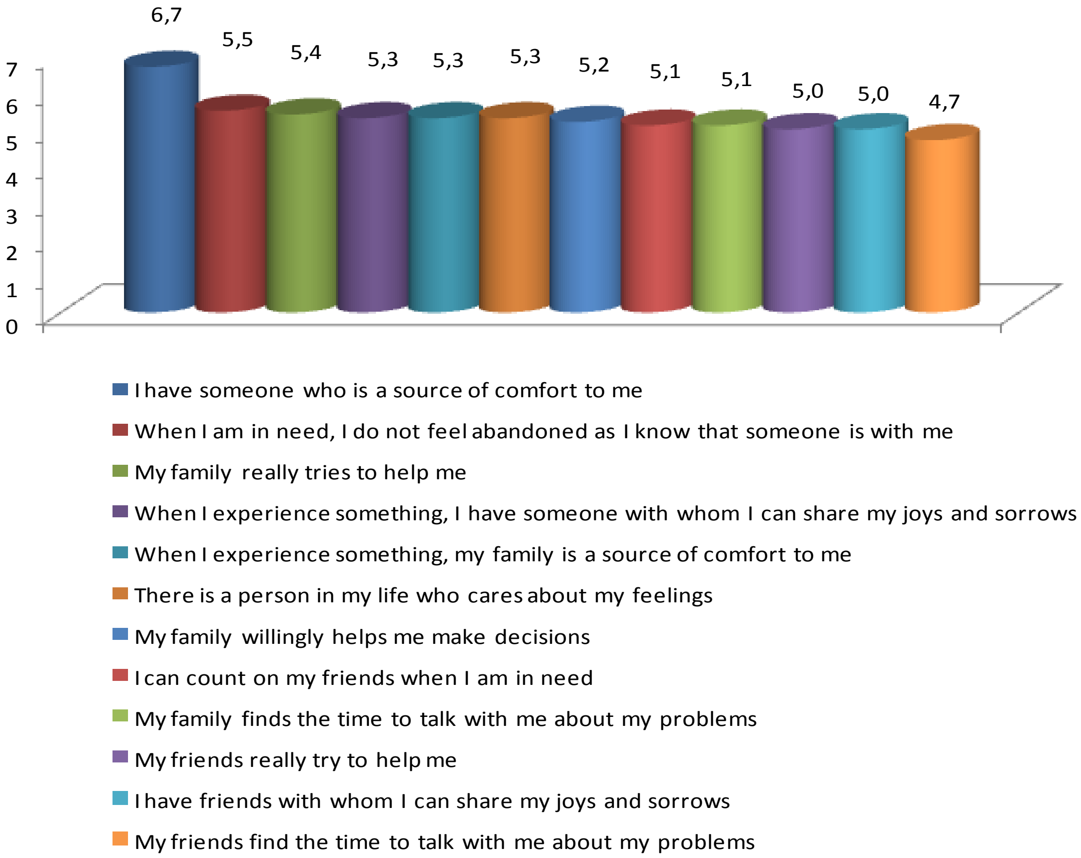


Fig. 1. Multidimensional Scale of Perceived Social Support.

The statement ‘I have someone who is a source of comfort to me’ received the highest score, i.e. 6.7, which was calculated as a mean value based on the respondents’ scores. This was followed by the statement ‘When I am in need, I do not feel abandoned as I know that someone is with me,’ which received a score of 5.5. The statement ‘My family really tries to help me’ received a score of 5.4, and a mean score of 5.3 was received by three statements:

'When I experience something, I have someone with whom I can share my joys and sorrows'; 'When I experience something, my family is a source of comfort to me'; and 'There is a person in my life who cares about my feelings.' The statement 'My family willingly helps me make decisions' received a mean score of 5.2, and a mean score of 5.1 was received by two statements: 'I can count on my friends when I am in need' and 'My family finds the time to talk with me about my problems.' A score of 5.0 was also given to two statements: 'My friends really try to help me' and 'I have friends with whom I can share my joys and sorrows.' The statement 'My friends find the time to talk with me about my problems' received the lowest score of 4.7.

Care Satisfaction Questionnaire

In this part of the questionnaire, the respondents were asked to choose one answer from five possible responses (Figure 2) for each of the given sentences.

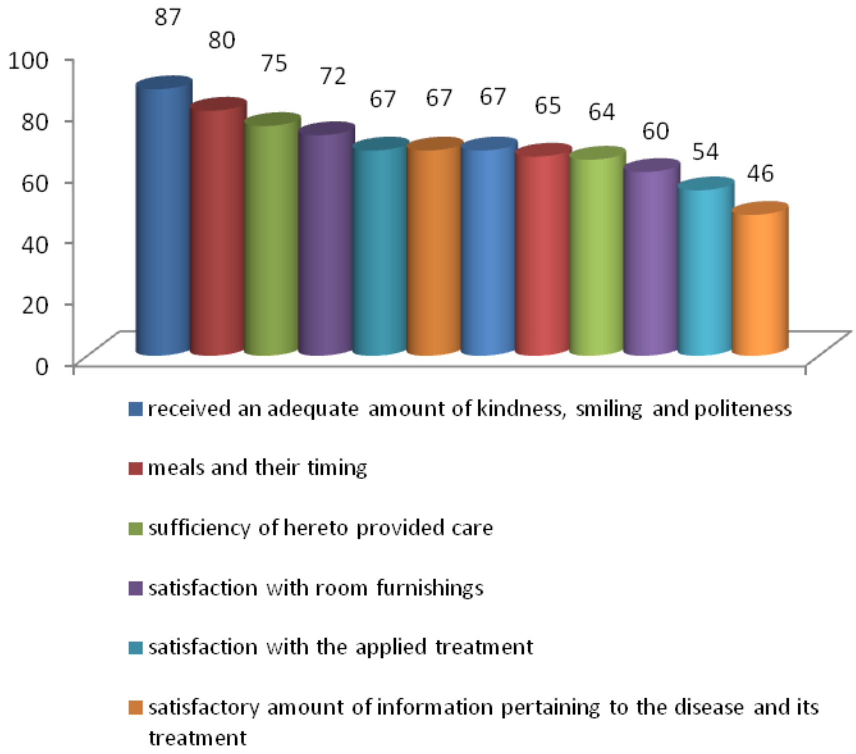


Fig. 2. Comparison of aspects of satisfaction with care.

The highest score, i.e. 87 points, and thus the highest satisfaction was associated with received kindness, smiling and politeness. This was followed by meals and their timing, which received a score of 80, and by sufficiency of the provided care, which received a score of 75. Satisfaction with room furnishings was given a score of 72. Three aspects (applied treatment, disease-related information received, and living conditions) were given an equal score of 67. Satisfaction associated with the frequency of conversations with a nurse or another carer was slightly lower (a score of 65), and then organizational aspects of care (a score of 64). The respondents were least satisfied with the amount of information on the course and prognosis of their diseases (a score of 60), information on the diagnosis (a score of 54), and finally with the number of conversations with the attending physician (a score of 46).

Discussion of the results

Problems related to care in patients varied considerably and may generally be divided in terms of occurring symptoms into three categories:

- in a small number of patients (up to 30% of all subjects)
  – associated with such conditions as lymphoedema, constipation, nausea, vomiting, or depressed mood associated with disease progression;
- in a large number of patients (30-60% of all subjects)
  – resulting from immobilization, loss of appetite, or dyspnea;
- in nearly all patients (more than 60%)
  – pain, weakness, limited self-care due to the progress of terminal disease, and all types of activities related to diagnosis and treatment (measurements, tests, injections, etc.).

It should be noted that the number of care-related problems varied in each patient; however, a certain pattern may be observed: initially, the number of patients increases along with the number of problems, then, after reaching a mean number of problems 'per' one patient, the number of patients slowly begins to decrease (Table 1).

Table 1. Distribution of care-related nursing problems on the number of patients.

Number of care-related problems in one patient	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
Number of patients with problem(s)	3.	11.	9.	4.	13.	6.	4.	3.	1.	1.

When comparing expectations with the number of patients who declared familiarity (or unfamiliarity) with the range of services provided by the center, it should be concluded that the expectations were similar in both groups and were mostly related to good care, improved general well-being, and control over ailments.

Only one out of 55 respondents had reservations about the punctuality of the services and about receiving information concerning their postponement. That same person and two other patients expressed their negative opinion on changing the appointed times/dates.

A similar situation may be observed in the case of recommending the center to acquaintances. Apart from one person who stated that "she/he was provided with the services for a too short a period of time," all respondents expressed their willingness to recommend the center mostly due to their satisfaction with good organization, availability of the personnel, as well as kindness, understanding and attentiveness of the medical staff. These were followed by expertise and professionalism. Convenient access and location were also important, however these two aspects were least frequently mentioned.

Multidimensional Scale of Perceived Social Support (MSPSS)

Mean value and the number of given scores were calculated for each statement after summing the individual scores (Table 2).

Data analysis indicates that:

- terminally ill patients received the most support from third parties, most frequently from the center's personnel;
- the sense of the presence of other people who are a source of comfort in difficult times and who are supportive in moments of loneliness and desolation was most important to patients;
- it was very important for patients to have a person who cares about their feelings.

When comparing further scores of the given statements, it may be observed that family and all it may offer in the form of support "came second" in terms of importance and was followed by friends and acquaintances.

The final part of the questionnaire was entirely devoted to the patient's satisfaction with the provided care. It may be concluded, based on initial analysis of the responses, that the care was generally positively assessed by all patients.

Table 3 shows the number of 'received' scores, which reflect patient satisfaction with the actions listed in the questionnaire. The collected data indicate that patients were more satisfied with the personnel's kindness, smiling and politeness, whereas they were least satisfied with contact with their attending physicians.

Table 2. Summary of MSPSS scores.

Multidimensional Scale of Perceived Social Support	**Mean score**	**Number of scores**							**Subject**
		7.	**6.**	**5.**	**4.**	**3.**	**2.**	**1.**	
I have someone who is a source of comfort to me.	6.7.	14.	19.	11.	5.	1.	1.	3.	
When I am in need, I do not feel abandoned as I know that someone is with me.	5.5.	18.	18.	11.	6.	2.	2.	1.	
My family really tries to help me.	5.4.	15.	18.	11.	3.	2.	3.	3.	family
There is a person in my life who cares about my feelings.	5.3.	12.	19.	10.	6.	3.	3.	2.	
When I experience something, my family is a source of comfort to me.	5.3.	13.	17.	14.	3.	4.	1.	3.	family
When I experience something, I have someone with whom I can share my joys and sorrows.	5.3.	14.	12.	15.	7.	3.	3.	1.	
My family willingly helps me make decisions.	5.2.	9.	21.	11.	7.	1.	3.	3.	family
I can count on my friends when I am in need.	5.1.	9.	15.	14.	10.	6.	1.	0.	friends
My family finds the time to talk with me about my problems.	5.1.	12.	11.	19.	4.	6.	0.	3.	family
My friends really try to help me.	5.0.	10.	12.	11.	15.	5.	2.	0.	friends
I have friends with whom I can share my joys and sorrows.	5.0.	11.	9.	16.	10.	5.	3.	1.	friends
My friends find the time to talk with me about my problems.	4.7.	6.	10.	18.	10.	4.	6.	1.	friends

Table 3. Assessment of satisfaction from particular actions.

Actions assessed in terms of satisfaction	Number of given scores					Total
	+2.	+1.	0.	-1.	-2.	
Did you receive an adequate amount of kindness, smiling and politeness?	34.	19.	2.	0.	0.	87.
Are meals and their timing to your satisfaction?	29.	23.	0.	1.	0.	80.
In your opinion, was the hereto provided care sufficient?	27.	21.	7.	0.	0.	75.
Are you satisfied with the furnishing of your room?	26.	20.	9.	0.	0.	72.
Are you satisfied with your living conditions?	23.	23.	8.	0.	1.	67.
Have you received a satisfactory amount of information pertaining to the disease and its treatment?	21.	26.	7.	1.	0.	67.
Are you satisfied with the applied treatment?	18.	31.	6.	0.	0.	67.
Is the frequency of conversations with a nurse or another carer satisfactory?	20.	25.	9.	0.	0.	65.
What do you think of the organization of care?	19.	28.	5.	2.	0.	64.
Have you received a satisfactory amount of information pertaining to the course and prognosis of the disease?	18.	24.	13.	0.	0.	60.
Have you received a satisfactory amount of information pertaining to the diagnosis of the disease?	11.	32.	12.	0.	0.	54.
In your opinion, is the number of conversations with the attending physician satisfactory?	14.	22.	15.	4.	0.	46.

Discussion

There are a number of literature reports on patient support and satisfaction with nursing care. These issues have been discussed by, among others, Mrówczyńska (2011), Krukowski (2011), Kózka (2010), Weber (2009), and Jakubów and Malarewicz (2008).

Kózka (2010) reported on social support during disease. Similar studies, which were mainly devoted to legal aspects, were conducted by Jakubów (2008). Krukowski (2011) and Mrówczyńska and Ziółkowski (2011) devoted their studies to the relationship between quality of care and patient satisfaction. Bielawska (2007) conducted research on support in the suffering of patients in palliative care [11-16]. Our research focused on social support and satisfaction with palliative care in a group of 55 patients.

The Multidimensional Scale of Perceived Social Support developed by Canty, Mitchell, Zimet, Dahlem, Farley, Powell and Werkman [7, 8, 9] was used.

Based on the obtained results, we concluded that the terminally ill were most frequently offered the greatest support by medical personnel, and that they found the sense of the presence of other people who are a source of comfort and support in difficult times and moments of loneliness and desolation the most important. Moreover, it was very important for patients to have a person who cares about their feelings.

The Care Satisfaction Questionnaire by de Walden-Gałuszko and Majakowicz (2009) [10] was the second tool we used in the study. Similar studies were conducted by Krukowski in 2010-2011 in groups of 30 patients from two inpatient hospices [13].

The presented results obtained with the Care Satisfaction Questionnaire correspond with the results obtained by other researchers. It may be concluded that the satisfaction of patients in the final stages of life relies on the quality of nursing care, i.e. the higher the care standards, the greater the feeling of satisfaction among patients. Psychological and spiritual support was more important than the treatment itself.

The obtained results confirm that the work of nurses, which involves care of patients in the final stages of life, plays a major role in patient quality of life and allows them to spend their last days in peace and dignity.

Conclusions

Analysis of the study results allowed to formulate the following conclusions:

1. Direct contact with carers had the greatest impact on palliative patients' satisfaction with care.
2. The nurses' every action was closely monitored and assessed by patients.
3. The work of nurses, apart from a measurable value, was also associated with considerable satisfaction with well-performed duties for both the patients and the nurses.
4. Respondents scored the work and commitment of the nurses highly.
5. Cooperation with attending physicians and the amount of information they provided received the lowest scores.
6. Psychological and spiritual support were more important for patients than treatment itself, however other aspects of nursing care as well as the conditions in which it was implemented were also important.

7. Most patients attached greater importance to human contact and support offered by medical personnel than by family or friends.
8. The living conditions in the center met the expectations of the studied group of patients.
9. The patients were of the opinion that they received sufficient information on the state of their health and on the applied methods of treatment.

References

1. Buss T., Lichodziejewska-Niemierko M., Opieka paliatywna w Polsce – od idei do praktyki (również lekarza rodzinnego), Forum Medycyny Rodzinnej, tom 3, Gdańsk 2008.
2. Głowacka A., Rola pielęgniarki w opiece paliatywnej i hospicyjnej. W: Humanizacja opieki medycznej nad człowiekiem w terminalnym okresie choroby nowotworowej. Stowarzyszenie Opieki Hospicyjnej Ziemi Częstochowskiej, Częstochowa 2000.
3. de Walden-Gałuszko K., Problemy psychiczne, duchowe i etyczne, [w:] Pielęgniarstwo w opiece paliatywnej i hospicyjnej, (red.) de Walden-Gałuszko K., Kaptacz A. (red.), Wyd. Lekarskie PZWL, Warszawa, 2005.
4. Trzebiatowska I.: Satysfakcja jako element oceny jakości opieki [w:] Ocena jakości opieki paliatywnej w teorii i praktyce, de Walden-Gałuszko K., Majkowicz M. (red.), Akademia Medyczna, Zakład Medycyny Paliatywnej, Gdańsk, 2000.
5. Tassinari D., Poggi B., Fantini M., Ravaioli A., Can we really consider quality of life as an outcome of palliative care? J. Pain Symptom Manage, 2003.
6. de Walden-Gałuszko K.: Problemy w ocenie jakości opieki paliatywnej [w:] Ocena jakości opieki paliatywnej w teorii i praktyce, de Walden-Gałuszko K., Majkowicz M. (red.), Akademia Medyczna, Zakład Medycyny Paliatywnej, Gdańsk, 2000.
7. Canty-Mitchell J., Zimet G.D.: Psychometric properties of the Multidimensal Scale of Perceived Social Support in urban adolescents, Am. J. Community. Psychol., 2000, 28, 391-400.
8. Zimet D.G., Dahlem N.W., Zimet S.G., Farley G.K., The Multidomensional Scale of Perceived Social Support, J. Pers. Assess., 1988, 52.
9. Zimet G.D., Powell S.S., Farley G.K., Werkman S., Berkoff K.A., Psychometric characteristics of the Multimedionsional Scale of perceived Social support, Journal of Personality Assessment 1990, 55, 610-617.

10. de Walden-Gałuszko K., Majakowicz M.: Ocena jakości opieki paliatywnej w teorii i praktyce, Gdańsk, 1992.
11. Weber T.: Oswajanie umierania, Kraków, 2009.
12. Mrówczyńska E., Ziółkowski M., Kisicki R., Stachowiak A., Feit J.: Badanie satysfakcji pacjentów i opiekunów z opieki medycyny paliatywnej jako wskaźnik jakości opieki paliatywnej, Med. Paliat., 2011, 4, 221-230.
13. Krukowski J., Gaworska-Krzemińska A., Majkowicz M., Ocena związku pomiędzy jakością opieki pielęgniarskiej a satysfakcją pacjenta w schyłkowej fazie choroby, Probl. Pielęg., 2011, 19, 282-287.
14. Kózka M., Wsparcie społeczne w chorobie [w:] Modele opieki pielęgniarskiej nad chorym dorosłym. Podręcznik dla studiów medycznych, Kózka M., Płaszewska-Żywko L. (red.), Wyd. PZWL, Warszawa, 2010, 45-49.
15. Jakubów P., Malarewicz A.: Wsparcie prawne w opiece paliatywnej. Medycyna Paliatywna w Praktyce, 2008, 4, 143-147.
16. Bielawska A., Pyszczorska M., Jędrasiak-Figna L., Walkowiak I., Bączyk G.: Wsparcie w cierpieniu – pacjent umierający i jego rodzina. Pielęg. Pol., 2007, 136-139.

Chmiel Izabela[1,2], Czekaj Janusz[1,2], Matusik Magdalena[2]

The functioning of an interdisciplinary palliative care team as perceived by its members

1. Faculty of Health Sciences of the Jagiellonian University Medical College in Krakow
2. Care and Treatment Center in Krakow

Introduction

A team is a group of people who are involved in a variety of mutual interactions and committed to a common purpose, which can only be achieved through the joint effort of all members [1,2]. It is also a certain number of people with complementary skills, who have a similar system of values and a similar approach, and who are all characterized by a sense of responsibility [3].

There are many types of interdisciplinary teams. A palliative care team is a special type of interdisciplinary team [4-10].

Palliative patients are put in the center of care provided by an interdisciplinary team. Cooperation and mutual trust of all team members are essential for professional care as well as to increase the efficiency of their actions. A seemingly simple activity such as cooperation may in fact prove difficult to accomplish.

Aim

The aim of the study was to evaluate the functioning of an interdisciplinary palliative care team as perceived by its members.

Materials and methods

The study was conducted from January to March 2013 in three medical institutions located in the south of Poland. At the request of the institutions their names are not disclosed. The study included 59 individuals. All participants were informed about the purpose of the study and that their anonymous participation was voluntary.

Our own interview questionnaire containing socio-demographic data as well as information on the perception of the subjects' participation in the interdisciplinary team, their cooperation and communication was used in the study.

The respondents were asked to select one or more answers from those provided. Some of the questions were open-ended, which allowed the participants to provide their own answers.

During data analysis, we took into account that the respondents were able to provide more than one answer to one question, therefore answers did not always add up to 100%.

Results

Characteristics of the studied group.

The study group consisted of 59 individuals, 50 (84.75%) female and 9 (15.25%) male. Institution A counted 25 (42.37%) individuals, Institution B 14 (23.73%), and Institution C 20 (33.90%).

The participants were aged 21 to 58 years. Respondents aged 30-45 years were the largest age group, 28 (47.46%), whereas respondents aged 21-29 years were the smallest group, 7 (11.86%).

A total of 34 (57.63%) respondents were married, 5 (8.47%) were widowed.

Participants with higher education (34; 57.63%) were predominant, and only one person (1.69%) had vocational education.

The largest group of 29 (49.15%) individuals reported living in the target city (of the study), whereas only 4 (6.78%) came from another town. Table 1 shows the socio-demographic characteristics of the studied group.

Professional work of the studied group

Out of 59 respondents, 36 (61%) chose to work in a palliative care setting based on their own decision, including 3 (5.1%) 'as a calling' responses. Ten respondents (16.9%) were assisted in their choice by parents, and 7 (11.9%) by friends or acquaintances. The remaining 6 (10.2%) made their choice due to the lack of options of finding work elsewhere.

When asked whether they feel appreciated by their employers, the majority, 37 (62.7%), of participants responded ‘no,’ 18 (30.5%) ‘yes,’ and 4 (6.8%) did not answer.

The respondents were asked to select nine sentences from those provided to describe their professional work. A total of 52 (88.14%) confirmed that the job was their main source of income. Only 2 (3.39%) participants reported that their job was a nuisance. Figure 1 presents the meaning of work for employees from institutions A, B, and C.

The respondents were asked to provide reasons why they liked their job and what bothered them the most about it.

Overall, the majority of respondents, 36 (61.02%), stated that they liked their job because it allowed them to help those in need and thus feel fulfilled. The least respondents (2 from each institution, 3.39%) valued autonomy and respect from their superiors in their work.

Table 1. Socio-demographic data of the studied group.

No.	**Analyzed variables**		**Institution A**		**Institution B**		**Institution C**		**TOTAL**	
			N	**%**	N	**%**	N	**%**	N	**%**
1	**Gender**	women	21	35.59%	10	16.95%	19	32.20%	50	**84.75%**
		men	4	6.78%	4	6.78%	1	1.69%	9	**15.25%**
	TOTAL		**25**	**42.37%**	**14**	**23.73%**	**20**	**33.90%**	**59**	**100.00%**
2	**Age**	21-29	6	10.17%	0	0.00%	1	1.69%	7	**11.86%**
		30-45	11	18.64%	10	16.95%	8	13.56%	28	**47.46%**
		50-58	8	13.56%	4	6.78%	11	18.64%	22	**37.29%**
	TOTAL		**25**	**42.37%**	**14**	**23.73%**	**20**	**33.90%**	**59**	**100.00%**
3	**Marital Status**	single	9	15.25%	4	6.78%	-	-	13	**22.03%**
		married	12	20.34%	7	11.86%	15	25.42%	34	**57.63%**
		separated/ divorced	2	3.39%	1	1.69%	4	6.78%	7	**11.86%**
		widowed	2	3.39%	2	3.39%	1	1.69%	5	**8.47%**
	TOTAL		**25**	**42.37%**	**14**	**23.73%**	**20**	**33.90%**	**59**	**100.00%**
4	**Education**	primary	-	-	-	-	-	-	-	**-**
		vocational	-	-	-	-	1	1.69%	1	**1.69%**
		secondary	8	13.56%	6	10.17%	10	16.95%	24	**40.68%**
		higher	17	28.81%	8	13.56%	9	15.25%	34	**57.63%**
	TOTAL		**25**	**42.37%**	**14**	**23.73%**	**20**	**33.90%**	**59**	**100.00%**
5	**Place of residence**	village	14	23.73%	8	13.56%	4	6.78%	26	**44.07%**
		target city (of the study)	9	15.25%	6	10.17%	14	23.73%	29	**49.15%**
		other smaller town	2	3.39%	-	-	2	3.39%	4	**6.78%**
		TOTAL	**25**	**42.37%**	**14**	**23.73%**	**20**	**33.90%**	**59**	**100.00%**

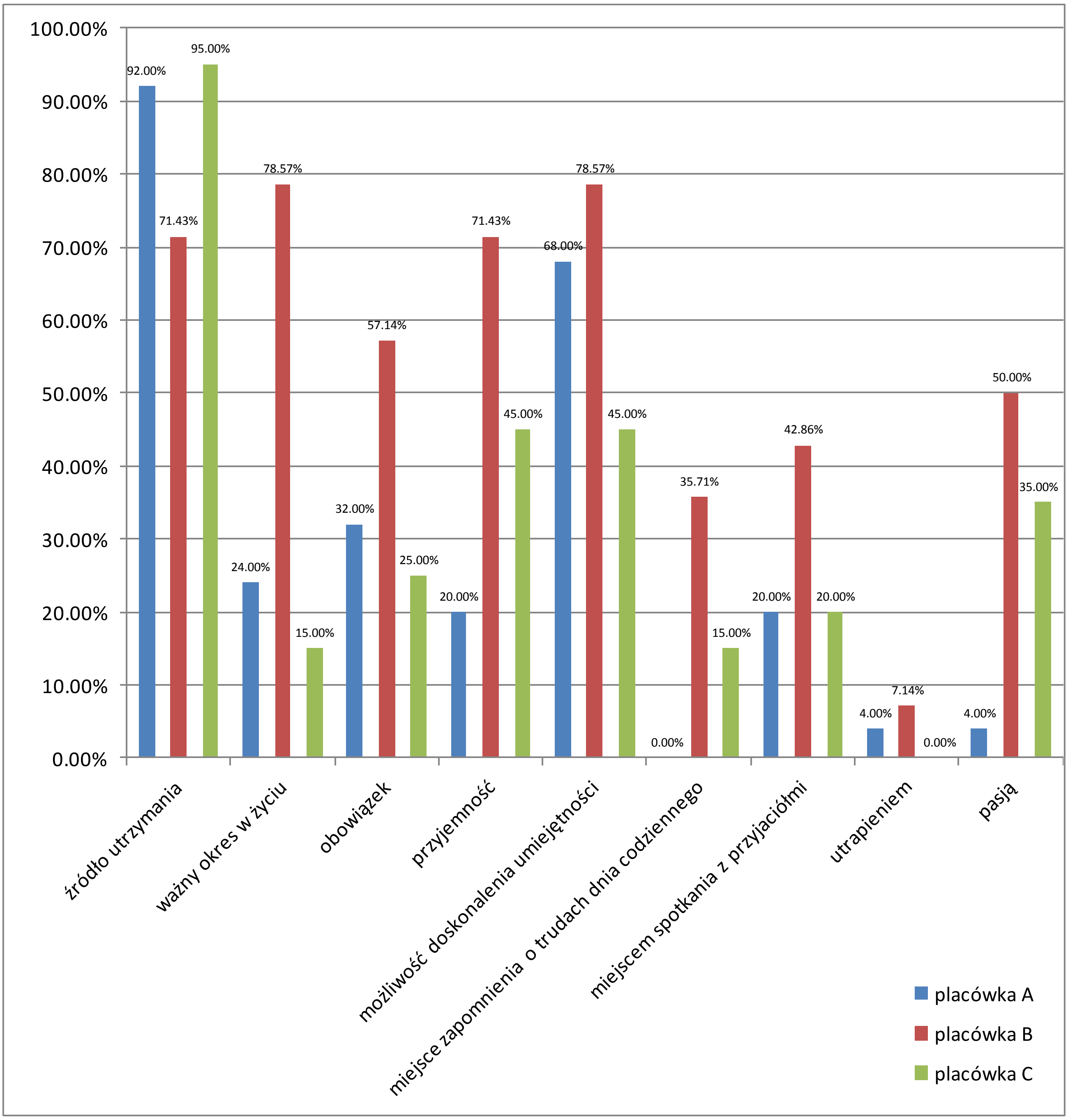


Figure 1. The meaning of work in the respondents' lives.

Table 2 shows the results for Institutions A, B, and C.

The majority, 33 (55.93%), of respondents from the studied group of 59 found the lack of cooperation and communication in their team the most bothersome aspect, whereas the least, 4 (6.78%), respondents found criticism, conflicts, informing on others, mobbing, and bureaucracy the most negative aspects.

Table 2. Advantages of the performed work according to the respondents.

		Institution A		**Institution B**		**Institution C**		**TOTAL**	
No.	**Analyzed variables**	N	%	N	%	N	%	N	**%**
1	To help those in need, feel fulfilled	13	52.00%	8	57.14%	15	75.00%	36	**61.02%**
2	To improve skills, to prove myself	12	48.00%	3	21.43%	4	20.00%	19	**32.20%**
3	Contact with other people	11	44.00%	2	14.29%	7	35.00%	20	**33.90%**
4	New experience	5	20.00%	-	-	-	-	5	**8.47%**
5	Good work conditions/pleasant atmosphere	5	20.00%	1	7.14%	2	10.00%	8	**13.56%**
6	Other (source of income, derive pleasure from work, gain confidence, being trustworthy)	4	16.00%	-	-	-	-	4	**6.78%**
7	Autonomy	2	8.00%	-	-	-	-	2	**3.39%**
8	Interesting work/satisfaction	2	8.00%	-	-	9	45.00%	11	**18.64%**
9	Respect from superiors	2	8.00%	-	-	-	-	2	**3.39%**

*Results do not add up to 100% - respondents were able to provide more than one answer

Table 3 shows the results for Institutions A, B, and C.

Perception of the interdisciplinary team in the respondents' workplace

The respondents were asked if an interdisciplinary team is present in their workplace. Overall, the majority, 38 (64.41%), of respondents answered 'yes,' whereas 21 (35.59%) ‘no’ or ‘not sure.’ Analyzing the results, it is worth noting that 18 (72%) out of 25 respondents from Institution A confirmed the presence of an interdisciplinary team, whereas 7 (28%) were of the opposite opinion. A similar situation occurred in Institution C, whereas the reverse was observed in Institution B. Details are presented in Figure 2.

According to the studied group, the interdisciplinary team primarily included the following professionals: nurses (40, 67.8%), physiotherapists (36, 61%) followed by psychologists (33, 55.9%), physicians (29, 49.1%), occupational therapists (22, 37.2%), speech therapists 16 (27.1%), and hospital domestics (9, 15.2%). The lack of a chaplain in Institution A as well as the lack of family members in Institutions A and B are worth noting.

Table 3. Disadvantages of the performed work according to the respondents

*Results do not add up to 100% - respondents were able to provide more than one answer

		Institution A		**Institution B**		**Institution C**		**TOTAL**	
No.	**Analyzed variables**	N	%	N	%	N	%	N	**%**
1	Lack of cooperation and communication	15	60.00%	7	50.00%	11	55.00%	33	**55.93%**
2	Other: being called "sister" (commonly used by patients in Polish hospitals for nurse), routine, pressure, hypocrisy, lack of respect from doctors, irritability of others	6	24.00%	1	7.14%	1	5.00%	8	**13.56%**
3	Income	4	16.00%	2	14.29%	2	10.00%	8	**13.56%**
4	Work conditions: lack of equipment/ small staff	3	12.00%	3	21.43%	8	40.00%	14	**23.73%**
5	Unfair treatment, selfishness	2	8.00%	2	14.29%	2	10.00%	6	**10.17%**
6	Mobbing	2	8.00%	2	14.29%	0	0.00%	4	**6.78%**
7	Criticism	2	8.00%	2	14.29%	0	0.00%	4	**6.78%**
8	Conflicts	2	8.00%	2	14.29%	0	0.00%	4	**6.78%**
9	Informing on others	2	8.00%	2	14.29%	0	0.00%	4	**6.78%**
10	Bureaucracy	2	8.00%	2	14.29%	0	0.00%	4	**6.78%**
11	Lack of time for patients	0	0.00%	5	35.71%	0	0.00%	5	**8.47%**

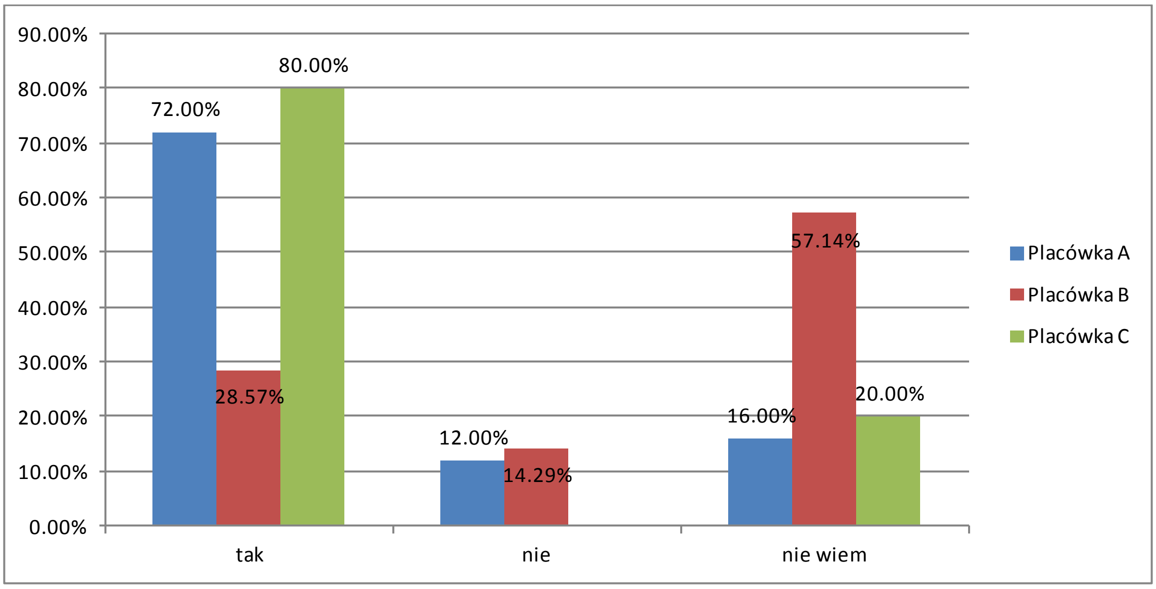


Figure 2. Respondents' knowledge on the presence of an interdisciplinary team in their workplace.

Table 4 presents the results for Institutions A, B, and C.

Table 4. Composition of the interdisciplinary team according to the respondents

		Institution A		Institution B		Institution C		**TOTAL**	
No.	**Team member**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
1	Physiotherapist	17	**68.00%**	10	**71.43%**	9	45.00%	36	61.02%
2	Nurse	17	**68.00%**	10	**71.43%**	13	**65.00%**	40	**67.80%**
3	Psychologist	17	**68.00%**	8	57.14%	8	40.00%	33	55.93%
4	Occupational therapist	12	48.00%	1	7.14%	9	45.00%	22	37.29%
5	Medical doctor	11	44.00%	10	**71.43%**	8	40.00%	29	49.15%
6	Speech therapist	11	44.00%	-	-	5	25.00%	16	27.12%
7	Hospital domestic staff	5	20.00%	2	14.29%	2	10.00%	9	15.25%
8	Assistant director/Director	5	20.00%	-	-	-	-	5	8.47%
9	Administrative workers	3	12.00%	1	7.14%	-	-	4	6.78%
10	Social worker	3	12.00%	1	7.14%	-	-	4	6.78%
11	Dietitian	1	4.00%	-	-	2	10.00%	3	5.08%
12	Police officer	1	4.00%	-	-	-	-	1	1.69%
13	Volunteer	-	-	7	50.00%	2	10.00%	9	15.25%
14	Priest/ chaplain	-	-	8	57.14%	4	20.00%	12	20.3%
15	Caregiver of an elderly person	-	-	-	-	7	35.00%	7	11.86%
16	Family member	-	-	-	-	1	5.00%	1	1.69%

*Results do not add up to 100% - respondents were able to provide more than one answer

In response to the question regarding familiarity with the duties of different interdisciplinary team members, half of the respondents, 30 (50.85%) answered 'yes,' whereas the other half, 29 (49.15) answered 'no.' Detailed results are provided in Figure 3.

A total of 36 (61.7%) respondents from the studied group of 59 felt responsible for the team's development, while the other 23 (38.3%) chose a 'no' or 'not sure' answer; however, none of the participants from Institution C chose 'not sure.' Detailed results are provided in Figure 4.

The participants were asked whether they have the opportunity to acquire new knowledge and skills in their workplace. Overall, 42 (71.19%) respondents answered 'yes.' The other 17 (28.1%) answered 'no' or 'not sure', have no such opportunity or no knowledge about it. Figure 5 shows the results for Institutions A, B, and C.

The interdisciplinary team members were asked if there were any communication barriers in their team. A comparable number of 36 (61%) respondents believed that no such barriers existed or were unable to identify them, whereas 23 (39%) respondents confirmed their presence. Detailed results are provided in Figure 6.

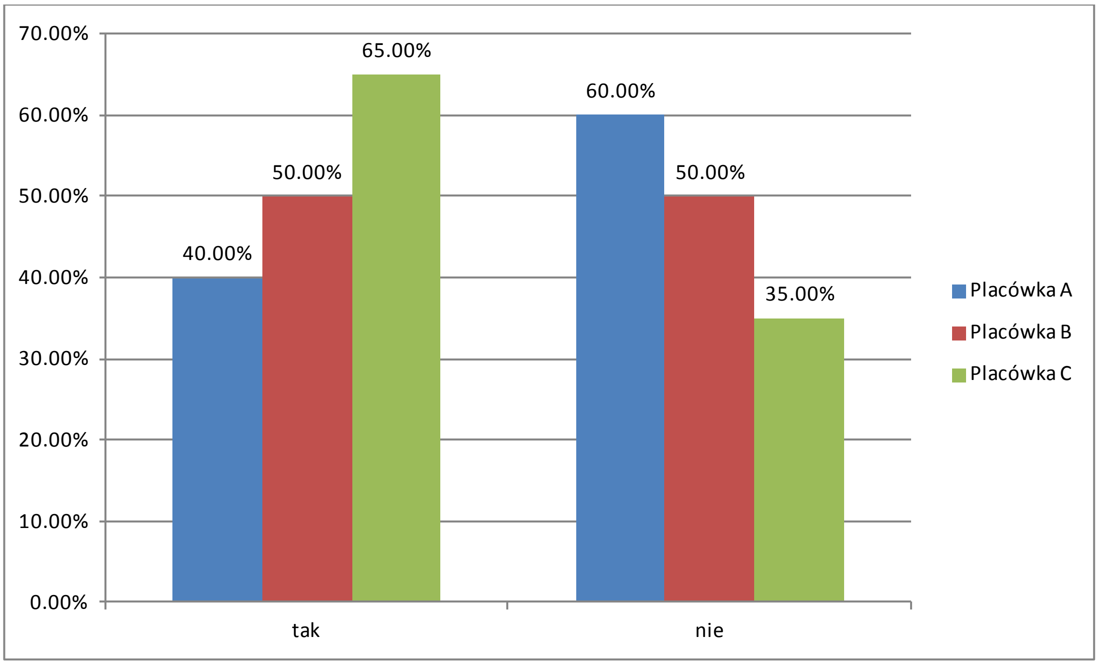


Figure 3. Respondents' familiarity with the duties of different interdisciplinary team members in their workplace.

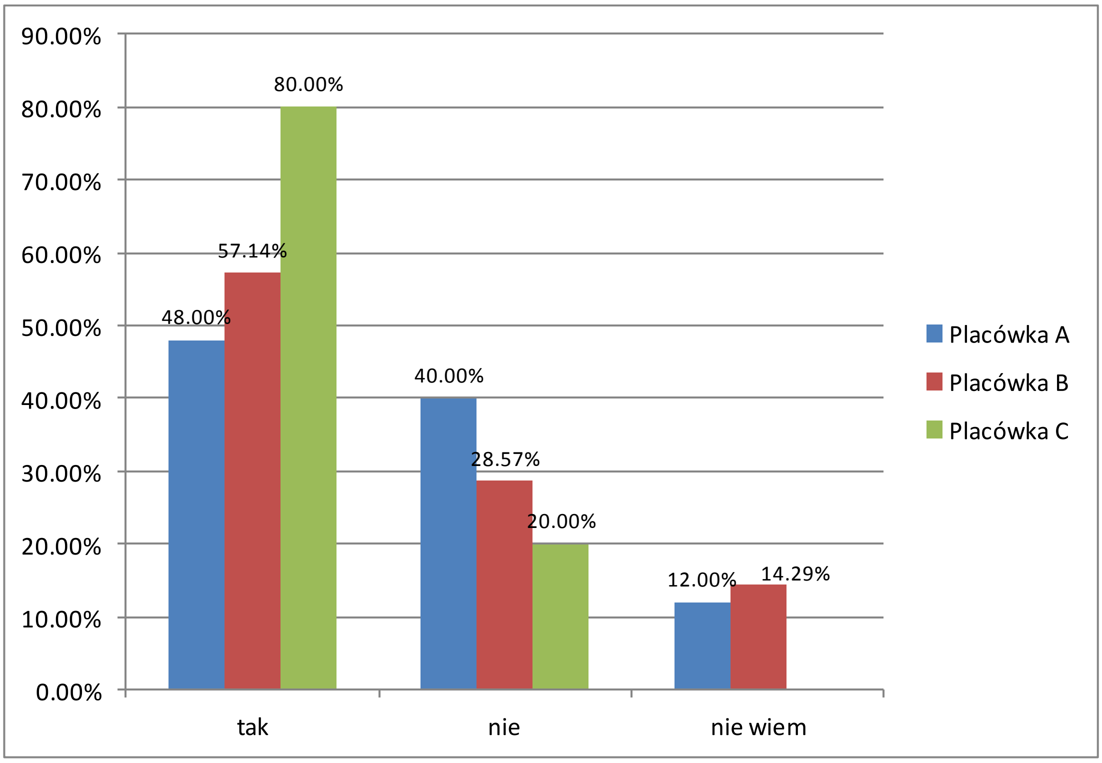


Figure 4. Feeling of responsibility for the development of the respondents' interdisciplinary team.

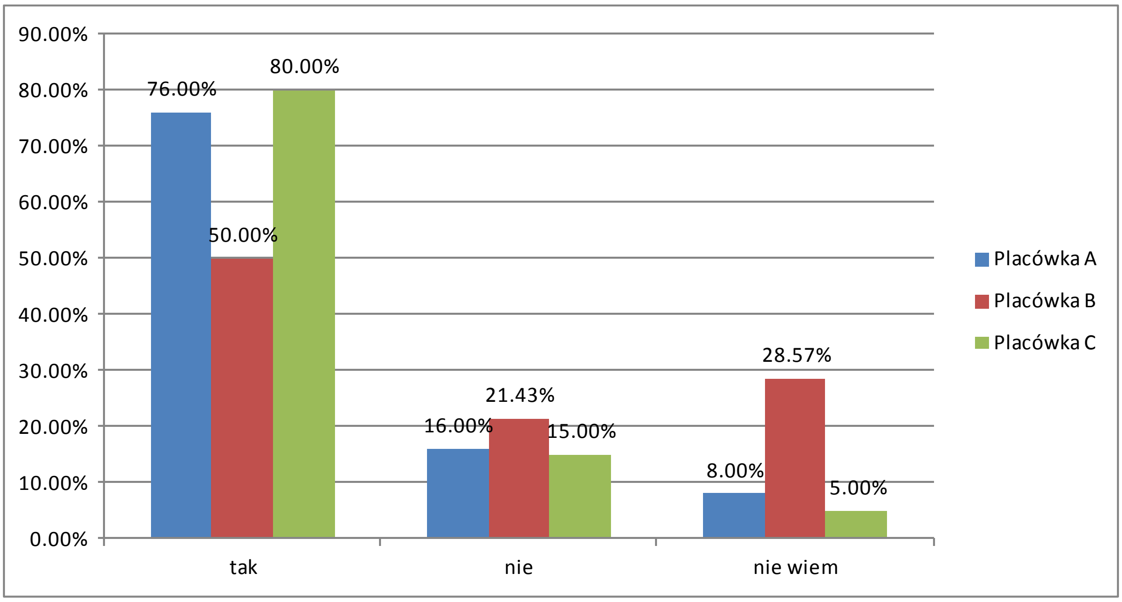


Figure 5. Possibility to acquire new knowledge and skills in the respondents' workplace.

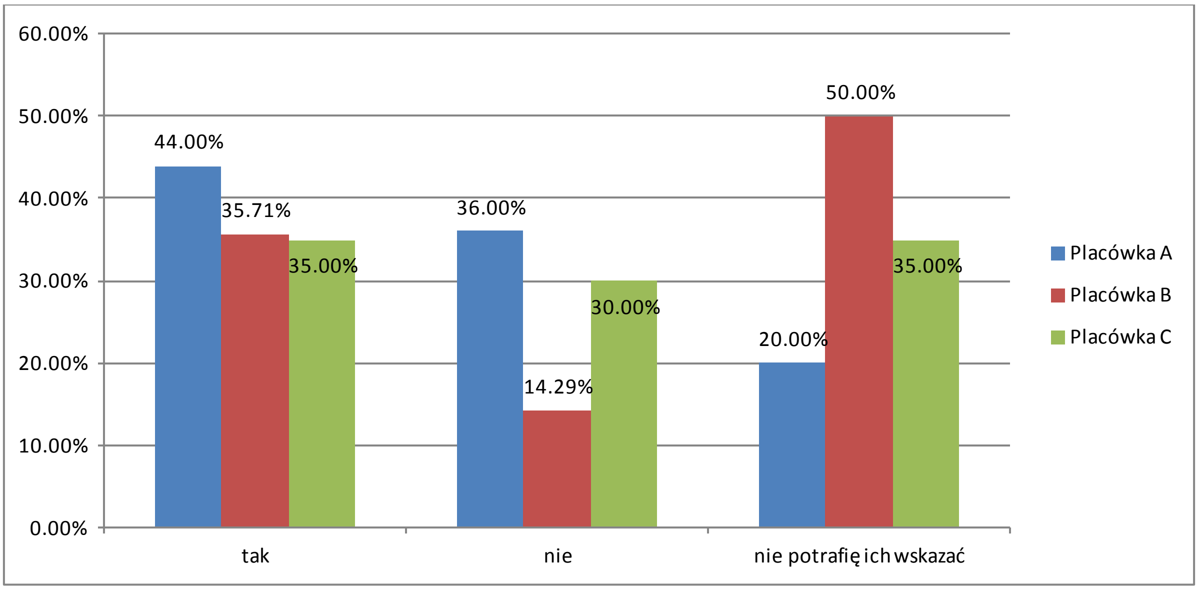


Figure 6. Presence of communication barriers in the studied interdisciplinary teams.

The respondents were asked to identify characteristics that have positive effects on the communication process in an interdisciplinary team. Overall, the majority, 34 (57.63%), of participants selected a desire to help others. Trust as a basis for effective communication was selected by 6 (10.7%) respondents only from Institutions A and C. Figure 7 shows the results for Institutions A, B, and C.

Next, the respondents were asked to provide a list of characteristics of the communication process in their interdisciplinary teams. Generally, the majority, 30 (50.85%), of the participants reported that the communication on their team was characterized by expressing one's own opinion and proposing different solutions. The least respondents, 3 from each institution (5.08%), reported obstinacy and verbal abuse of other team members. Table 5 shows the results for Institutions A, B, and C.

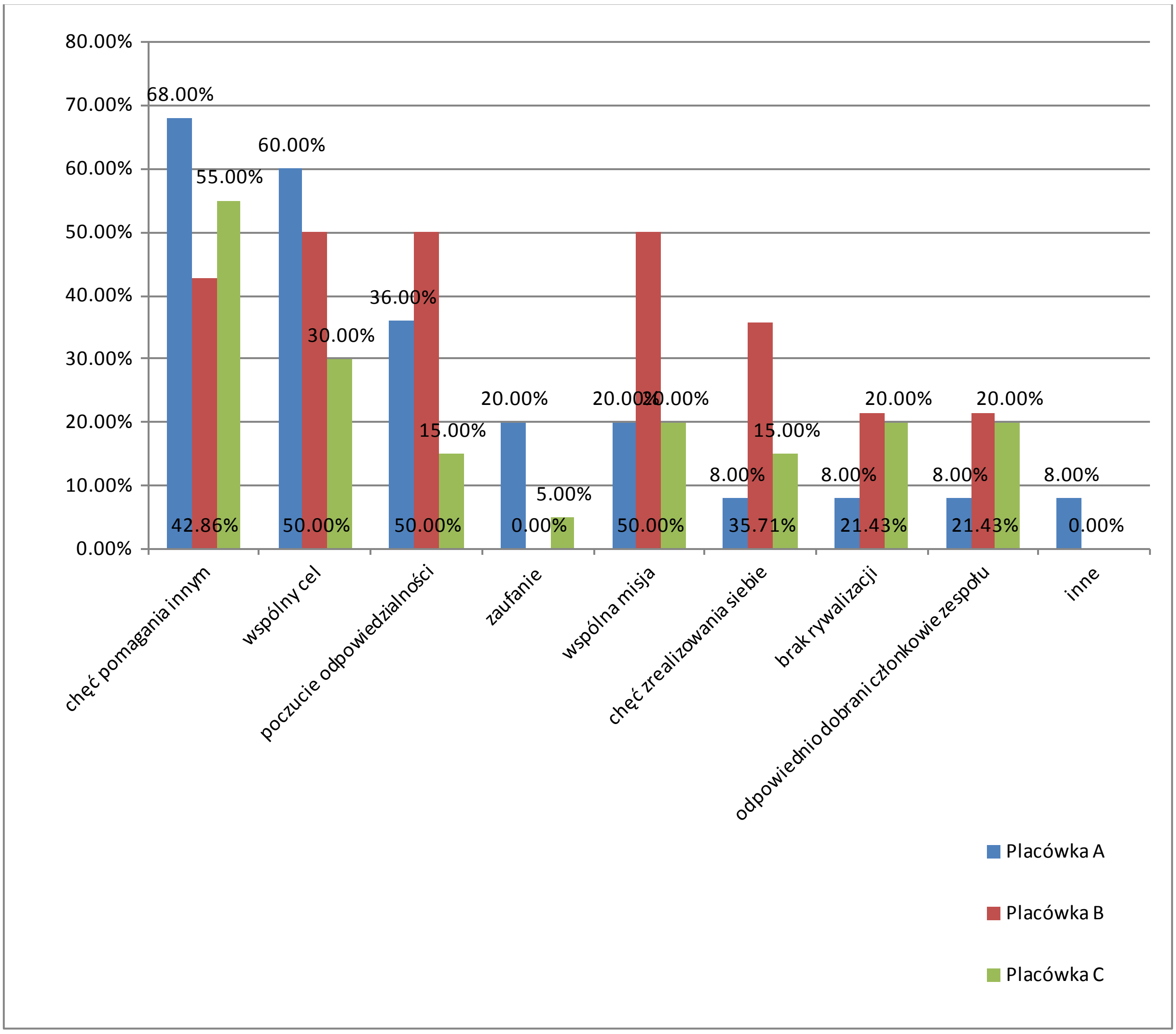


Figure 7. Favorable characteristics for good communication in the opinions of the respondents.

Table 5. Characteristics of the communication process in the studied interdisciplinary teams.

		Institution A		Institution B		Institution C		TOTAL	
No.	**Analyzed variables**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
1	Conversations about career-related topics and not related to work	14	56.00%	8	57.14%	5	25.00%	27	**45.76%**
2	Expressing one's own opinion	11	44.00%	10	71.43%	9	45.00%	30	**50.85%**
3	Proposing different solutions	9	36.00%	11	78.57%	10	50.00%	30	**50.85%**
4	Listening to each other	9	36.00%	10	71.43%	5	25.00%	24	**40.68%**
5	Want to meet with each other	7	28.00%	8	57.14%	4	20.00%	19	**32.20%**
6	Giving feedback	5	20.00%	5	35.71%	-	-	10	**16.95%**
7	Interrupting when others are speaking	4	16.00%	-	-	1	5.00%	5	**8.47%**
8	Obstinacy	3	12.00%	-	-	-	-	3	**5.08%**
9	Verbal abuse of other team members	2	8.00%	-	-	1	5.00%	3	**5.08%**
10	Possibility to talk about a difficult unpleasant topic	2	8.00%	7	50.00%	-	-	9	**15.25%**
11	Criticizing other's ideas	2	8.00%	3	21.43%	3	15.00%	8	**13.56%**
12	One team member dominates	1	4.00%	1	7.14%	2	10.00%	4	**6.78%**

*Results do not add up to 100% - respondents were able to provide more than one answer

Summary and conclusions

The philosophy of palliative care management assumes, among other things, that palliative and hospice care should be provided by an interdisciplinary team. The members of such a team, which includes both medical and non-medical personnel, are not random but exceptional and find the interest of others and selfless help a priority. The philosophical principles of palliative care also relate to the fact that an improvement in the life of terminally ill patients as well as their families may only be achieved through effective cooperation of a team of people who know their duties, are in healthy interpersonal relationships with effective communication, and where all members have the opportunity to improve their qualifications. We came to the following conclusions from this study:

1. There is a lack of basic knowledge on hiring, functioning and the duties of palliative interdisciplinary team members among the personnel from each surveyed institution.
2. Current interpersonal relations between team members create an unfavorable atmosphere at work.
3. The lack of knowledge on the basic principles of effective communication results in an inability of interdisciplinary teams to function properly and perform their basic tasks.
4. The lack of knowledge regarding the possibility to improve qualifications as well as little interest in further training will in time result in stagnation and, consequently, a decrease in the quality of care and medical services.
5. It is essential to activate the board of the surveyed healthcare institutions in terms of a broad improvement in the functioning of their interdisciplinary teams.

The final conclusion of the study may be summarized as follows:

"Not only patients, but also the interdisciplinary teams need help."

References

1. Kohn S.E, O'Connell V.D.: Definicja zespołu i jego skuteczność [in:] 6 nawyków wydajnego zespołu. OnePress, 2008, 37-38.
2. Adams K., Galanes G.J.: Małe grupy jako serce społeczeństwa [in:] Komunikacja w grupach, red. Betlejewska A., Wyd. Naukowe PWN SA, Warszawa, 2008, 21-26.
3. http://www.grupafocus.com/ Efektywna praca w zespole [cited: 21.02.2014]
4. Ciałkowska – Rysz A., Dzierżanowski T.: Ocena sytuacji w opiece paliatywnej w Polsce w 2011 roku. Med. Paliat., 2011, 4, 214-220.
5. de Walden- Gałuszko K.: Filozofia postępowania w opiece paliatywnej [in:] Podstawy opieki paliatywnej, de Walden- Gałuszko K (red.), Wyd. Lekarskie PZWL, Warszawa, 2008, 11-19.
6. de Walden Gałuszko K.: Podstawy opieki paliatywnej, PZWL, Warszawa, 2006.
7. Rozporządzenie Ministra Zdrowia z dnia 29 sierpnia 2009 r. w sprawie świadczeń gwarantowanych z zakresu opieki paliatywnej i hospicyjnej (Dz. Journal of Law No. 139, pos. 1138) are used.

8. Jankowiak B., Bartoszewicz A.: Komunikowanie się w obrębie zespołu terapeutycznego [in:] Komunikowanie interpersonalne w pielęgniarstwie, Kwiatkowska A., Krajewska-Kułak E., Panek W. (red.), Wyd. Lekarskie, PZWL, 2012, 117- 125.
9. http://mfiles.pl- Metody pracy zespołowej [cited: 21.02.2014].
10. Flakus J.: Pozamedyczne aspekty opieki paliatywnej. Działalność hospicjów w opinii różnych grup społecznych. Med. Paliat., 2009, 1, 33-39.

Godawa Grzegorz

Grandparents facing the illness and death of a child in hospice care

Faculty of Social Sciences, The Pontifical University of John Paul II in Cracow, Poland

Introduction

Being elderly has a number of connotations. Most frequently, it is perceived as a negative and difficult phenomenon, related to numerous risks. It would be hard to oppose such a vision of the elderly; however, at the same time, it is worth noting that there are positive approaches towards this period of human life, where being elderly is portrayed as an opportunity, a stage in human development, as a task [1-7]. The feeling of satisfaction and happiness is not reserved exclusively for young people; it is also possible to attain it at an elderly age. One of the positive events related to elderly age is being a grandfather or a grandmother. It is the source of many valuable stimuli that encourage the activity of the grandparents, provide valuable experience for the grandchildren and reinforce the family system.

Sometimes, such family system is subject to overload because of a disease. Terminal illness and the death of a child are the factors that may disrupt the functioning of the whole family, as well as of its particular members. The specific repercussions resulting from the occurrence of these factors might be observed also in the life of the grandparents. It seems that the effects of the illness and death of a grandchild have not been sufficiently researched and described. The experience of suffering due to an illness of a child is most frequently analysed within the context of the feelings of the parents, less frequently - of elder siblings; the suffering of grandparents is described only accidentally. Such a gap shall be filled in.

The aim of this paper is to focus the reader's attention to the suffering of the grandparents of a child in hospice care. Outlining the problem within the context of such care will allow for determining important features that hospice activity has. In order to improve the precision of the problem in question, it is necessary for us to briefly characterize the role played by the grandparents within the family, in particular their relationship with the grandchildren. Furthermore, it is necessary to indicate the basic areas of disruptions caused by the illness and death of a child and to relate them to the feelings of the eldest members of the family. This will allow for providing a number of postulates regarding the ways of hospice care directed towards the grandparents.

Grandparents and grandchildren

Although, in the light of available literature, it is difficult to provide a uniform timeframe for the stages of human development that would be acceptable for all authors, it can be assumed that the fact of becoming a grandfather or a grandmother mostly takes place after fifty years of age, when late adulthood and ageing commences [8]. In the period when most of the people experience the so-called mid-life crisis, forcing them to make a summary of the years that have passed, being a grandfather or a grandmother constitutes a factor that reinforces self-esteem [9]. For many elderly people, it is the source of happiness and motivation for being active, since the grandchildren "*are new life, new hope and happiness, are as if a reward for the difficulties of raising children. These difficulties now result in the appearance of a new generation, that seems to prolong the life of the grandparents for the next many years*" [6].

The social role of the grandparents is strictly related to the relationship that commences when, in a multi-generation family, children are born. The parents, as the first people who are the most significant to a newly born child, shape its personality, self-esteem and its type of relationships with the world [5]. The realisation of these tasks is supported and supplemented by the grandparents, and in some cases parents are substituted by the grandparents. This happens when the parents cannot or do not want to take up tasks normally expected from them.

The experience of the everyday life of Polish families shows that the grandparents are not always the foundations of coherence and effectiveness of families. Some of them are reluctant to participate in family life or make a decision as to partial or total separation from younger generations. It is also the case that the grandparents, by engaging in family life, exceed their competences, instigating conflicts related to the bringing up of the youngest generation or to the day-to-day functioning within the family [6].

It should be remembered, however, that the presence of the grandparents in the family can become an irreplaceable element of happy life and an optimal function in the nursing and educational process. Assuming that elderly people have "*the charisma of breaking cross-generation borders before they even appear*" [10], we might say that their creative presence might improve the quality of family life.

Cross-generation family relationship created between the grandparents and grandchildren is characterised by particularly strong emotional ties. "*The phenomenon of* *grandchildren's ties with their grandparents is, to a large extent, shaped on the basis cognitive and emotional needs that complement each other*" [5]. Grandmothers become a source of love and understanding for their grandchildren, and grandfathers - a source of knowledge, wisdom and experience [9]. Nowadays, when the parents, more and more often, do not have enough time to talk with their children, grandparents can satisfy the children's curiosity about the world expressed by them in questions. For the correct development of a child, it is crucial that such curiosity be satisfied in a wise and responsible manner, therefore the significance of having such conversations is worth stressing.

The issue of the position of elderly people within Polish families is related to its axiological aspect. Elderly people being part of a multi-generation family can bring eternally true and objective values into the family, i.e. selfless interest in another person lack of excessive attachment to transitory things, devotion for others, spiritual and religious values. Such models are necessary for the young generation, and their realisation makes the grandparents unquestionable authorities for younger members of the family [4]. These beliefs are supported by research carried out in 2012 by the Public Opinion Research Centre, according to which grandparents are important people in the lives of the majority of Poles [11].

Almost three quarters of adult Poles (72%) feel that they owe something to their grandmother or their grandfather. In comparison with the research carried out in the years 2000 and 2007, now a vast majority of respondents declare that they feel gratitude towards their grandparents. At the same time, there are less respondents whose opinion is different and those who have never known their grandparents. It supports an opinion that was being expressed before, i.e. that in Poland the role of the grandparents is growing. This happens most probably because of their growing participation in bringing up their grandchildren. Nearly general is the conviction among young people aged under 35 that they owe gratitude towards their grandparents. Most frequently, such gratitude encompasses recognising the role played by the grandparents in education and nursing (65%) and in giving their love (64%). Slightly more than a half of the respondents owe their grandparents for a knowledge of the history of their family, teaching them moral principles and faith (54%). Less frequently, the respondents state that they owe to their grandparents such features of character as: sense of duty, diligence, self-discipline or strong will (48%).

In the light of analysed data, two things are worth stressing: an express reference to axiology in connection with the role played by the grandparents in families and their active participation in the educational and nursing function of the family. A key issue is the engagement of the grandparents in the care over the grandchildren. 83% of the respondents have experienced such care, which allowed them to characterise their relationship with their grandparents as very close [11]. The above mentioned results may constitute one of the reasons why the grandparents may experience the feeling of satisfaction and happiness.

The wellbeing of elderly people may be disrupted by the factors that are inherent to elderly age. Among the most frequent crisis-causing situations we can list the following: the deterioration health and physical fitness, being a widow(er), loneliness, a lower social and economical status, a loss of the feeling of usefulness and prestige, a loss of physical attractiveness, the awareness of approaching death, the necessity of moving into a nursing home [12]. Each of them may cause distress in elderly people, which results in a decrease in the level of their wellbeing and leads to the state of depression.

Difficult life situations related to late adulthood and elderly age might include events that go beyond the private world of the elderly person. The engagement in family life results in the fact that any major disruption of its functioning becomes significant for the grandfather or the grandmother. Particular repercussions in the family are caused by an illness of the grandchild, in particular when the illness becomes terminal and leads to death. Those events influence, in a significant way, the performance of the social role of the grandparents within the family, and at the same time change their life. In order to demonstrate the influence of the illness and the death of a child on the grandparents, it is reasonable to show the context of the appearance of an illness in the family.

Family facing illness and death of a child

Illness and death are among the most difficult experiences ever faced by a human being. They are often incomprehensible, in particular, the event of the death of a child that was born in order to live: „*Although the death of the elderly, disabled, or infirm in our society is often considered a «blessing», the death of children or adolescents is seen as the ultimate tragedy*" [13].

An illness is primarily a personal drama of the patient, experienced to a varying degree, depending on e.g. his or her age, which usually determines the level of consciousness. The suffering related to death goes beyond physical pain: "*A terminally ill person, in particular when nearing death, does not only suffer physically, but he or she also experiences spiritual, existential suffering. There is a growing feeling of loneliness in them (...), a feeling so strong that even those believing in God feel that God has abandoned them in such a moment"* [14].

The model of total pain [15] indicates that the effects of the illness affect not only the patient but also his or her relatives. These can be observed in somatic, psychological, spiritual and social spheres. The model of total pain is related to the systemic approach towards suffering and highlights the very significant influence of a disease on the whole family. This is represented, i.e. in the modification of the conditions of the function of the whole family and the necessity of implementing adaptive action. The disruptions that appear in the family system as a result of the child's illness, consist i.e. in not being able to satisfy the needs related to functioning in extreme conditions: "*The child's illness, in particular cancer, is an event that disrupts the daily rhythm of family's life and produces strong psychological shock. It changes the previously established lifestyle which becomes subject to restoring the child's health*" [16].

Among the needs there is a particularly strong necessity of medical support, getting a professional diagnosis, providing the child with adequate care, getting information as to the child's state of health, and their risk of death, which facilitates proper preparation for such death [17]. An important need of the relatives is the possibility of being close to the sick child and helping him or her, realising his or her wishes and caring for such a child. Family members expect support, especially during the moments of increased intensity of the illness and related emotional difficulties. Particularly difficult is the period of child's dying and the period of mourning.

The support provided to the caretakers is reflected in the emotional state of the child and facilitates his or her treatment [18]. Satisfying this kind of needs may become an occasion to eliminate improper behaviour of some members of the family that might appear in relation to the sick patient, making his existence even harder. An important need experienced by many families with a sick child, is social support. Such support is very often a necessary condition for an appropriate care for the child, which, in Polish circumstances, has been laid upon the family and social institutions that support it. Many people caring for a sick child also experience a shortage of spiritual and religious space, which becomes particularly important in the perspective of the child's death. Seeing the necessity to refer to spirituality becomes a more and more widespread conviction of the researchers dealing with the problem of thanatology [19].

Grandparents facing the suffering and death of their grandchildren

A specific group living through the suffering and death of a child are its grandparents. This takes place when said grandparents take an active part in the life of the family of a sick child and are affected by total suffering. Blocking or limiting the possibility of contacting the sick child is a great burden for the grandparents. The awareness that the child is suffering results in the fact that the happiness of being a grandparent is transformed into a constant state of worrying and sadness.

It happens, however, that at the moment when the illness commences, the grandparents or one of them withdraws from their engagement in the process of caring for the grandchild. This indifference does not necessarily stem from egoism; sometimes it is a way of hiding the feelings of anxiety and pain. An incorrect diagnosis of the grandchild's illness is usually taken by the grandparents with a very strong emotional reaction: „*They often mirror the emotions expressed by the parents such as disbelief and anger, but also often an overwhelming sense of the injustice of the situation*" [20]. Being overwhelmed by the child's illness and the feeling of injustice becomes a very difficult experience for its grandparents. Such situation raises questions about the reasons of the lack of logic in human existence, as exemplified by the death of a young child who should not die when its grandparents, advanced in age, are still alive.

Grandparents' way of reacting to the diagnosis and treatment of the child depends i.e. on the knowledge about the illness, its effects and the principles of palliative care. Often, such knowledge is fragmentary and ignores the current achievements in medicine [20]; therefore the anxiety of the grandparents is even greater. The wellbeing of the grandparents depends, to a large extent, on the level of communication within the family. The decisions regarding the decision-making and taking action are not the competence of the grandparents, but they are the competence of the sick child's parents. The conversations between grandparents and parents about what is happening and about what they feel might be more difficult due to the differences in the emotions experienced, the level of knowledge, and hope [21].

The grandparents „*are not always well-aware of the situation, since an adult child wants to protect them on one hand, and on the other hand does not have enough strength to talk about what is happening. The result is that the grandparents are the last to learn about a chronic disease of their grandchild and feel disregarded. This may lead to the appearance or escalation of tension (...) They are petrified, often ill themselves. They have not imagined their elderly age that way*" [22]. Relieving intra-familiar tension, if done in the atmosphere of nervousness and exhaustion, may significantly diminish the potential of the strength inherent in the family, and by that, weaken its regeneration abilities. Such behaviour is a defensive mechanism for each of the parties, since the parents often subconsciously want to protect themselves, they fear that if they inform the grandparents of the condition of the grandchild, then, apart from having to cope with their own feelings they would have to support the grandparents and help them cope with the situation [23].

Because of that, the grandparents become convinced that they should not express their feelings and opinions too often and too openly, since than would have an adverse effect on the parents of a sick child and on the atmosphere at home. However, not satisfying the need of expressing such feelings and opinions might become a source of additional suffering. The grandparents might be treated as invisible members of the family whose needs in comparison with the child's suffering seem to be insignificant. Such a form of marginalization, although accepted by the grandparents, is the source of additional suffering.

A particularly difficult experience for the grandparents is the agony and death of the child: „*The death of a child is one of the, if not the, most devastating losses that a family can suffer. Everyone is affected – parents, surviving siblings, future siblings, grandparents (...)*" [24]. The life experience of an elderly person includes the experience of the death of close relatives. However, the death of a grandchild is usually a new and extremely traumatic event. It has to be remembered that the mourning of the grandparents has a double dimension: it is caused by the death of the child and by the awareness of the suffering experienced by their adult child [25-26]. With the death of a grandchild, especially if it was the only grandchild, there is a break of a bond that to a large extent determines the identity of an elderly person in the family. There is a widespread conviction of the grandparents that nothing can restore happiness in their life.

The pain of mourning after the loss of a grandchild may be so difficult that the grandparents might feel unable to help the family in living through it. They might feel guilty that they are alive while the grandchild had to die: "*Most grandparents feel a terrible guilt that they will still be alive when their grandchild will be dead. This seems to be totally against the natural order of things and grandparents may feel especially powerless because of this*" [27]. The anxiety felt by the grandparents might be escalated by the feeling of guilt for the fact that the illness was inherited by the child, or for infecting the child, by e.g. using the same cosmetics [28].

Being confronted with the death of a child determines the level of preparation for the grandparent's own death. The approaching perspective of the end of life brings hope for the reencounter with the grandchild. The grandparents who identify themselves with faith and religiousness, during the period of illness and mourning often pray for the child and for its family. The religiosity of an adult person and of an elderly person facilitates providing such type of support. Finding partial relief of their pain in such support, they reinforce their conviction that their prayer is a way of demonstrating love for a deceased child. Mature religiosity, although not eliminating the pain, helps to face the problem of suffering and death in a positive and creative way [29].

It could seem that abundant life experience and usually an independent place of residence can lower the intensity of mourning. Life demonstrates that things are different, in particular if the grandparents are widows or widowers, since that fact magnifies the suffering experienced. Then, their sadness, brought about by the memories left after the grandchild and the spouse is really enormous.

It is worth highlighting that the illness, despite having a destructive influence on the family system, might become a stimulus for positive changes in its structure, in which the grandparents may play an active part. Their attitude might contribute to the strengthening of familiar bonds and relieve exhausted parents. The grandparents may become an indispensable help for the parents and siblings of a sick child. They can prove to be the best form of relieving care that facilitates the functioning of the family in total suffering. They can also become a safety buffer for the siblings of a sick child who can direct part of their questions and hardly acceptable emotions to their grandparents, especially during the period of mourning [29].

Within a family with a sick child we might observe new subsystems, in which the previously existing relationships acquire a new meaning, e.g. the relationship between the healthy children and their grandmother [30]. The grandparents may, in the new circumstances, take up the tasks of educators, whose advice and support may raise hope and feeling of confidence within the family and the closest relatives. In order for things to be that way, there is a need of support that will allow the grandparents to fulfil the social role designated for them in an optimal way.

Hospice-provided support for grandparents

Child hospice, as an institution of social support, provides help for the sick child and its family, abiding by fixed standards. The model of realising palliative and hospice care might be described by means of a principle: „*Caring for the whole person, and their family, with a multidisciplinary team*" [31]. Hospice care assumes providing support both for the sick child and for its family, understood as a system of mutual interactions. The holistic character of the help is observed, e.g. in the all-encompassing approach towards the patient and his or her relatives, which allows for adapting the action taken to their real needs. This is all made possible by virtue of an inter-disciplinary team, composed both of medical and non-medical workers. Directing the actions of the team towards each of the members of the family system includes also the grandparents of a terminally ill child. On the basis of the analyses that have been carried out, one might give a number of suggestions, facilitating the help towards the elderly.

An important form of support is the adequate amount of information regarding the illness and the treatment, provided by the doctor. The way of informing should meet the requirements of interpersonal communication [32] and be adjusted to the perceptive abilities of elderly people. By that, one can avoid the misunderstandings related to the lack of information or to the disruption of the manner of providing such information.

The postulate of improving communication applies also to intra-familiar relationships, upon which the family system is based. The importance of communication is even greater if there is some tension related to the illness of the child and appears in the period of particularly severe attacks of the illness. An open way of communication between family members constitutes a foundation of resolving any problems that might appear [27]. An important thing is to encourage family members to express their emotions and ask any questions that might appear in connection with the illness [20]. It is necessary to create opportunities in which the grandparents will feel safe and will be certain that their sharing of emotions will not increase the pain of the family. This can be achieved by organising family meetings and enabling family members to express their emotions and helping them to develop forms of communication that shall be binding for the duration of the illness and after the death of a child.

An important thing is to keep the balance between an excessive overload of the grandparents or separating them and preventing them from participating in the care over the child. The possibility of engaging the grandparents in family life is perceived by such grandparents as a proof of trust, especially if they can, to a certain extent, participate in the care of the sick child. On the other hand, excessive overload might lead to the appearance of burnout syndrome [33]. The help provided by hospice staff shall balance the level of engagement, in which a conversation with the child's parents and grandparents might help. Taking up such form of support cannot disturb the autonomy of the family, which is why staff members are expected to act with particular delicacy and professionalism in arranging and leading such a conversation.

An important form of support given by the child's grandparents is their spiritual and religious help. It can contribute, to a large extent, to e.g. eliminate unjustified feeling of guilt. It might also provide relief stemming from faith in eternal life and give a spiritual meaning to the suffering that is being experienced. The support of family members, in particular of the child's grandparents - believers, shall also be something that encourages prayer for the whole family. Spiritual and religious help provided to a dying child and his or her family is one of the most difficult tasks of support teams. Coping with such tasks requires huge subtlety, a deep knowledge of the issue in question, a methodology of helping and cooperation between team members.

The help becomes of utmost importance during the period of dying and mourning. The support given to grandparents during the period of mourning, i.e. a complex of psychological, physical and social experiences, is supposed to be in reference to their grief, sorrow, feeling of emptiness and guilt, and wondering about the meaning of life [30]. Professional support should include help in terminating personal ties with the deceased, help in learning to live without him or her, help in expressing difficult feelings. The spiritual dimension of support may help in reformulating the meaning and objectives of life. Of great help may be the religious support of gaining a new perspective of eternal life, by which the grandparents' confrontation with the death of their grandchild and with the perspective of own death receives a deep meaning.

Conclusion

The presence of grandparents in the process of education carried out in a modern Polish family meets more and more frequently with the approval of the society. Although the grandparents do not always take up nursing and education tasks within their family, if their activity in the family is sufficient, the benefits are shared by all family members. This also happens when the illness and death of a child disrupts family life.

The results of the analyses have demonstrated that the grandparents participate in the suffering of the child to an extent depending on their engagement with family life. The particular character of such participation is seen, i.e. in the feeling of helplessness as to the unfavourable family situation, in the confrontation with their own death and with the feeling of being rejected and not understood. Their suffering is intensified by the awareness of the suffering of their own children. The grandparents of a sick child are deprived of the possibility to fully realise their own nursing and educational tasks, and sometimes they even lose the contact with the child altogether. The death of the child adds to their difficult experience. The range of the different experiences of the grandparents of a terminally ill child is vast and its full description trespasses the scope of this paper. It constitutes the starting point for empirical research, expanding and verifying the understanding of the issue presented above.

The grandparents, in order to be able to function correctly, ought to be provided with the support that is able to satisfy their needs. By virtue of such support, the system of the family with a sick child is reinforced. Among the actions taken by the support team, there ought to be actions providing support for the eldest members of the family with respect to their emotional, spiritual and religious, social or informative state. An important postulate is improving intra-familiar communication. It seems that an adequate realisation of hospice support may effectively strengthen the grandparents and allow them to fulfil their roles, despite the factors that disrupt the functioning of the family system. It may affect the improvement of the quality of life of the sick child, its family, and cause the grandparents to experience their elderly years with more ease.

References

1. Brzezińska M.: Proaktywna starość : strategie radzenia sobie ze stresem w okresie późnej dorosłości. Difin, Warszawa, 2011.
2. Hansen M. V.: Najlepsza reszta życia., Poznań: W Drodze, 2007.
3. Leszczyńska-Rejchert A.: Człowiek starszy i jego wspomaganie – w stronę pedagogiki starości. UWM, Olsztyn, 2010.
4. Pikuła N.: Etos starości w aspekcie społecznym. Gerontologia dla pracowników socjalnych. WAM, Kraków, 2011.
5. Steuden S.: Szczęśliwi po pięćdziesiątce. Rzeczpospolita, 2009, 84, 86.
6. Wiśniewska-Roszkowska K.: Starość jako zadanie. Pax, Warszawa, 1989, 102, 100-101.
7. Irek W.: Koniec czy początek? Szkice o godnym starzeniu się i umieraniu. PWT, Wrocław, 2009.
8. Harwas-Napierała B., Trempała J.: Psychologia rozwoju człowieka. vol 2., PWN, Warszawa, 2000.
9. Brzezińska A. I.: Dziadkowie, rodzice i dzieci: o relacjach miedzy pokoleniami. Remedium. 2013, 2, 1-3.
10. Jan Paweł II: Adhortacja apostolska „Familiaris consortio" (22.11.2981). Available from: http://www.vatican.va/holy_father/john_paul_ii/apost_ exhortations/documents/hf_jp-ii_exh_ 19811122_familiaris-consortio_pl.html [cited: 15.03.2014]
11. Centrum Badań Opinii Społecznej: Rola dziadków w naszym życiu (01.2012). Available from: http://www.cbos.pl/SPISKOM.POL/2012/K_008_12.PDF [cited: 16.03.2014].
12. Pakuła M.: Trudne sytuacje życiowe a poczucie szczęścia w fazie starości. [In:] Zagrożone człowieczeństwo, vol 2: Obszary zagrożeń człowieka w realiach

współczesności. Kantowicz E., Orzechowska G. (eds.). Impuls, Kraków, 2012, 207-227.

13. Waechter E. H.: The Adolescent With Life-Threatening Chronic Illness. [In:] The Child and Family Facing Life-threatening Illness. Krulik T., Holaday B., Martinson I. M. (eds.), Philadelphia: J. B. Lippincott Co, 1987, 190-209.
14. Szczeklik A.: Kore. O chorych, chorobach i poszukiwaniu duszy medycyny. Znak, Kraków, 2007.
15. Binnebesel J.: Opieka nad dziećmi i młodzieżą z chorobą nowotworową w doświadczeniu pacjentów. UMK, Toruń, 2003.
16. Antoszewska B.: Dziecko z chorobą nowotworową – problemy psychopedagogiczne. Impuls, Kraków, 2006.
17. de Walden – Gałuszko K.: Problemy psychiczne, duchowe i etyczne [In:] Pielęgniarstwo w opiece paliatywnej i hospicyjnej. de Walden – Gałuszko K., Kaptacz A. (eds.). PZWL, Warszawa, 2008, 194-221.
18. Godawa G.: Wsparcie psychopedagogiczne rodziny dziecka w cierpieniu wszechogarniającym realizowane w warunkach hospicyjnych. An. Cracov. 2011, 43, 43-58.
19. Makselon J.: Główne wątki badań tanatopsychologicznych. [In:] Człowiek wobec śmierci. Aspekty psychologiczno-pastoralne. Makselon J. (ed.), PAT, Kraków, 2005, 49-60.
20. Harris A., Curnic S.: Care in the Community. [In:] The Child with Cancer. Family-Centred Care in Practise. Langton H. (ed.), London: Bailliere Tindall, 2000, 291-310.
21. Parent Project Muscular Dystrophy. Rodzina –podstawowe informacje. Available from: http:// http://parentproject.org.pl/index.php/dmdbmd/podstawowe-informacje/rodzina. [cited: 18.03.2014].
22. Rogiewicz M., Paczkowska, A.: Rodzina przewlekle chorego dziecka. [In:] Przewlekle chore dziecko w domu. Poradnik dla rodziny i opiekunów. Binnebesel J., Bohdan Z., Krakowiak P., Krzyżanowski D., Paczkowska A., Stolarczyk A. (eds.), Fund. Hosp. Gdańsk, 2012, 221-238.
23. Aldridge J.: Jak żyć z poważnie chorym dzieckiem. WAM, Kraków, 2008, 114.
24. Seyda B. A., Fitzsimons A. M.: Infant Deaths. [w:] Children's Encounters With Death, Bereavement, and Coping., Corr C. A., Balk D. E. (ed.), Springer Publishing CO, New York, 2010, 83-107.

25. Davies B., Worden W., Orloff S. F., Toce S.: Bereavement. [In:] Palliative Care for Infants, Children, and Adolescents. Carter B. S., Leventown M. (eds.) JHU Press, Baltimore, 2006, 196-219.
26. Dominica F.: Just My Reflection. Helping Parents to Do Things Their Way When Their Child Dies., London: Darton, Longman and Todd, LTD, 1997.
27. Goldman A.: Care of the dying child., London: Oxford University Press, 1994.
28. Stevens M. M., Rytmeister R. J., Proctor M-T., Bolster P.: Children Living With Life-Threatening or Life-Limiting Illnesses: A Dispatch From the Front Lines. [In:] Children's Encounters With Death, Bereavement, and Coping. Corr C. A., Balk D. E. (eds.), Springer Publishing Company, New York , 2010, 147-168.
29. Opalach C.: Rodzina z osoba terminalnie chorą. [In:] Psychologiczny wymiar cierpienia. Teoria i badania. Kalus A., Krok D. (eds), WTUO, Opole, 2007, 39-49.
30. Winch B.: Możliwości wsparcia rodzin podopiecznych hospicjum w trakcie choroby ich bliskich i w żałobie. [in:] Chore dziecko – chora rodzina. Holistyczne opieka nad terminalnie chorym dzieckiem i jego rodziną. Materiały konferencyjne. Gdańsk, 2010, 9-12.
31. Ashby M., Mendelson D.: Family cares: ethical and legal issues. [In:] Family Carers in Palliative Care. A Guide for Health and Social Care Professionals. Hudson P., Payne S. (eds.), Oxford University Press, Oxford , 2009, 93-111.
32. Krakowiak P., Paczkowska A., Janowicz A., Sikora B.: Sztuka komunikacji z osobami u kresu życia. Poradnik dla profesjonalistów i opiekunów nieformalnych – rodzin i wolontariuszy. Fund. LP, Gdańsk, 2013.
33. Maciarz A.: Psychoemocjonalne i wychowawcze problemy dzieci przewlekle chorych. Impuls, Kraków, 2001, 41.

Sivakova Svetlana Pavlovna, Naumov Igor Alekseevich, Aleksandrovich Aleksandr Sulejmanovich

Medico-social aspects of the relation of medical staff to problem euthanasia

Education establishment «Grodno State Medical University», Grodno, Republic of Belarus

Introduction

Now the euthanasia is one of the major and most discussed problems of bioethics in medicine [1,2].

The euthanasia means both active and passive actions of the medical worker, which accelerate process of offensive of biological death of the patient. So, for example, a passive euthanasia (differently – «the method of the postponed syringe») assumes the termination of rendering of the medical aid referred on prolongation of a life of the patient. As an active euthanasia («a method of the filled syringe»), in turn, understand introduction to the patient of any medicinal or other agents, and other actions involving fast and painless offensive of death [3]. Thus, the euthanasia affects the right to a life as one of fundamental laws of the person [4].

In a society and among medical staff the relation to an euthanasia is ambiguous: from categorical aversion both active, and passive its forms, to a recognition of legitimacy of carrying out by its physicians [5]. So, for example, according to sociological interrogation, supporters of euthanasia in the Netherlands make 92 % as it, ostensibly, promotes the termination of «intolerable sufferings» the patient [6]. Opponents of euthanasia base the opinion that the term «intolerable sufferings» is very subjective, and, hence, on this basis it is impossible to solve destiny of the patient [7]. Besides, opponents of a euthanasia often lean and against morally ethical aspect of the given problem [8]. Therefore, from the point of view of Christian morals, the euthanasia cannot be applicable or justified, as encroaches on the human life given by the God. Thus, the euthanasia is represented as the certificate of deliberate deprivation of a life of the patient even if the request proceeds from it. Besides, according to church, nobody can demand from medical staff to make murder of the patient to straight lines or indirectly [9].

In many countries, the euthanasia is recognized legislatively [10]. Thus, however, conditions of its carrying out are specially stipulated. The first – the euthanasia should be voluntary, the second – only the doctor can carry out it, the third – the condition of the incurable patient should be the extremely serious [10].

Besides, in many countries, despite an existing interdiction, the euthanasia practices illegally at the tolerant relation of the authorities. Thus, the given processes in some cases get uncontrolled character and leads to abusing [11]. Not casually therefore, that medical staff, as a rule, aspire to keep the information on an euthanasia a secret: admit it only 2,59 % of experts in the Netherlands, 0,3 % – in Belgium, 0,27 % – in Switzerland [12].

In republic of Belarus the euthanasia is legislatively forbidden, and for conservation a life of the patient has the corresponding rights: on reception of the information on a state of health, diagnostic possibilities and degree of risk of applied methods of treatment, on confidentiality of rendering of medical aid and medical secret, on the information concerning quality of medical aid and observance of standards of health services. The right of the patient to the consent or refusal of a medical intervention is besides, legislatively fixed. In a case of disturbance of these rights the law provides the responsibility of medical staff providing, including, and compensation of the put injury to health of the patient at medical aid rendering [1,13]. Nevertheless, despite legislative prohibition, the relation of medical staff of the country to euthanasia remains not studied problem that defines research urgency.

Research objective: studying of priority medico-social aspects of the relation of nurses and students of medical college to euthanasia problem.

Materials and methods

The sociological method of research is applied. With application of the questionnaire developed by us the relation to euthanasia nurses the organizations of public health services of Grodno (209 persons), and students of the second year of the Grodno state medical college, trained on a specialty «Sisterly business» (110 persons) is studied.

The age structure interrogated nurses was the following: till 29 years – 62,9 %, from 30 till 49 years – 30,7 %, at the age of 50 years also are more senior – 6,4 %. The age of students of medical college made from 18 years to 21 years.

Results are processed with use of a package of applied programs STATISTICA 6.0.

Results

It is paradoxical, but about euthanasia 32.2 % of students of medical college and only 27,9 % of nurses which had the appreciable experience of work with patients had correct representation only. And in both groups among wrong answers about essence of euthanasia the following (totally more than 70 % of such answers) prevailed: «suggestion to the patient of serious thoughts», «the pessimistic relation of the patient to a life», «suicide», «death from mistakes of the medical personnel».

Apparently, absence of representation about euthanasia was defined at respondents by that they did not consider the given problem actual for the Belarus society, demanding the prime decision and an intervention from the state (more than 70 % of answers in both groups). And, nurses assumed (84,7 % of answers), that the majority of people because of presence at them more «essential» problems and low legal culture do not reflect on such questions as an euthanasia or the rights of seriously ill patients of patients. Moreover, 15,7 % nursesи in general heard nothing 39,3 % of students of medical college about discussions in mass media about the possible rights of some categories of patients to premature death.

On a question: «As you understand an active euthanasia?», more than 50 % of respondents of both groups could not give the answer. Thus the most frequent answers were: «To the patient give a poison» (nurses – 46,4 %, students of medical college – 38,3 %) and «The doctor solves independently, disregarding opinions of the patient, to treat it or not» (nurses – 42,7 %, students of medical college – 36,9 %). About an active euthanasia 26,1 % of students of medical college and 38,9 % of nurses had correct representation only. Still smaller there was a share of the respondents who have made accurate definition of a passive euthanasia: among nursesих a specific gravity has made 7,7 %, among students of medical college – 6,8 %.

Low level of knowledge in this problem, apparently, was defined by that circumstance, that in medical college in this problem is not studied. Therefore, the majority of respondents have received the information on an euthanasia from mass media. The lead interrogation has shown, that the basic sources of reception of the information about the euthanasia is the following: telecasts (for 51,9 % of students and 66,8 % of nurses); articles in newspapers – for 35,3 % of students and 41,1 % of nurses; the information from friends and relatives – for 12,6 % of students and 14,1 % of medical staff; the Internet – for 5,6 % of students and 1,9 % of nurses.

Apparently, the knowledge disadvantage played a key role and in incomplete the generated personal relation nurses and students medical college to euthanasia problem. So, 28,5 % – at the age of 30–49 years were at a loss with the answer to this question of 29,4 % of medical workers aged till 30 years, and also almost all nurses aged are older than 50 years. Because among students this indicator has made 73,7 %, and 9,1 % of respondents at all have not answered this question, we had been analyzed the relation to euthanasia only among nurses.

13.5 % of nurses are established, that only, being based on religious beliefs, did not consider possible carrying out of an euthanasia under any conditions. At the same time accepted the right of the patient to premature death of 65.2 % of medical workers. And, them all them have noticed, that the euthanasia can be applied only at legal security of the patient and only under condition of the rigid control over carrying out of this procedure.

As basic «indications» for carrying out of euthanasia by respondents the following has been defined: «the conscious and persevering request of the patient» – 17.9 %, «the remediless forecast of disease or exact and doubtless validity of impossibility to salvage the patient» – 10.1 %, «intolerable sufferings of the patient» – 9.9 %. And 24.6 % of medical workers have answered, that only set of these conditions can become the main argument for euthanasia carrying out. Appreciable variability of answers and a low specific gravity even their basic variants in structure «conditional indications for an euthanasia» in addition testifies to absence of the accurate and developed representations on given to a question among nurses.

Conclusion

Thus, the received results testify that the euthanasia problem has difficult and ambiguous representation in public consciousness, and the age and education of respondents make on the relation to it the expressed impact. In this connection, it is necessary to form even in the course of training at future nurses a civil liability and understanding of the high importance of a human life.

References

1. Bogomjagkova E.S.: Euthanasia as a social problem. Jour. invest. soc. Politics, 2010, 8, 32–34.
2. Tchernyshev J.A.: Euthanasia: the past, present, future. The law and the right. 2008, 5, 54–59.
3. Sabirov V.Sh.: About world outlook bases of modern western thanatology. Person. 2002, 5, 99–111.
4. Millard D.U.: Euthanasia: debate in Britain. Soc. Clin. Psychiatr. 1996, 4, 107–109.
5. About public health services: Law Rep. Belarus from 20.06.2000 №363-z the Adviser Plus: Belarus. Technology 3000 [The electron resource], Open Company «UrSpectr», Nat. The centre a legal inform. Resp. Belarus. – Minsk, 2006.
6. Salnikov V.P. Starovojtova O.E.: Euthanasia: pro and contra. The Legal world. 2005, 3, 42–48.
7. Palkina T.N.: Problem of realization of the right to a life. Soc. and a pens. provision.

2008, 4, 5–11.

8. Kurtts P.: Ethics of humanism. P. Kurtts; the transl. from English I.V. Kuvakina. – Ed. 2, – M: Rus. human. society, 2002, 189.
9. Kapinus O.S.: Light death or soul salvage? Theology and euthanasia problems. The Law, 2005, 6, 106–113.
10. Krylov N.E.: Euthanasia: criminally-legal aspect. N.E. Krylov, Vest. Moscow State University. – S. 11. – The right. 2002, 2, 17–36.
11. Declaration on the Promotion of Patient's Rights in Europe. – Copenhagen, WHO. Regional Officefor Europe, 1994 (document ICP HLE 121).
12. Kapinus O.S.: Euthanasia as the socially legal phenomenon. M: Bukvoved, 2006, 400.
13. Agievets, S.V.: Theoretical of a problem of legal adjustment of medical aid: Monographies / S.V. Agievets. – Grodno: GrStU, 2002, 68.

Wróblewska Izabela, Zawierucha Elżbieta, Błaszczuk Jerzy

Decubitus wounds care in lying elderly patients - own research

Nursing Institute, State Medical Higher Professional School in Opole

Intoduction

The term bedsore (Latin *decumbo*) means *"to lie down, fall to the ground"* indicating the cause of this type of wound. They can consist of the skin, subcutaneous tissue, muscle and bone damage. They most often arise in areas of the body where the skin covers the bony eminence (the retaining points the skeleton) [1]. Decubitus is damage to the skin presenting as an ulcer. The main cause is tissue ischemia due to pressure, friction, trauma, shear forces, infection, poor care, moisture and skin diseases. The first stage is characterized by redness, followed by ischemia, and ultimately tissue necrosis. There are three types of compression in the mechanism of the formation of pressure ulcers. Simple pressure, rubbing the surface of the body with linen, lateral tensile forces and shear [2]. The changes occur in areas unsuitable for compression and exposed to constant pressure mostly caused by prolonged immobilization. The most common places for pressure ulcers formation are the heel, near the sacrum and trochanters, which is the result of the customary laying sick on his back. Depending on the criterion several types of pressure ulcers can be distinguished. They can be: ordinary, atherosclerotic, terminal, in the formation stage, epidermal (surface), dermal, dermal-subcutaneous, subcutaneous, total, old, fistula [3].

It is estimated that up to 60-70% of all pressure sores occur in patients older than 65 years. In this group accumulation of causal factors in the form of disturbances of consciousness, permanent or temporary immobilization, paralysis, paresis, poor nutritional status, urinary incontinence and bowel, emaciation/overweight/obesity, dehydration, anemia, atherosclerosis, changes in biochemical composition of the blood, diabetes and fever, can be expected. Multi-factor and the complexity of the formation and treatment of pressure ulcers is a serious problem for medicine [4].

Pressure ulcers are described according to the established classifications which determine their severity, depending on the appearance, size and depth. For this purpose gradually scales have been established (Torrance, Enisa and Sormiento, Shea, Yakoniy'ego and Kirk Seiler, Guttman, Campbell, color scale, classification by the Department of

Palliative Care in Poznan), which are responsible for the description and evaluation of the wound. They allow for an appropriate choice of dressings also [4,5]. Identification of patients at high risk and determination of the causes and factors that contribute to the sore formation is the responsibility of nurses. It is enhanced by the use of risk scores. Appropriate assessment and the use of risk rating questionnaire allows to increase the effectiveness of nursing actions. Quick and appropriately respond to signs of the formation of decubitus wounds allows for the proper use of appropriate projects to prevent the development of pressure ulcers. That's why education in recognition and protection methods against these changes is so important for the sick people and their caregivers and medical personnel also. In the field of nursing set of standards in prevention of pressure ulcers was published as a relevant recommendation of the National Consultant. They describe in detail the procedures to be implemented in order to avoid complications [3].

The aim of the study was to investigate opinion of nurses' dealing with elderly patients lying and suffering from sore wounds about the most effective methods of care.

Material and methods

The study was conducted in the region of Opole Caritas, which includes 9 stations of care and 8 rehabilitation offices where employees are nurses and physiotherapists. The study included 66 (100%), community nurses, long term care and home hospice-palliative care exercising comprehensive home-care of the elderly patients with pressure ulcers. They were women aged 30 to 60 years (mean age 38.24 ± 7.53). 36 (54%) of them had college education and 30 (46%) university level.

Anonymous self-prepared questionnaire consisting of two parts was used. First comprised anthropometric data and second 13 closed questions concerning: the most common places of pressure sores occurrence, changing position of the patient, wound-healing environment, the most effective treatments according to the respondents, auxiliaries and pharmaceuticals, sources of information on modern methods of treatment and who should communicate this information to patients.

Results

Responders answered that the most vulnerable place to the formation of decubitus wound are in the order occurrence: the heel (25, 37.87%), followed by the spine (18; 27,27%), lateral femur (11, 16,66%), the scapula (7 , 10.60%) and the back of the head (5, 7.50% (Fig. 1).

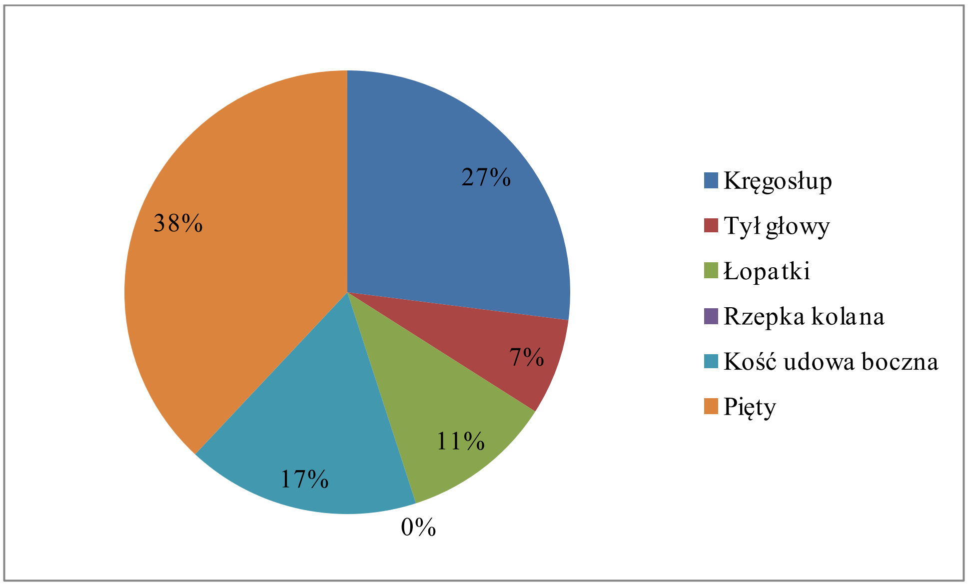


Fig. 1. Places on the patient body with the higher risk of bedsores formation.

All of the interviewed nurses indicated that the diet used in elderly patients with sore wounds affect their healing (66, 100%) with the 46 (69.69%) considered that the impact was significant, and 20 (30.30), that moderate. All our respondents (66, 100%) stated that protein diet is most beneficial for those people. None of the respondents indicated carbohydrate or fat diet. The majority of respondents (60, 90.90%) found that in order to avoid the occurrence of new and counteract the deepening of existing changes, the position of the patient to should be changed every 2 hours. 6 (9.09%) of the respondents said that the change should occur every 4 hours. None of the respondents indicated that the patient should change his position every 6 hours or that they do not know how often it should be changed.

Most of the surveyed nurses claimed that the pressure ulcers wound is healing better in a humid environment (60, 90.90%), 6 (9.09%) believe that the more favourable is dry environment. An overwhelming number of respondents considered that the most beneficial effect on decubitus wound healing has variable pressure mattress (58, 87.87%), water and static mattress were indicated by 4 (6.06%) individuals each. None of the surveyed indicated sponge mattress and antibedsore pipeline mattress. Nurses were also asked about the most effective means of the patient supporting and multiple answers were possible. Most respondents choosed the pads on the elbows and heels (48, 72.71%), 46 (69.69%) answered rollers and wedges, and 14 (21.21%) pillows. According to the respondents the best results of decubitus wound healing were observed after following pharmaceutical offered on the market. They are listed according to the efficacy: octenisept (52; 78,78%), 0,9% NaCl (12; 18,18%) and manusan (2; 3,03%). None of the nurses indicated response "rivanol" and "hydrogen peroxide". Respondents among treatments improving blood circulation listed: delicate massage (50, 75.75%), percussion (14, 21.21%) and the gentle rubbing of the skin with salicylic alcohol (2, 3.03). The nurses were asked to perform subjective assessment of the ulcer dressings used in the care of the elderly with bedsore. The largest number of respondents considered that the most effective are hydrocolloids then hydrogels, alginin dressings, semipermeable membrane, odor absorbing dressings and dekstranomers (Table 1).

Table 1. Assessment of wound dressings used in decubitus (several answers possibly)

Dressing type	Number	%
Hydrocoloids	56	84,84
Hydrogele	54	81,81
Alginin dressing	22	33,33
Semipermeable membrane	16	24,24
Odor absorbing dressing	8	12,12
Dekstranomers	4	6,06

The respondents were asked to answer which are the most common sources from which they derive information about the recent treatments for decubitus wounds. They reported in the order: training, specialised journals, internet, conferences and books (Table 2).

Table 2. Sources of information on the recent treatments for decubitus wounds (several answers possibly)

Source	Number	%
Training	62	93,93
Specialised journals	44	66,66
Internet	38	57,57
Conferences	28	42,42
Books	18	27,27

The largest portion of respondents (40, 60.60%) said that the doctor should provide the most information related to the treatment, diet and the prevention of the formation of decubitus wounds. In second place was the nurse (26, 39.39%).

Discussion

Despite advances in medicine pressure ulcers wounds are still a serious problem both nursing and therapeutic. This is the damage which is affected by several interacting factors together (immobilization, age above 65 years, coexisting disease, incontinence, infections, cachexia, poor hygiene, chronically used drugs and lack of proper care of the patient). The risk of developing pressure ulcers, determined by the prediction scale is greatest in the elderly [5]. Knowledge of the factors causing wounds contributes to the rapid assessment of the patient's condition and enables construction of proper treatment plan and carrying out of good care. So mental state, neurological, nutritional, physical activity and the efficiency of the sphincter of patients are estimated which is critical in the care of these individuals [3,6]. An important part of caring for people who are at risk or already suffer from bedsores is the use of appropriate methods of treatment and care. The adequate knowledge of caring for patients is therefore essential.

The study shows that in direct contact with patients are contact nurses, long term care nurses and home care hospice-palliative nurses. It is the staff who have secondary or higher education. Information about the recent treatment for decubitus wounds derives mainly from specialized training and medical journals. This demonstrates the high and the rich base of the knowledge needed for the care of patients combined with experience. It is important in case of home care for an elderly patient where the care is mainly aimed at pain relief, alleviation of suffering, both physical and mental health and support patients and their families [6,7]. Of great importance in the care of patients with bedsore is prevention. The information of the avoidance of uniform alignment, causing constant pressure should be given to the patient and his family. Systematic change of the patient position should be performed often in order to prevent the redness of the skin and therefore at least every 2 hours. One should also often check bed in order to prevent folds creation which may contribute to the formation of bedsores. Anti-bedsore equipment is helpful as it reduces the power of oppression and stimulates blood circulation. The range of static and dynamic anti-bedsore mattresses is available. The first is intended for patients with a low risk of developing pressure sores. Their function is to evenly redistribute body weight. However, they are quickly deformed and cannot be used for a long period of time. The second provide a variable compression of the part of the body, stimulating circulation and increasing the comfort of the lying patient. There are also bedsore cushion pads for elbows and heels, shafts and splines [8,9]. The respondents have knowledge about these measures and apply them in practice.

In the prevention of pressure ulcers it is important and appropriate to nurture the skin and massage particularly vulnerable to pressure places. The regularity in controlling the skin and its appearance is of utmost importance. It is advisable to eliminate the factors that lead to dry out or rewetting the skin and use gentle measures that do not irritate [10,11].

As is clear from our research respondents applied modern, commercially available preparations of care, massage, gentle patting and rubbing the patient's body. In addition to the above it is also important to use a proper diet, selected individually depending on the condition of the patient, so as to ensure an adequate amount of all nutrients, vitamins and trace elements. Protein deficiency should be prevented through the use of high protein diet. The nurses had a knowledge of the basic principles concerning nutrition of patients. They propose the diet basing on the frequent consumption of small amounts of protein, in particular animal. It is believed that proper diet has a significant effect on decubitus wound healing and the prevention effectively prevents their formation [2]. It is difficult to distinguish the most effective method of treatment of the pressure ulcers. They are divided into natural and pharmacological. According to the literature the most effective is combination of both methods increasing the effectiveness of actions [3]. Surveyed nurses working with patients suffering from bedsore wounds know and use in their work a number of natural treatments, as well as pharmacology. Among natural methods they describe the use of diet, frequent change of position of the patient, the use of auxiliaries, the most common are the elbow pads and heel rolls and wedges, as well as the use of mattresses. Such natural treatment as improving blood circulation of the skin by gentle massage is used by most of them. The results of the study are in this regard consistent with the analysis of the literature [5,6,7].

Most of the nurses surveyed claimed that moist environment has a positive effect on bedsore wound healing. This is consistent with literature reports, where it is noted that such an environment significantly accelerates the healing process [12,13].

The most common pharmacological treatment and recognized as the most effective disinfectant was Octenisept, most nurses used it at their practice. The most effective in the care of these patients were hydrocolloids and hydrogels.

Conclusions

Taking into account the results of the study it can be concluded that the elderly patients are under supervision of skilled and experienced nursing staff that knows and uses the latest techniques for the decubitus wound care.

Refernces

1. Machyńska-Bućko Z.: Odleżyny [w:] Leczenie ran trudno gojących się, Oszkinis, Gabriel, Pukacki i wsp. (red.), Blackhorse Scientific Publishers Ltd, Warszawa, 2006, 245-285.
2. Rosińczuk-Tonderys J., Uchmanowicz I., Arendarczyk M.: Profilaktyka i leczenie odleżyn, Wyd. Continuo, Wrocław, 2005.
3. Szewczyk M. T, Jawień A.: Leczenie ran przewlekłych, PZWL, Warszawa, 2012.
4. Szkiler E.: Poradnik pielęgnacji ran przewlekłych,Evereth Publishing Sp. z o.o.; Warszawa, 2011.
5. Krasowski G., Kruk M.: Leczenie odleżyn i ran przewlekłych, PZWL, Warszawa, 2008.
6. Krakowiak P., Krzyżanowski D., Modlińska A., Przewlekle chory w domu, Fundacja Lubię Pomagać, Gdańsk, 2011.
7. Krzyżanowski D., Śniechowska-Krzyżanowska E., Fal A.M.: Pielęgnowanie chorego z ranami przewlekłymi, Fundacja Hospicyjna, Gdańsk, 2010, 163-174.
8. Krysiak I.: Odleżyny, PZWL, Warszawa, 2008.
9. Wieczorowska-Tobis K., Talarska D.: Geriatria i pielęgniarstwo geriatryczne. PZWL, Warszawa, 2008, 312-318.
10. Ślusarska B., Zarzycka D., Zahradniczek K.: Podstawy pielęgniarstwa, Czelej, Lublin, 2008.
11. Widomska-Czekajska T., Górajek-Jóźwik J.: Encyklopedia dla pielęgniarek i położnych, PZWL, Warszawa, 2010.
12. Sepioło A., Mroczek B., Modrzejewski A.: Nowoczesne metody leczenia ran w opiece środowiskowej – opis przypadku, Family Fam. Med. Prim. Care Rev., 2012, 14, 91–96.
13. Szewczyk M., Sopata M., Jawień A., i wsp.: Zalecenia profilaktyki i leczenia odleżyn. Lecz Ran, 2010, 7, 79–106.

Antoszewska Beata, Bartnikowska Urszula, Ćwirynkało Katarzyna

Death as Perceived by Adult Children Caring for Aging Parents

Department of Special Education, University of Warmia and Mazury in Olsztyn

Introduction

> *"Those whom we support hold us up in life"*
> *Marie von Ebner-Eschenbach*

Death is an inherent element of life on Earth and this will probably always be so. We will die. All of us – we are perfectly aware of this. We do not know, however, when and how. People generally tend to shove away any thought of death, because death induces negative feelings such as grave sadness, anxiety, fright. "We try to survive confronted with transience; we try to retain by all means the appearances of youth, clinging to this life" [1].

It is undeniable, as frequently noted, that the moment of birth marks the beginning of the process of dying.

Cackowski [2] remarks that human drama is basically rooted in the bonds connecting human life with that of other people's, in the relationships within the human world, in separations and partings. The stronger the bonds with people and the human world are, the greater this drama. Bauman [3] comes to similar conclusions and emphasizes the devastating and painful effect of human death on others, while not disturbing the continuity of perception of those who remain alive. The author indicates that one can be much more terrified of the death of a relative or close friend than of one's own, because inevitably such death is followed by a period of "specific nothingness and emptiness caused by the passing away of the beloved one...", and the person who remains alive is fully aware of this.

Literature dealing with this subject reports a view that the death of an elderly person appears to be a normal event: "In the cycle of human life it is natural, because of generational change – older people pass away, the younger ones remain" [4]. However, if one investigates relationships and bonds between adult children and their parents, such a situation is not emotionally easy to deal with. When a child is born, he or she occupies a specific place in the family and creates a strong, sometimes surprisingly strong bond with his or her parents. The connection between parents and children is in its essence unbreakable and always present. Mother and father always remain exceptional persons for their children [5]. The prospect of losing a parent with whom one is so closely linked is an extremely difficult experience that deprives an adult of any support [4]. *"Father will always remain in my memory as a "traveller". For me, especially when I was small, it was one of the biggest sacrifices to allow him to go away with my mother. But the moment when we could be together again, the waiting, fear and the feeling of being abandoned were as if erased"* [6].

A parent's death re-organizes one's life and way of thinking; it enforces the closure of one's "history" as a child – because with no parents, one is no longer a child.

Poland is one of the countries in which strong family ties can be observed. Caring for an elderly, ill or disabled person takes precedence in the activities undertaken and carried out by the family [7]. Results of the research conducted within the framework of the DIALOG Population Policy Acceptance Study (PPAS) project demonstrated that Poles most frequently indicated children as care takers of aging parents (90.1%). Almost 85.1% of the respondents declared a willingness to live together with their elderly parents. Among the researched populations, Poles most frequently expressed the opinion that the elderly should live in their family homes in order to be taken care of by their children or relatives (60.2%) [8].

A decision to care for an elderly, lonely or ill parent is never easy. The current situation in the country, difficult access to nursing homes and problems connected with maintaining a well-paid job are not conducive to providing such care. However, there exists a group of adult children who by all means undertake the task of providing care at home and refuse to place a parent in an institutional care framework.

Caring for one's aging, ill parents is in many cases a significant emotional and physical burden. "There are people who are ready for unbounded sacrifice. (...) Many (...) task-oriented individuals stubbornly sustain fading life, dress putrefying wounds and search for some sparkle in the parent's eyes confirming that it makes sense (...)" [9].

It is easier, however, to come to terms with a parent's passing away and end the relationship when one feels that one did whatever was possible to be done and consequently it is then easier to go through grieving [10].

Disease, disability and awareness of a parent's imminent death place children in a completely new situation. Internal dilemmas appear:

1. Growing accustomed to the awareness of a parent's imminent death versus the denial of this awareness,
2. Desire to be close versus inclination to escape from a dying parent [10].

In the modern world the belief in need for the authentic human life and creating for a dying person conditions for a dignified death become more forcefully expressed. In this context authenticity means genuineness, courage to face what is inevitable in life and what must come [11]. This companionship is also significant for children who have for a long time provided care for their ill and disabled parents.

Materials and methods

Research focused on dying and death as perceived by adult children caring for disabled / ill parents. The research question was formulated as follows: How do the subjects describe the issues connected with death and dying?

Due to the uniqueness of the research field and a specific research group, the research procedure was based within the interpretative paradigm and a qualitative approach was employed. Data was collected via interviews focused on respondents' subjective theories, whereas data analysis was based on the phenomenographic approach [12] with elements of grounded theory according to Kathy Charmaz [13] (2009). Considering the phenomenographic approach, it was important to adhere to the second-order perspectives, that is descriptions of human experiences [14] and determining various ways of understanding or experiencing different phenomena [15]. Grounded theory provided the source of inspiration in the process of coding. These codes were not pre-established, but emerged from the utterances of the subjects [13].

The inclusion was targeted and conducted according to the following criteria: 1) age of majority, 2) caring for an ill or disabled parent for at least 6 months, 3) consent for being included in the research.

The research group consisted of 13 individuals (12 females and one male) who provide care for their parents (including parents-in-law). The feminization of care giving is easily discernible in the research group [7], which means that the major caregiver is usually a female (daughter, wife, daughter-in-law).

As regards parents' disabilities / diseases, they most frequently included: physical disability (5 cases), serious memory deficiencies (5), vision impairment (5), hearing impairment (2) and serious chronic diseases: Alzheimer's disease (4), cardiovascular diseases (3), gastrointestinal disorders (2), psychiatric disorder, condition following cerebro-vascular incident and others. In the majority of cases (9) a parent's disability or disease has lasted for at least 5 years, in the remaining cases: 2-5 years (3 individuals) or nearly one year (1). The period of nursing aging parents is similar among the respondents. The age of the caregivers ranges from 42 to 65 years, and the nursed parents from 65 to 100 years. As regards marital status, the majority of the respondents are married (9 females), the remaining ones are divorced (3), and the male caregiver lives in a cohabitation. All caregivers have children: most frequently two (5 individuals), rarely more (4) or one (3). They assess their financial situations as good (8), rarely as very good (2), average (2) or difficult (1). Apart from three cases, the respondents live permanently with their parents. As regards employment, 6 subjects work professionally, 5 are retired, one receives disability pension. As for education, 5 subjects obtained higher education, 4 – secondary level or post-secondary school education, 3 – vocational, 1 – elementary. The following codes to differentiate among the respondents were used in the research analysis:

- F 1 – female, 45, higher education, divorced, employed as a teacher, lives in a detached house in a village with her daughter (18) and mother who suffers from vascular disease, malignant breast cancer and additionally such medical conditions as: hearing impairment, progressive vision impairment, mobility difficulties and others;
- F 2 – female, 48, higher education, married, has two children (16 and 23), lives in a detached house in a small town, caring for her 73-year-old mother-in-law for 5 years;
- F 3 – female, 61, secondary level education, retired, married, has two adult children, caring for her 91-year-old mother with Alzheimer’s disease for 14 years, lives in a flat in a small town with her husband and mother;
- F 4 – female, 58, higher education, employed (presently on health leave), lives in a small town in a newly-built detached house with her husband and (for the last 3 years) 87-year-old mother suffering from autoimmune hepatitis, has three adult, independent children;
- F 5 – female, 47, vocational education, does not work professionally, lives in a detached house in a village with her child, for the last 6 months caring for her 71-year-old father suffering from chronic diseases (asthma, heart disease, lower-extremities problems), who lives in the same village;
- F 6 – female, 49, vocational education, does not work professionally, lives in a detached house in a village with adult children (3), husband and 82-year-old mother who is bed-ridden following a cerebro-vascular incident;
- F 7 – female, 42, vocational education, employed as a cleaner, lives in a small town with her 65-year-old mother (suffering from paranoid schizophrenia), husband and 2 children; additionally provides care (though not so intensively) to her father (amputated lower extremities);

- F 8 – female, 59, post-secondary level education, retired, divorced, lives in a two-room flat in a small town with her 91-year-old mother who suffers from various diseases (e.g., heart disease – implanted pacemaker, hypertension, thrombosis, underwent several surgical interventions, additionally has cataract, hearing impairment, osteoarthritis);
- F 9 – female, 59, higher education, retired but still working professionally, has two adult children who live independently, lives in a flat in a small town with her physically disabled 86-year-old mother (wheel-chair bound for years), the respondent herself has a significant level of disability (due to rheumatoid arthritis, vision impairment);
- F 10 – female, 63, elementary education, has 4 adult children, caring for her 100-year-old mother-in-law with Alzheimer's disease, lives with her and her husband in a detached house in a village, owns a farm;
- F 11 – female, 65, higher education, caring for her 93-year-old mother who has been physically disabled for 10 years (moves with difficulties, with the walking frame), has an implanted pacemaker, impaired vision and is incontinent; lives in a detached house in a small town with her husband and mother;
- F 12 – female, 62, secondary level technical education, receives disability pension (due to a significant level disability – vision impairment), lives in a flat in a city with her husband, for 5 years provided care (together with her two siblings – mother lived for 2 months with each of the siblings in turns) to her presently 83-year-old mother who has hypertension, diabetes, osteoporosis, venous thrombosis and Alzheimer's disease, for about last 5 years the mother has lived in a nursing home, and Urszula – due to her own disability – only visits her there;
- M 1 – male, 43, secondary level education, works professionally, divorced, lives in a cohabitation, providing care for 10 years to his seriously ill, bed-ridden adoptive father (83), lives partially in his own flat, partially with his father in a city.

Results

The analysis of the conducted interviews demonstrated two major themes in which issues concerning death and dying emerged: 1. parent's death (closer, real perspective), 2. one's own death (distant, future perspective). Thus these major concerns fall into two categories: (1) death/ dying/ the final stage of a parent's life; (2) references to the image of the end of one's own life. Other sub-categories included: place, conditions/ circumstances, human usefulness, uncertainty and inevitability as well as the meaning of death.

Within the category of "place," the considerations and dilemmas of the respondents mainly involved home versus institution (most frequently termed nursing home, old people's home, peaceful old age home). Home was frequently characterised by the respondents as definitely the best place where a human life could end. This is consistent with the results of the research reported in the publication entitled "There comes old age – social policy versus preparation for population aging in Poland." The respondents ranging in age from 45 to 65 years old, most often indicated children as those who could secure the best aid to the elderly. Equally frequently (87.3%) the respondents pointed to wife/ husband (partner) as those individuals who can provide support. Research devoted to the life situation of old people (65+) demonstrates that 70% would never want to live in a nursing home, whereas 22% considered such a possibility, but would actually treat it as the last resort. Aversion expressed with reference to such institutions stems from perceiving them as places for the poorest, who cannot cope with their lives, who are rejected by family or excluded from society [8]. On the other hand, *Report on the social development Poland 1999. Towards dignified, active aging* indicates that the most desirable model is that of living close to children but separately. Simultaneously parents expect from their children aid in case of disease or other difficult life situations. This demonstrates the importance of lasting and strong family ties [8].

The respondents of our research discuss the choice of "home versus institution" in the context of multiple conditions, with two groups being most significant. One refers to the parent, the other to the child caring for the parent. The following table summarises the major issues in this regard (Table 1).

The conditions relating to the parent as the charge include mainly: physical and mental health, adaptive difficulties, feelings and needs of the parent (who – according to the respondents – either requires specialist care that cannot be provided at home, or – conversely – most of all needs family home and warmth).

"For sure I wouldn't consider any nursing home. Definitely not, because I know mummy would feel bad there." (F1)

The second group of conditions relating to the child caring for the parent includes: physical strength (health), mental strength, feelings towards the parent, financial security, legal regulations (favourable or hindering as regards undertaking such care), possibility of obtaining support, lack of further responsibilities (e.g., providing care to other family members that requires a lot of time and labour). The following is an exemplary utterance that illustrates, on the one hand, feelings of the respondent towards her mother, and on the other – inflexibility of legal regulations making it impossible to further devote herself to care giving:

“Most of all I was broken by the news that I would have to work for such a long time (...) Generally I planned to take a health leave to be able to fully enjoy this mummy (...) I learnt that if someone has a farm (and this is, after all, the source of my upkeep, so what that I don’t grow [anything]), then it is impossible to take it [leave]” (F1).

Table 1

Place	Conditions		
		Referring to the respondent’s role of a caregiver	Referring to the respondent’s potential role of a charge
Family home	Referring to the charge:	- physical and mental health - limited adaptive skills - feelings (love, attachment)	- being “useful,” needed, - physical and mental health
	Referring to the caregiver:	- physical health - mental resistance - ability to combine providing care with other responsibilities / availability - possibility to obtain support - favourable legal regulations - desire to maximally use the time with the dying person - the feeling of obligation towards the parent	- willingness of children to care for the respondent in the future
Institution	Referring to the charge:	- worsening health condition of the parent, - parent’s cognitive functioning: lack of consciousness / memory deficits	- being “unuseful” - financial means to use institutional care - reluctance to burden one’s own child
	Referring to the caregiver:	- legal regulations unfavourable to home care, - other responsibilities (professional work, taking care of children) - lack of strength, poor health, disability that hinders, limits or makes it impossible to care for the parent, - insufficient external help, - finding a good (fulfilling the parent’s needs) institution	- legal regulations unfavourable to home care, - children’s involvement in professional careers, - insufficient external help

Source: own research

The smaller the number of the fulfilled conditions, enumerated above, that facilitate the decision to nurse the parent, the greater the willingness to use indirect solutions (e.g., external help) or institutional care.

"I would more see to it that someone for instance moved to us. So that mummy is in the same place. For mummy it is difficult to even change the room in the house" (F1)

"I know that when it's really bad with mum, then physically I won't deal with everything because it's hard 24 hours a day. Then I'll try to arrange that someone is here during the day" (F4)

"It also depends on how I will feel because I can get ill (...) I wouldn't want to give her away. This would be the last resort. Maybe my mind won't cope. Sometimes I had such days when I thought I wouldn't deal with it anymore" (F3)

"When she was cut off from home, it was as if she was switched off from electricity" (F3) – a description of experiences related to a friend's mother, yet illustrating the effect of placing an elderly person in an institution and the concern that such a situation arises.

The respondents' statements mirror some features significant for organizing home care as described in literature. These are:

1. Family structure, presence of a person /persons who can fulfil the role of a caregiver;
2. Health condition and physical condition of family members;
3. Having time to provide care, home and external roles of family members;
4. Financial situation;
5. Living conditions;
6. Emotional situation, family ties and motivation to provide care as well as the degree of acceptance of the role of a long-term caregiver;
7. Knowledge and skills to provide care [7].

The respondents' utterances also uncover the issue of assuming new roles: the respondent takes over the role of the parent (who now requires support), assuming the parent's previous role of a care-provider, whereas the parent assumes the role of a charge, and the respondent anticipates that in the future he or she will also require support, thus his or her children will assume the role of caregivers. Considering the present experiences, this notion becomes real and emerges naturally.

"My children will also take care of me if it's needed. Since their childhood I've been teaching them that caring for the elderly is very important" (F2)

"If I'm taking care, so someone will take care of me, because children watch, children visit

(...) They see every day what work this is and what it means, and how much devotion and patience is needed, so I think that some day they will return the same towards me." (F10)

This situation seems to be analogous to the one in which the parent has found himself or herself, but there appears one, major differentiating factor. The respondents do not consider the parent's situation within the context of "usefulness" ("being needed"). However, they relate their own placement in a family home or institution during the final stages of their life to this condition being fulfilled.

"I wouldn't want to live so many years that children would look after me (...) If there was a need like that, if I had a mind like my mum who is now completely spaced out, I think it would be better if I were in such a [nursing] home. Because it's a big effort... Big effort for children. Really very big. Why should they exert themselves? Each of us has one health and one life." (F3)

"Only not to be a problem to others, because it's so ... hard." (F4)

"I wouldn't want to be a burden to my children; I wouldn't want to be dependent on children." (F6)

"I suppose if I had financially secured myself, I would go to old people's home, for instance. Not to be ball and chain to anyone (...) If I had any diseases, I would want to spend my old age in such old people's home. If I were physically healthy till the end of my days, then of course at home, with my children, because I would be simply helpful. This would be actually quite a good solution." (F7)

"I wouldn't want – looking at what is happening with me – my children, and I have two, my children to have to be doing some day what I'm doing now (...) If I were to go somewhere and there would be such places, I would choose such a place as not to be a burden for the loved ones." (F8)

It is possible that their identities are shaped by the concept of "usefulness" if only in the role of a "useful employee" or "useful caregiver" of their own parents. Transition to the role of an "unuseful" charge is a difficult, unimaginable situation.

Only one individual out of all respondents accepts the idea that in the future children will provide care for her:

"Of my future (in the sense of old age) I don't think. I try to keep physical and mental health, to be independent as long as possible and not to be a problem to anyone. Providing care by children enters the picture only when I am completely disabled. I would like to be close to them, so as not to feel lonely. Old age needs peace, intimacy, time for thinking [...] and doing

what you like doing and for what there was no time and conditions earlier. Fit old age is a time for making the dreams from youth come true." (F11)

The analysis of this statement indicates that although K11 also expresses unwillingness to "being a problem to others," she is different from other respondents in that she is much more attentive to her own needs (first – when still in a good condition – realizing her dreams, then – in case of becoming disabled – realizing her own need to be among relatives in order not to feel lonely) than (at least in this respect) to the needs of her children.

Another issue that emerges from these utterances is inevitability that refers both to health condition (its worsening in a long term perspective) and death (also including attempts to avoid it – issues referring to euthanasia) as well as roles taking over (the respondent in the role of someone who requires support, his / her child in the role of caregiver).

"The next must be (...) someday something worse will come, years don't go back, they go forward." (F4)

"I think she won't be able to move in some time..." (F6)

Along with the issue of inevitability, there appears the question of euthanasia that can be regarded as an attempt to avoid the inevitability of being bed-ridden and requiring other's support in the future.

"But who will look after me? Maybe some euthanasia will be permitted by then... It may be so. And I will additionally pay for it because it's private (...) I don't know how it will be." (M1)

The next category is that of uncertainty. The situation of our respondents is difficult to foresee. This refers, for example, to the parents' health problems, the moment when they die, the respondents' own possibilities (financial, physical condition) and relationships with others (partners, distant family, friends), that are also influenced by nursing their parents.

"This may be a year, half a year. And maybe even longer." (M1)

"How long this will last, this is unknown. I may pass away sooner. The doctor even told me so. She told me it's not known." (F3)

"I tell myself that perhaps I will not be like that, I will manage. But mum was also really brave... now it's different. That's why I don't know what will happen." (F4)

"I have no idea (...) I don't know how it'll come out." (F5)

"I don't know what will be next, maybe it will change. Because now it is... I treat it like my duty. I don't know what it will be like later." (F7)

"I don't know how long it'll last, what it'll look like. It just doesn't depend on me and I have

not the slightest influence on it, so I don't bother myself with it." (F8)

"My future I don't imagine as great. If my vision completely goes, I'll have to sit at home and be at my husband's mercy, but if my husband goes away, I can't imagine my life." (F12)

Almost all these utterances are linked by the category of uncertainty (of time, aftermaths, and one's own influence). Uncertainty appears almost in each context, with reference both to the parent's health, gradual passing away and future, and the respondent's own health and future.

<u>The meaning of death</u> is not explicitly expressed, but it can be indirectly detected in the utterances.

"I'm not afraid of her death. You shouldn't be afraid of a dead man, you may be afraid of the living one." (F3)

"My mother is terribly afraid of death. If anything happens, anything hurts – immediately massages, medications, doctors, specialists. She has become such a hypochondriac. She is afraid she'll die. I'm also afraid of her death; I prefer not to think of it, I would like always to be like it's now." (F8)

"The only thing I wouldn't want is to become a vegetable. This is probably the worst thing. When the body can't manage, and the mind still functions... Such a vegetable is the worst thing. The body – nothing, and you know everything, understand everything, so it's better for the brain to switch itself off. If I couldn't move and I would see that everyone must do something for me, and the brain still functions, you are conscious, then I would probably prefer to switch off the brain. If the brain is switched off, then you don't care anymore." (F4)

The subjects ascribe various meanings to death itself. They almost automatically consider it from two perspectives: their parent's death and their own death. Their own fear of death is either foregrounded (as in the case of F3 and F8) or there is no fear at all (F4). The statement of F4 demonstrates that this woman is not completely free of fear; it is not, however, fear of death, but of suffering and disability. For this respondent, death appears to be a kind of liberation:

"Man will die, it's OK... This period is the worst, not knowing: I'm alive, I'm not alive... If I die, I'm still energy anyway. From the point of view of matter, of physics, energy doesn't disappear; it only changes from one form to another. If I'm what I am, so I was given this form, but I know very well that if I talk with my father, brother, parents-in-law [...], and they always help me, [...] I feel that they exist. It's not like I imagine it... I just know they exist. [...] We call this ghosts, angels, souls, but this is energy. I am technical and I know that this is

energy. It couldn't have disappeared; it's only in a different form. And that they help me, it's certain. [...] So after that I will exist somehow. And this death it's not such death. Well, I will go away from this body, some energy will disappear, because it's matter after all, but the rest will generally go further. The next must be." (F4)

Another aspect that emerged from the statements of some respondents was preparation for death:

"She is prepared for it. She has her clothes prepared in the wardrobe: petticoat, costumes: one more for winter, autumn, the other more for summer. Depending on the weather she wants to be dressed in one of them. She prepared herself for it a long time ago (...)." (F8)

Inevitability of death on the one hand, but primarily advanced age (in the case of F8's mother – 91 years old), diseases and parent's disability on the other, bring the perspective of death closer and force one to consider it, and sometimes to take some specific measures (as for example, securing the loved ones, securing the financial means for the gravestone, preparation of clothes for the funeral). It may be assumed that such activities can be also significant for becoming accustomed to death (one's own and that of a parent).

The last issue concerns the aftermaths of death. Apart from the obvious one, that is the feeling of loss, there appear additionally: expected feeling of relief, awareness of gaining free time, possibility of getting rest and changing the hitherto habits:

"I will toil with him for some time yet (...) I think I will miss him for a long time, because you get used to it, being with him all the time (...) For sure something will change in my life after he's gone. Some relief because now I feel bleary all the time." (M1)

Such considerations appear primarily in the statements of these respondents who have provided care for at least several years, whose parent's condition is very serious, and consequently nursing is physically demanding (e.g., lifting the parent, changing diapers, bathing) and mentally exhausting (awareness of the parent's suffering, difficulties in satisfying one's own needs along with those of the parent and other people).

Discussion and conclusions

Caring for elderly, ill and frequently disabled parents is a very difficult challenge. It should be always analyzed from the perspective of a specific family or the individual who must face this challenge. One may risk a statement that a situation when children are focused on themselves and their own affairs and so they do not provide appropriate care, despite adequate living and financial conditions as well as care-providing resources is an improper one.

Discussions concerning this subject frequently feature comparisons of caring for a parent with care that was previously provided by the parent to a child (the current caregiver). However, these situations should not be and cannot be equated, because their scopes are dissimilar and they require a “different” involvement. The consequences for caregivers are also different (e.g., emotional and physical exhaustion).

Literature reports and conducted studies indicate the areas of helplessness and difficulties that children who nurse their parents must face. In many cases these difficulties exceed the care-taking potential, leading to the individual’s internal disorganization. Kawczyńska-Butrym [7] demonstrates that family members who do not get sufficient external support:

- resign from their life plans and professional careers,
- experience physical and mental burdens, and long-term mobilization connected with stress,
- make a difficult decision to resign from a more extensive involvement in providing care and search for other solutions.

Each of the chosen options generates a risk of:

- disturbances in their physical and mental health,
- neglect that can affect the person who requires support or other family members,
- family dysfunction (e.g., as regards educational or financial issues) or even family break-up.

Such risk may be also avoided, whereas proper preparation for death may enable experiencing it with dignity. As the research conducted by van Gennip et al. [16] demonstrates, there are some factors associated with a dignified death of an older relative: feeling peaceful and ready to die, absence of anxiety and depressive mood, presence of fatigue, and a clear explanation by the physician of treatment options during the final months of life.

This paper discusses a significant, though not well investigated issue. The conducted research indicates that for adult children not only the very fact of caring for an aging, disabled parent may be difficult, but also the awareness of the parent’s imminent death. Moreover, both experiences do not necessarily have to be perceived solely pessimistically, because nursing may also provide satisfaction stemming from a well-done task and contentment with being together with the parent, whereas the awareness of the parent’s imminent death is not only associated with the perspective of loss, because simultaneously some caregivers may experience relief or a perspective of (long awaited) one's own rest. Contemplating the issue of the (approaching) death of a parent stimulates the respondents to consider their own futures and death. The issues connected with death, disease, disability and dying that emerge in the interviews refer to the place of residence before death (family home or institution – along with a number of factors associated with the choices made), usefulness of a human being, uncertainty (of time, aftermaths, one's own impact), inevitability and meanings ascribed to death, preparation for it and expected aftermaths.

One of the young volunteers wrote: "I believe that what we do in life is meaningful, that there is a cause and effect; that we take the consequences of our deeds. If I punch somebody on the jaw, someone will punch me; If I am good and emphatic, I will be happy. I help so I will be helped. I give, so I receive." [1]

References

1. Arendt-Dziurdzikowska R.: Możesz odejść bo Cię kocham. O śmierci, pożegnaniach i nowym życiu. Wyd. Zwierciadło, Warszawa, 2012.
2. Cackowski Z. : Trud i sens ludzkiego życia. Książka i Wiedza, Warszawa, 1981.
3. Bauman Z.: Śmierć i nieśmiertelność. O wielości strategii życia. Wyd. Naukowe PWN, Warszawa, 1998.
4. Orwid M.: Trauma. Wyd. Literackie, Kraków, 2009.
5. Jagieła J: Relacje w rodzinie a szkoła. Wydawnictwo Rubikon, Kraków, 2007.
6. Trobisch I.: Ucząc się żyć po utracie ukochanej osoby. POMOC, Wyd. Misjonarzy Krwi Chrystusa, Częstochowa, 2006.
7. Kawczyńska-Butrym Z. Wyzwania rodziny: zdrowie, choroba, niepełnosprawność, starość. Wyd. Makmed; Lublin, 2008.
8. Bojanowska E.: Ludzie starsi w rodzinie i społeczeństwie [w:] O sytuacji ludzi starszych (Hrynkiewicz J. ed.), tom 3, Rządowa Rada Ludnościowa, Warszawa, 2012.
9. Wilk E.: Rodzice swoich rodziców, Polityka, 2013, 35, 26-28.
10. Ogryzko-Wiewiórowska M.: Umieranie i śmierć w rodzinie, Piel. 2000, 1999, 4, 24-30.
11. Tyburski W.: Śmierć człowieka w ujęciu filozoficznym (szkic do tematu). Udar Mózgu, 2007, 9, 1-7.
12. Marton F.: Phenomenography [In:] Postlethwaite TN, Husén T. (ed.). The International Encyclopedia of Education. Pergamon; 1994, 2nd, Vol. 8., 4424 - 4429.

13. Charmaz K.: Teoria ugruntowana. Praktyczny przewodnik po analizie jakościowej. Wyd. PWN, Warszawa, 2009.
14. Marton F.: Phenomenograpgy – describing conceptions of the world around us. Instr Sci. 1981,10, 177-200.
15. Paulston R.G.: Pedagogika porównawcza jako pole nakreślania konceptualnych map teorii paradygmatów [in:] Spory o edukację. Dylematy i kontrowersje we współczesnych pedagogiach, Kwieciński Z, Witkowski L. (ed.), IBE-Edytor, Warszawa, Toruń, 1993, 25-50.
16. Gennip van I.E., Pasma H.R.W., Kaspers P.J., et al.: Death with dignity from the perspective of the surviving family: A survey study among family caregivers of deceased older adults. Palliat. Med., 2013, 27, 616-624.

QUALITY OF LIFE

Jankowiak Barbara[1], Osełka Monika[2], Krajewska – Kułak Elżbieta[1], Rolka Hanna[1], Kowalewska Beata[1], Klimaszewska Krystyna[1]

Quality of life of patients with soft tissue sarcoma

1. Department of Integrated Medical Care, Medical University of Białystok, Poland
2. Department of Soft Tissue and Bone Cancer, Institute of Oncology, Warsaw, Poland

Introduction

Sarcomas are rare, malignant tumors of the mezenchymal origin, of soft tissue and bones. They appear mostly in the chest or limb area [1]. The most common morphological types are: fibrohistiocytoma malignum, liposarcoma, sarcoma synoviale, fibrosarcoma and leiomyosarcoma [2, 3].

Sarcomas constitute around 2% of malignant tumors among adults and 10% among children. Effective treatment depends mainly on early diagnosis. The treatment chances are influenced by various factors (age, size and histology of the tumor, depth of changes – surface or deep, placing of the tumor). Around 90% and 98% recurrence is observed after 5 and 10 years. A period of 5 years of life without a recurrence is seen in 60% - 80% of patients. Small chances for cure have patients who were diagnosed late with advanced malignancy, or patients whose cancer recurred with metastasis to other organs [4,5].

A basic symptom is a painless tumor and its rapid growth within a few months. Some patients, whose sarcoma is located on a limb, may suffer from ischemia of the peripheral parts of this limb and cardiac edema, which can lead to pain, sense disorders or muscle atrophy.

The basic element in sarcoma treatment is microscopic diagnosis and the stage of the disease. Individual or accompanying methods of oncological treatment are used: surgery, radiotherapy and chemotherapy.

There are 4 distinguishable types of surgical procedures: palliative removal of the tumorous mass, „flaking of the tumor" (also a palliative procedure), broad removal of the tumor and amputation [6,7,8,9,10].

Radiotherapy accompanied by surgery is the standard treatment of sarcoma patients. Depending on the timeline pre-surgery, in-surgery or post-surgery radiation may be used. In exceptional situations radiotherapy may be used alone or accompanied by systemic treatment. Pre-surgery radiotherapy is very beneficial due to smaller area being radiated, lower dosage of radiation and assisting the surgery. This method entails the danger of complications due to badly healing post-surgical scar. Radiotherapy as only means of treatment is used with inoperable patients, as palliative treatment [11- 18].

The role of chemotherapy in treating sarcoma is still not entirely clear and thus controversial, which is why it is used only in selected cases. Monotherapy as well as supplementing therapy is used. It attempts to use chemotherapy as a supplement to localized treatment, especially in soft-tissue sarcoma located on limbs, is justified by the fact 30-50% of patients with the primary origin have distant metastasis [19- 22].

Modern medicine, apart from striving to entirely cure, or prolong the life of the patient, should also attempt to give the patient the maximum amount of comfort, relief from physical, mental or spiritual cares. This is why the assessment of a patient's quality of life is so important.

The term 'quality of life' is strictly connected with the definition of health. The *World Health Organization* presents the quality of life as one's subjective view of their life position, in a cultural context, and the system of values one applies to in respect to the goals, expectations, role models and fears one faces. The quality of life conditioned by health (HRQL) is governed by the physical state and motoric functions, mental state, social and economical condition, and somatic experiences. One has to remember that the quality of a patient's life at different stages of treatment may vary. It changes due to advancing disease, diagnostic methods used and treatment.

Quality of life may be assessed by means of objective assessment (by doctors, nurses, psychologists) or subjective assessment (by a patient in a certain life and health situation). Cancer is a variable disease. The prognosis and course of the disease vary and it influences a person in all aspects of life: physical, mental, social and spiritual. The most common physical symptoms of this condition are: pain, loss of body mass, exhaustion, sleep and eating disorders. Treatment entails nausea and vomiting with patients on chemotherapy, skin burns, nausea and diarrhea with radiotherapy patients. The mental aspect is dominated by: dear, depression, anger and aggression which lead to lowering the quality of life in oncology patients.

Studies of the quality of life and determining its factors are helpful in selecting treatment matching each patient's individual needs. The main goal of the researchers is to determine the factors lowering a patient's the quality of life, and finding ways of equalizing this deficit. Very often good relations with the patient, emotional support, warmth and kindness have the ability to improve the quality of life, especially in hospitalized patients.

One can also assume that studies of the quality of life are the result of a humanistic approach to medicine [23, 24, 25].

Material and methods

Studies were conducted at the Soft Tissue and Bone Cancer Clinic, Center of Oncology, Warsaw on a group of 100 subjects in various stages of treatment with consent of the Bioethical Committee of the Center of Oncology, Warsaw.

Resource for the study was gathered via an anonymous QLQ – C30 questionnaire (version 3.0), designed by the European Organization for Research and Treatment of Cancer (EORTC) and a self-designed questionnaire. The QLQ – C30 questionnaire has 30 questions, of which 5 concerned patients general functionality, 23 – physical and mental state, 2 – general quality of life.

The self-designed questionnaire comprised of 15 questions, of which 7 concerned general patient information, 6 – family and personal situation, 2 – subjective quality of life assessment.

The respondents were informed that the study is anonymous.

The results are presented in a quantitative form, and statistically relevant dependencies were verified with the χ^2 test assuming statistical relevancy to results where $P \leq 0{,}05$. The statistical calculations were conducted with Excel and Statistica 5.0 software.

Results

The study group comprised of 100 patients with diagnosed soft tissue sarcoma, of which 37% were women and 63% were men. The largest group consisted of patients 51-60 years old (25%), 31 – 40 years old were 20%, and 21-30 years 18% of the respondents. The average age was 40 years. The youngest person in the study group was 17 years old, the oldest – 80. The majority of the group lived in cities (68%), with country inhabitants being 32%. Nearly 70% of the subjects were married, with 23% being single. 48% of the respondents were employed; 23% were pensioners, 15% - students, 11% - retired and only 3% were unemployed.

The longest disease time span was 16 years, the shortest 1 month. The largest percentage was suffering from cancer for 1 year (58%). Patients were diagnosed with liposarcoma, leiomyosarcoma, rhabdomyosarcoma, synovial sarcoma, sarcoma Ewingi. They were treated with various oncological methods. The largest group (70%) was treated with cytostatics; 18% were recovering from a surgical procedure and included chemotherapy, and 12% were treated with radiotherapy.

In order to estimate the state of patients' physical functionality several questions were asked about everyday tasks and difficulties in their performing (shopping, preparing meals, cleaning, etc.). Patients had difficulty sometimes in 41% of cases, often in 21% and very often in 19%. These results were statistically relevant, as when difficulties in everyday activities dependent on gender are concerned (*p= 0.1140*) women had these difficulties more often (89%) than men (76%).

Soft tissue sarcoma largely influences the physical condition. Long walks were difficult to 70% of the respondents. Nearly 30% never felt tired after a long walk. 54% of men and women answered that they needed rest during the day. 10% of men stayed in bed often, the same as 13% of women. 19% of the respondents never rested during a daytime. Physical condition was worse observed in elderly people than in the ones under 40 years of age (*p=0,0069*).

Nearly half of the respondents admitted that air loss was a symptom which made their lives more difficult. It presented itself in 45% of cases. Another factor lowering the quality of life in 85% of cases was pain. Only 15% of respondents did not complain of pain-related symptoms. The dependence of pain occurrence according to gender was analyzed (p=0.0012),, which showed that 24% of women admitted to never feeling pain-related symptoms, whereas 19% felt them very often (Tab. I).

Table. I. Pain-related symptoms according to gender

	Women		**Man**		**Together**	
	N	**%**	**N**	**%**	**N**	**%**
Never	9	24%	6	10%	15	15%
Sometimes	16	43%	38	60%	54	54%
Often	5	14%	11	17%	16	16%
Very often	7	19%	8	13%	15	15%
Together	**37**	**100%**	**63**	**100%**	**100**	**100%**

The relation between the time span of the disease and pain assessment and its influence on the patient's quality of life was also analyzed. (*p=0.0713*). People suffering from cancer for more than 4 years assessed their quality of life as worse due to pain intensification.

Symptoms within the gastrointestinal tract were also experienced by patients. Lack of appetite was named by 56% of respondents; nausea by 48%, vomiting was named by 31% constipation – 51% and diarrhea – 33. These symptoms occurred 6% more often with women than with men (*p=0.1140*).

Tiredness was a common symptom with soft tissue sarcoma patients. Both men and women sometimes felt tired in 46% of cases. 19% of women and 11% of men felt tired very often. 11% of women and 10% of men never felt tired. Despite being tired often, 76% of the respondents admitted having sleeping trouble (81% of women and 73% of men).

The feeling of annoyance was experienced by 83% of respondents. Among women these percentage was 93%, whereas among men – 78%. Along with annoyance, 78% of patients named the feeling of depression. Every sixth woman and every fourth man admitted to never feeling depressed. The results in this case were also statistically relevant (*p= 0.00129*). People suffering from cancer for more than a year were depressed more often than those who were suffering for over four years.

A cancer diagnosis and beginning treatment, means a great change in everyday course of life. Only 34% of respondents said that their health condition and treatment did not disrupt their family life. Only one in four patients answered that the condition did not affect his social life (Tab. II).

The respondents answered quite unanimously to the question about limitations in fulfilling their hobbies and other life pleasures. Nearly 73% experienced various degrees of limitation, and 24% of women and 29% of men said they never had any limitations connected with their health condition.

However, the illness was a cause of financial problems. Over 74% of respondents stated their illness as a main cause of these problems. 30% of women never had financial problems resulting from their illness, the same as 24% of men.

The crucial part of the study was checking the assessment of health condition conducted by patients themselves. Only 9% of respondents said that they were never worried by their health condition. That is why they were asked to assess their condition in the week prior to filling out the questionnaire, on a scale from 1 to 7 where 1 meant borderline bad, and 7 – very good. Most of the marks were in the 4-5 bracket (Fig. 1). These data varied by 2-4% according to age group.

Table II. Amount of family and social life disruption due to health condition.

	Women		**Man**		**Together**	
Family life	**N**	**%**	**N**	**%**	**N**	**%**
Never	14	38%	20	32%	34	34%
Sometimes	14	38%	29	46%	43	43%
Often	6	16%	9	14%	15	15%
Very often	3	8%	5	8%	8	8%
Together	**37**	**100%**	**63**	**100%**	**100**	**100%**
Social life	**N**	**%**	**N**	**%**	**N**	**%**
Never	9	24%	16	25%	25	25%
Sometimes	19	51%	27	43%	46	46%
Often	7	19%	11	17%	18	18%
Very often	2	6%	9	14%	11	11%
Together	**37**	**100%**	**63**	**100%**	**100**	**100%**

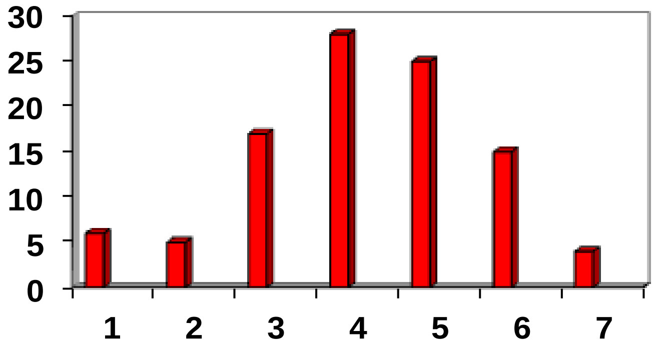


Fig. 1. Assessment of health condition by patients.

36% of respondents assessed their quality of life as 4 on a 1 to 7 scale, in the week prior to the questionnaire answers (Fig. 2).

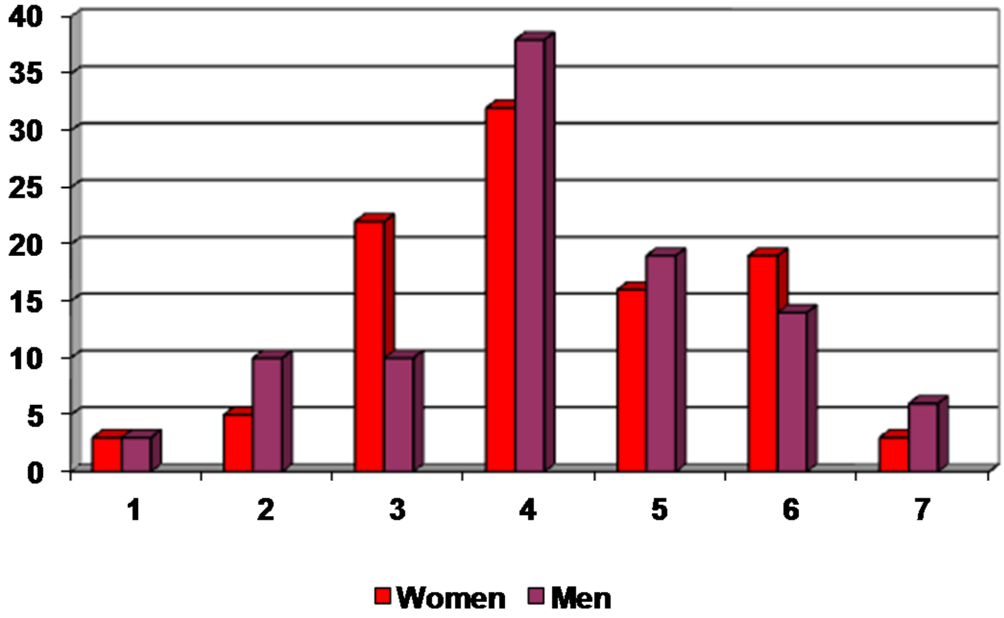


Fig. 2. Quality of life on a scale from 1 to 7.

The respondents were asked 'What could be done to improve the quality of life?' and having several variants to choose from, they selected: improve health condition (93%), acquire more information about health condition (10%), and relieve the suffering (8%).

Discussion

Regarding the problem at hand there are not many publications discussing the quality of life of patients with soft tissue sarcoma. This may result from a low rate of cases among adults in comparison to other oncological conditions like breast, lung, stomach cancer etc. Hence, the focus of this paper will be on selected aspects of the quality of life and the elements that judge its value.

A cancer diagnosis is a significant turning point in one's life. Both the patient and his family may be marked by the society, especially when the effects of the illness and treatment are visible. This situation leads to the creation of stress-relieving mechanisms and often is disruptive to the mental, social and spiritual state of the patient.

The definition of health by WHO was the basis for Till`a, Mc Neil`a i Bush`a to name the quality of life as „a global concept, which includes mental, social and physical activity, positive aspects of wellbeing, as well as negative effects of disease or infirmity" [26]. However it may be so, that people who identify QOL with the definition of health may develop the so called '*satisfaction paradox*' – regarding their quality of life as very good, despite their negative condition's symptoms. The person reaches this conclusion through the belief that his or her health may be influenced by existing resources, thus dealing with the illness rationally, which in turn leads to satisfaction in other areas of life.

Attempts to unify the definition of the quality of life led to the creation of *health related quality of life (HRQL).* This term was introduced by Schipper, who defined it as 'the functional effect of an illness and its treatment as perceived by the patient'. In other words it is the assessment of our own life situation in time of illness and treatment, with attention to their role [27]. With the coining of HRQL various attempts were undertaken to assess the quality of life of patients. The attempts to measure the quality of life result mainly from the will to popularize a holistic health model, identifying a human being not only with clinical norms, but also with widely acknowledged biological, social and mental wellbeing [26, 27, 28].

It seems that the most valid and credible is the subjective, direct assessment of personal situation by the person in question. This is confirmed by Hunt and McKenna, who believe that a person's quality of life is strictly linked to that person's ability to satisfy his or her needs. The higher is the level of fulfillment of those needs, the better the quality of life [29]. The quality of life perceived as a subjective notion or the patient's own opinion of the illness and treatment process, is an important aspect of the treatment's assessment by the patient. Turning the attention towards HRQL results from modern approach in medicine, where not only the results of the treatment are taken into consideration but also the improvement of the patient's life quality [27].

Studies conducted by us took also into account the subjective assessment. It is worth mentioning, that our most of our respondents underwent often crippling surgical procedures. It could be expected, that the assessment of HQRL would be low due to the clinical state and therapy. The respondents assessed their life quality quite high on a scale from 1 to 7. 28% marked their health condition as 4, and 25% - 5. Only 6% chose 1, whereas 4% - 7. The subjective assessment of life quality was similar. This was surely influenced by the time that passed from the diagnosis. Our studies have shown that recently diagnosed patients were far more critical when assessing their health condition and life quality. General mental discomfort was also a factor lowering the life quality of patients during their treatment. The disproportions between men and women in this study were insignificant.

The quality of life of oncology patients is nowadays studied more often. Until now the assessment criteria of oncological treatment, were predicted lifespan, time of life without symptoms and the tumor's reaction to treatment. At present more attention is paid to minimizing the side-effects of treatment. A complete success is the maximum prolonging of the patient's lifespan with at the same time keeping the quality of life.

Results of studies among soft tissue sarcoma patients concerned all aspects of life.

Pain was an important factor influencing the quality of life. Cancer pain is chronic, physically exhausting and often leads to depression. Among sarcoma patients, according to own studies, pain was experienced by 85% of respondents, which places them high on the list comparing to other cancer patients. That is why patients in our clinic use the help of the Center for Pain Treatment and Palliative Care, cooperating with the clinic's staff.

At the same time own resources stated that side-effects of treatment such as lack of appetite, nausea, vomiting, diarrhea or constipation were not a large concern to patients. Only 19% of the patients never required rest during the day. Most patients are able to accept even drastic measures in therapy, as long as this gives a chance of curing them.

Our patients experienced great discomfort in mental and emotional aspects as well. 90% of the respondents felt tired and 81% weak. Problems concentrating were reported by 58%, and tension - 69% of the respondents. 91% were worried with their health condition, and 83% were annoyed by this fact, whereas 78% felt depressed. Emotional problems are caused by mental stress, physical symptoms, biological factors, sensitivity, lack of support, social factors and bad relations with hospital staff.

Fear of death is another problem facing patients with cancer. A cancer diagnosis is perceived by many patients as a death sentence, being often an incurable condition. This situation causes patients to be unable to deal with their mental issues alone, and the medical staff unable to help due to lack of qualifications and experience in this field. In such cases, a psychologist's role is unparalleled.

In the studied clinic, there is a possibility of receiving psychological help, as one is employed by our institute's Center of Rehabilitation. This help is given on patient's request, or doctor's or nurse's suggestion. However, patients reported lack of immediate psychological care which would not have to be scheduled and preceded by procedure. In the clinic, the role of a psychologist is often taken by a nurse. Patients tell nurses about their families, problems and cares. Nurses in our clinic spend much time talking to patients and their families. This work is, however, not appreciated by patients. 32% of the respondents said that they received support from nurses, while 85% stated that the support was from doctors.

Gill and Feinstein while defining the quality of life noticed that it is the way a patient reacts to his health condition and other medical aspects of his life. They therefore think that the quality of life consists of not only health related factors but also nonmedical ones such as: work, family and other life circumstance [30]. Sickness and treatment means a change in lifestyle. It is often connected to temporary hospitalization, often away from home, which means parting with family and sometimes the loss of employment. 66% of the respondents stated that the illness disturbed their family life in a great way. 74% of the respondents felt largely limited in the performance of working duties.

Interest in a person and his functioning in all three dimensions is equally as important as searching for new treatments prolonging his lifespan. A patient and his family are on the verge of an enormous shock of being given a cancer diagnose and suggested treatment. Cancer is still feared and shunned by the society. That is why more and more people require specialist nursing care to improve their quality of life [27]. Hence a nurse is the person, with whom the patient is in most frequent contact during treatment. Measuring of QOL by nurses has proven to be very helpful in information flow, communication, identifying the aspects of life most important to patients and in planning and assessment of individual healthcare. Thanks to them, a nurse can study every aspect of the patient’s life, assess it, draw conclusions and through targeted actions, may help the patient to regain balance on the required level. It is important to stress, that nurses are able to judge not only biological but also mental and social needs of patients and are able to help them develop positive strategies of coping with the new condition [31]. That is why the quality of life with cancer requires further research.

Conclusions

1. People suffering from cancer for more than 4 years assessed their quality of life as worse due to pain intensification. General mental discomfort was also a factor lowering the life quality of patients during their treatment.
2. Soft tissue sarcoma largely influences the physical condition.
3. Our patients experienced great discomfort in mental and emotional aspects as well.

References

1. Colville R.J., Charlton F., Kelly C.G.: Multidisciplinary management of head and neck sarcomas. Head Neck, 2005, 27, 814-824.
2. Brennan M.F., Singer S., Maki R.G., O'Sullivan B.: Sarcomas of the soft tissues and bone [in:] DeVita VT, Hellman S, Rosenberg SA: Cancer. Principles and practice of oncology. 7th ed. Lippincott Williams and Wilkins, Philadelphia 2005, 1581–1686.

3. Murray P.M.: Soft tissue sarcoma of the upper extremity. Hand. Clin., 2004, 20, 325–333.
4. Pollock R.E.: The seminal role of Cancer in our understanding of sarcoma. Cancer, 2008, 1, 113(7 Suppl), 1969-1979.
5. Mendenhall W.M., Indelicato D.J., Scarborough M.T., Zlotecki R.A., Gibbs C.P., Mendenhall NP, Mendenhall CM, Enneking WF: The management of adult soft tissue sarcomas. Am. J. Clin. Oncol., 2009, 32, 436-442.
6. Mankin H.J., Hornicek F.J: Diagnosis, classification, and management of soft tissue sarcomas. Cancer Control, 2005, 12, 5–21.
7. Cormier J.N., Pollock R.E: Soft tissue sarcomas. CA Cancer J. Clin., 2004, 54, 94–109.
8. Flugstad D.L., Wilke C.P., McNutt M.A., Welk R.A., Hart M.J., McQuinn W.C.: Importance of surgical resection in the successful management of soft tissue sarcoma. Arch. Surg, 1999, 134, 856–861.
9. Refaat Y., Gunnoe J., Hornicek F.J., Mankin HJ.: Comparison of quality of life after amputation or limb salvage. Clin. Orthop. Relat. Res., 2002, 397, 298–305.
10. Rougraff B.: The diagnosis and management of soft tissue sarcomas of the extremities in the adult. Curr Probl. Cancer., 1999, 23, 1–50.
11. Pennacchioli E, Deraco M, Mariani L et al.: Advanced extremity soft tissue sarcoma: prognostic effect of isolated limb perfusion in a series of 88 patients treated at a single institution. Ann Surg. Oncol., 2007, 14, 553–559.
12. Strander H., Turesson I., Cavallin-Stahl E.: A systematic overview of radiation therapy effects in soft tissue sarcomas. Acta Oncol., 2003, 42, 516–531.
13. Fayette J., Blay J.Y., Ray-Coquard I.: Soft tissues sarcomas: good medical practices for an optimal management. Cancer Radiothér., 2006, 10, 3–6.
14. Zagars G.K,. Ballo M.T., Pisters P.W., et al.: Prognostic factors for patients with localized soft-tissue sarcoma treated with conservation surgery and radiation therapy: an analysis of 1225 patients. Cancer, 2003, 97, 2530–2543.
15. Llácer C., Delannes M., Minsat M., et al: Low-dose intraoperative brachytherapy in soft tissue sarcomas involving neurovascular structure. Radiother. Oncol., 2006, 78, 10–16.
16. Rachbauer F., Sztankay A., Kreczy A., et al: High-dose-rate intraoperative brachytherapy (IOHDR) using flab technique in the treatment of soft tissue sarcomas. Strahlenther Onkol, 2003, 179. 480–485.

17. Delannes M., Thomas L., Martel P.: Low-dose-rate intraoperative brachytherapy combined with external beam irradiation in the conservative treatment of soft tissue sarcoma. Int. J. Radiat. Oncol. Biol. Phys., 2000, 47, 165–169.
18. Nag S., Shasha D., Janjan N., Petersen I., Zaider M.: The American Brachytherapy Society recommendations for brachytherapy of soft tissue sarcomas. Int. J. Radiat. Oncol. Biol. Phys., 2001, 49, 1033–1043.
19. Brandon G., Bentz M.D., Bhuvanesh S., et al.: Head and neck soft tissue sarcomas: a multivariate analysis of outcomes. Ann. Surg. Oncol., 2004, 11, 619-28.
20. Spears J.: Emotional support given by ward-based nurses to sarcoma patients. Eur. J. Oncol. Nurs., 2008, 12, 334-341.
21. Casali P.G., Picci P.: Adjuvant chemotherapy for soft tissue sarcoma. Curr Opin. Oncol., 2005, 17, 361–365.
22. Grobmyer S.R., Maki R.G., Demetri G.D., et al.: Neo-adjuvant chemotherapy for primary high-grade extremity soft tissue sarcoma. Ann Oncol., 2004, 15, 1667–1672.
23. Wilson I.B., Cleary P.D.: Linking clinical variables witch health-related quality of life: a conceptual model of patients outcomes. JAMA, 1995, 273, 59-65.
24. Saxena S., Orley J.: Quality of life assessment: The WHO perspective. Eur. Psychiatry, 1997, 12, 263-266.
25. Testa M.A., Simonson D.C.: Assesment of quality-of-life outcomes. N. Engl. J. Med., 1996, 334, 835–840.
26. Mc Millan S.C., Mahon M.: Measuring quality of life in hospice patients using a newly developed Hospice Quality of Life Index. Qual Life Res, 1994, 6, 437-447.
27. Schipper H: Quality of Life: Principles of the clinical paradigm. J. Psychosocial. Oncology, 1990, 23, 171-185.
28. Ferrans C.E: Quality of life: conceptual issues. Seminars in Oncology Nursing, 1990, 4, 248-254.
29. Hunt S.M., Mc Kenna S.P.: The QLDS: A scale for the measurement of quality of life in depression. Health Policy, 1992, 3, 307-319.
30. Gill T.M., Feinstein A.R.: A critical appaisal of the quality of quality – of life measrements. JAMA, 1994, 8, 619-626.
31. Burr S., Gradwell C.: The psychosocial effects of skin diseases: need for support groups. Br. J. Nurs., 1996, 19, 1177- 1182.

Jurczyk Zofia Malgorzata[1], Abramczyk Anna[2]

Selected aspects of quality of life in nurses in the Polish studies

1. Department of Nursing, Faculty of Medical Sciences, University of Warmia and Mazury in Olsztyn
2. Department of Public Health, Epidemiology and Microbiology, Faculty of Medical Sciences, University of Warmia and Mazury in Olsztyn

Introduction

The quality of life is one of the popular issues of all sciences and fields including lives with reach human existence [1]. The literature review about the research on the quality of life is revealing a lot of ambiguity about the understanding, as well as in defining this notion [1]. The quality of life as a category, is both determined through an objective indicators (average life lasting, reaching the poverty level of the scholarization), as well as subjective (step of satisfaction from the living conditions and different of his aspects, level of happiness, stress, meaning of life) [2]. Also sum of man efforts , struggle, fight carried on often with oneself, ability of making appropriate choices, ability to compromises, above all decision-making skills are perceived and of accepting their consequence with the entire responsibility. It is also a quality perceived by surroundings, manifesting itself in how we live, how we are getting dressed what we are going by, how we are feeding, how we are spending the leisure time, how we refer to other people, whether we are open to human problems and the likes [3].

The identified quality of life is also with such dates as: conditions of the existence, living conditions, style of living, a lifestyle [4]. In the opinion of some authors the quality of life includes needs which the individual regards most significant for their life, and opinions of the individual about the level of satisfying them [5]. The identified quality of life is both with the quality of the world, as well as the quality of the man [6].

The World Health Organization in 1993 defined the quality date of life (QoL - quality of life), considering him as the concept multi-storey, being a result of the joint action of factors affecting the health: physiological, psychological and social [7]. In other words quality of life (QoL) is being taken hold as the way of perceiving by units of their practical position, in the cultural context and a system of values which live in and with reference to their tasks, expectations and assigned standards with environmental conditioning [8].

The identified quality of life is both with the quality of world, as well as the quality of the man [6]. The World Health Organization in 1993r. defined the sweep this way a course of physical health, a mental state, the level includes independences (freedoms), of social relations, expectations and references to the natural environment [9]. The quality of life is involved in values, is correlating with them, and results from certain values [4]. He is an axiological notion. World of the value is part of the spiritual sphere of the man which is deciding about his individuality and is in the very nature of things subjective [4]. For the harmonious development of society a guidance won't be enough with economic indicators, because achievements or deficiencies aren't interleaving themselves with the stimulus valid for the sphere of social and individual systems of values which are of transformations [10,11]. The identified quality of life is both with the quality of world, as well as the quality of the man [6].

The World Health Organization in 1993r. defined the sweep this way a course of physical health, a mental state, the level includes independences (freedoms), of social relations, expectations and references to the natural environment [9]. In spite of the 20th century lasting for the eighties of an growing interest in the concept the quality of life still is lacking the definition which could be without reservations accepted irrespective of interdisciplinary diversities [12].

Quality of life for some it is a notion very broad, meaning almost everything apart from information about the death of the individual, for other however these are only certain elements of the life, or public and psychological aspects of the quality of life [13.14].

Aim of the work

Describing the selected aspects concerning the quality of life of professionally active persons with the law of the practising a profession is a purpose of the work nurses (of nurses) and of factors diversifying the evaluation of the quality of life.

Materials and methods

The research material comes from 575 people (of nurses) with the law of the practising a profession of the nurses in the country. For the purposes of the work they conducted research with the anonymous questionnaire of the questionnaire form made available via e-mail, and the regular mail amongst using nurses from randomly of selected centres of the postgraduate education of nurses in the country.

They conducted research in basing 26 questions for the anonymous questionnaire of the questionnaire form supplemented for the questionnaire with WHOQOL-BREF, containing the version. Questionnaire of the quality of life (WHOQOL - abridgement) is a research tool known and often applied in the benchmarking above the quality of life [15] and Polish adaptation of the WHOQOL questionnaire, is recognised behind the solid and accurate tool for examining the quality of life of both healthy persons and sick persons [16,17].

The questionnaire lets the quality of life for getting the profile in the physical, psychological, environmental aspect and the relation social and for the evaluation of the global quality of life. For every question examined could receive from 1 to 5 points. A better quality of life of the examined person corresponded to the higher number of points.

Results

Among the examined population women constituted the 98%, but men of the 2%. Persons were the most numerous group in century 41 - 60 years (61%). Every third examined was no more than 40 years old (38%). The majority of respondents settled in the city (74%), and what fourth in the country environment (26%). Examined persons have most often been functional in the matrimony (66%). The majority of nurses was characterized by a higher directional education (56%). Graduates of the college of the first degree constituted the most numerous group (undergraduate) (40%). Education get as a result of leaving the secondary school or the medical school (of vocational college) declared the 44% examined. Persons employed on the position of the more senior nurse constituted the most numerous group (46%). The every third respondent declared employing the nurse on the position (34%). For having a specialization it showed the 23%, but the course in the qualifying 49% of respondents. Majority examined worked in the public healthcare centre (73%), hospital (72%), and in the profession of over 10 years. Table 1 is presenting data.It appears from the quality analysis of living amongst nurses participating in the examination that critically they have most often assessed their environmental conditions, and most favourably social class determined with relations and the support, Table 2 is presenting Data.

Analysis of the research material showed, that what the tenth respondent (11.3%) negatively he assessed the quality of his life, and recognised the 51.3%, that the quality of their life was good or very good.

A little bit nurses positively have more often assessed the quality of their life (60%) than the health (51%). Twice they have more often declared displeasure at its medical condition (10%) than qualities of life (5%). Data are shown in Table 3.

Both women and men have most often thought that the quality of their life is very bad or bad. The quality of life is most often very bad in the opinion of persons at the age of 41-60 (100%) which left the medical school (57%), have a specialization (47%) or qualifying course (47%), are settling in the city from 10 to 20 thousand residents (43%), with the work experience in the profession amounting to 21-30 years (57%). Persons being functional in the matrimony have most often thought that the quality of their life is bad (82%).

Table 1. Characteristics of the examined population.

Tested feature	N	[%]
Sex:		
woman	564	98,0%
man	11	2,0%
Age:		
amount of years 22-40	218	38,0%
amount of years 41-60	350	61,0%
amount of years 61 and more	7	1,0%
Living place:		
village	148	26,0%
City to 5 thousandresidents	29	5,0%
City from 5 thousand to 10 thousand residents	32	6,0%
City from 10 thousand to 20 thousand residents	64	11,0%
City from 20 thousand to 100 thousand residents	121	21,0%
City above 100 thousand residents	181	31,0%
Marital status:		
younggirl / bachelor	129	22,0%
marriedwoman / married	377	66,0%
widow / widower	10	2,0%
divorced / divorced	48	8,0%
in the separation	11	2,0%
Education:		
Senior medical collage	144	25,0%
Medicalcourse	108	19,0%
bachelor degree study (first cycle of nursing)	232	40,0%
bachelor degree study(of first cycle)	6	1,0%
economics	2	0,0%
obstetrics	1	0,0%
pedagogy	1	0,0%
pedagogy and the promotion of health	1	0,0%
undergraduate studies leading to a master's degree (of second cycle or uniform)nursing	87	15,0%
Undergraduate studies leading to a master's degree (of second cycle)	37	6,0%
doctorate studies (third cycle)	1	0,0%
Professional/academictitle:		
nurse	252	44,0%
bachelor's degree of nursing science	232	40,0%
master 'sof nursing science	87	15,0%
Master's of otherstudies	31	5,0%
doctor's degree of medical sciences	2	0,0%
Position:		
nurse	194	34,0%
more senior nurse / more senior male nurse	264	46,0%
Departmental headnurse	62	11,0%
family nurse	11	2,0%
instructor	4	1,0%
assistant	5	1,0%
academicteacher	6	1,0%
assistantprofessor	1	0,0%
director of nursing/ weed principal	1	0,0%

specialist	12	2,0%
manager	4	1,0%
Other: accountant, receptionist in a doctor's surgery, dispatcher	3	1,0%
dep. of the charge nurse	3	1,0%
Specialization:		
yes	135	23,0%
not	440	77,0%
Completed qualifying course:		
yes	279	49,0%
not	296	51,0%
Area of the work:		
public healthcarecentre	422	73,0%
non-public healthcarecentre	84	15,0%
he /she is working at a hospital	414	72,0%
he/she is working at the other institution than the hospital	161	28,0%
Work experience in the profession		
1-5 years	104	18,0%
6-10 years	33	6,0%
11-20 years	136	24,0%
21-30 years	219	38,0%
over 30 years	61	11,0%
no data	22	4,0%

Table 2. Under scale of the Questionnaire of the quality of life (n = 575).

Quality of life:	Medium	Minimum	Maximum	SD
In the somaticsphere	14,09	9	20	2,34
In the psychologicalsphere	14,80	12	20	2,35
In the social class (of relation)	15,07	9	20	2,82
In environmentalconditions	13,36	12	20	2,21

Table 3. Replies in the quality of life amongst examined persons.

Tested feature	Evalution:									
	Very bad		Bad		Neithergood nor bad		Good		Very good	
Total population	2,65%		8,72%		37,24		38,76		12,63	
Quality of life	7	1,0%	22	4,0%	204	35,0%	316	55,0%	26	5,0%
Satisfaction of the health	14	2,0%	47	8,0%	221	38,0%	258	45,0%	35	6,0%
Physical, somaticsphere:										
Physicalpain	21	4,0%	95	17,0%	231	40,0%	130	23,0%	98	17,0%
A medical treatment is needed for everyday functioning	35	6,0%	40	7,0%	174	30,0%	131	23,0%	195	34,0%
Energy in the daily living	5	1,0%	23	4,0%	245	43,0%	224	39,0%	78	14,0%
Frame of mind	4	1,0%	41	7,0%	258	45,0%	231	40,0%	41	7,0%
Satisfaction from itsdream	25	4,0%	113	20,0%	167	29,0%	220	38,0%	50	9,0%
Satisfying from the function in the everyday life	4	1,0%	38	7,0%	215	37,0%	269	47,0%	49	9,0%
Satisfaction from its ability (readinesses to work	2	0,01%	26	4,99,0%	160	28,0%	323	56,0%	64	11,0%
Psychologicalsphere:										
Joy in the life	7	1,0%	47	8,0%	226	39,0%	206	36,0%	89	15,0%
Livingmakessense	7	1,0%	10	2,0%	153	27,0%	207	36,0%	198	34,0%

Concentration of attention	1	0,0%	14	2,0%	176	31,0%	291	51,0%	93	16,0%
Physicalappearance)	14	2,0%	37	6,0%	184	32,0%	222	39,0%	118	21,0%
Satisfaction from oneself	2	0,01%	28	4,99,0%	166	29,0%	320	56,0%	59	10,0%
Experiencing negative emotions, so as depression, despair, fear, depression	6	1,0%	55	10,0%	212	37,0%	283	49,0%	19	3,0%
Environmentalsphere:										
Safety in the daily living	14	1,0%	25	2,0%	287	33,0%	204	47,0%	45	16,0%
Surroundings are supporting the health	14	2,0%	25	4,0%	287	50,0%	204	35,0%	45	8,0%
Money for itsneeds	71	12,0%	124	22,0%	259	45,0%	99	17,0%	22	4,0%
Accessibility of information needed in the daily living	4	1,0%	39	7,0%	255	44,0%	183	32,0%	94	16,0%
Opportunity of carrying one's interests out	30	5,0%	79	14,0%	294	51,0%	116	20,0%	56	10,0%
Satisfaction from its housing conditions	12	2,0%	48	8,0%	145	25,0%	277	48,0%	93	16,0%
Satisfaction from medicalfacilities	45	8,0%	163	28,0%	265	46,0%	90	16,0%	12	2,0%
Satisfaction from the communication (of transport)	26	5,0%	104	18,0%	256	45,0%	165	29,0%	24	4,0%
Social class, of social relations:										
Satisfaction from its personal relations with other people	2	0,01%	20	2,99%	132	23,0%	338	59,0%	83	14,0%
Love life	21	4,0%	55	10,0%	158	27,0%	229	40,0%	112	19,0%
Support, support he is getting which from its friends	4	1,0%	26	5,0%	156	27,0%	259	45,0%	130	23,0%

More favourably respondents assessed the quality of their life in the century to 40 not having year of age, young girl, person of specialization (81%) or of qualifying course (65%). Table 4 is presenting data.

Very much badly respondents declaring bad financial circumstances assessed the quality of their life (57%), sensing complaints (100%), in the opinion which nurses are earning far less in comparing to representatives other competition ((86%), are having worse chances in the life (71%), are being discriminated (86%), the share of nurses on managerial positions towards the participation of nurses amongst the whole of employees in the workplace is lower (71%), the career is bringing less benefit than losses to their family circumstances (29%), they would resign from their job, if the practical husband/partner earned enough for the maintenance families on the satisfactory level (43%). Table 5 is presenting data.

Table 4. The evaluation of the quality of life, but the sex, age, living place, education, marital status, work experience of examined persons.

Tested feature	Evalution									
	Very bad		Bad		Neithergood nor bad		Good		Very good	
Sex:										
woman	7	100,0%	21	95,0%	202	99,0%	309	98,0%	25	96,0%
man	0	0,0%	1	5,0%	2	1,0%	7	2,0%	1	4,0%
Age:										
amount of years 22-40	0	0,0%	5	23,0%	75	37,0%	123	39,0%	15	58,0%
amount of years 41-60	7	100,0%	17	77,0%	127	62,0%	189	60,0%	10	38,0%
amount of years 61 and more	0	0,0%	0	0,0%	2	1,0%	4	1,0%	1	4,0%
Living place:										
village	1	14,0%	4	18,0%	54	26,0%	85	27,0%	4	15,0%
City to 5 thousandresidents	0	0,0%	0	0,0%	17	8,0%	11	3,0%	1	4,0%
City from 5 thousand to 10 thousand residents	0	0,0%	0	0,0%	10	5,0%	19	6,0%	3	12,0%
City from 10 thousand to 20 thousand residents	3	43,0%	2	9,0%	20	10,0%	34	11,0%	5	19,0%
City from 20 thousand to 100 thousand residents	1	14,0%	3	14,0%	40	20,0%	72	23,0%	5	19,0%
City above 100 thousand residents	2	29,0%	13	59,0%	63	31,0%	95	30,0%	8	31,0%
Marital status:										
younggirl / bachelor	1	14,0%	3	14,0%	46	23,0%	74	23,0%	5	19,0%
marriedwoman / married	3	43,0%	18	82,0%	124	61,0%	212	67,0%	20	77,0%
widow / widower	0	0,0%	0	0,0%	8	4,0%	1	0,0%	1	4,0%
Education:										
Senior medical collage	0	0,0%	7	32,0%	56	27,0%	74	23,0%	7	27,0%
medicalcourse	4	57,0%	4	18,0%	44	22,0%	53	17,0%	3	12,0%
bachelor degree studies (first cycle of nursing science)	3	43,0%	6	27,0%	87	43,0%	125	40,0%	11	42,0%
undergraduate studies leading to a master's degree of nursing science (of second cycle or uniform),	0	0,0%	5	23,0%	17	8,0%	60	19,0%	5	19,0%
undergraduate studies leading to a master's degree of nursing science (of second cycle)	1	14,0%	1	5,0%	8	4,0%	23	7,0%	4	15,0%
doctorate studies (third cyle)	0	0,0%	0	0,0%	0	0,0%	1	0,0%	0	0,0%
Work experience in the profession										
1-5 years	0	0,0%	4	18,0%	32	16,0%	64	20,0%	4	15,0%
6-10 years	0	0,0%	0	0,0%	10	5,0%	20	6,0%	3	12,0%
11-20 years	2	29,0%	6	27,0%	50	25,0%	70	22,0%	8	31,0%
21-30 years	4	57,0%	9	41,0%	86	42,0%	112	35,0%	8	31,0%
over 30 years	1	14,0%	1	5,0%	17	8,0%	40	13,0%	2	8,0%
no data	0	0,0%	2	9,0%	9	4,0%	10	3,0%	1	4,0%
Specialization:										
yes	3	43,0%	6	27,0%	47	23,0%	74	23,0%	5	19,0%
not	4	57,0%	16	73,0%	157	77,0%	242	77,0%	21	81,0%
Completed qualifying course:										
yes	4	57,0%	10	45,0%	97	48,0%	159	50,0%	9	35,0%
not	3	43,0%	12	55,0%	107	52,0%	157	50,0%	17	65,0%

Table 5. The evaluation of the quality of life but financial circumstances, complaints and chosen features of the work.

Tested feature	Evalution:									
	Very bad		Bad		Neithergood nor bad		Good		Very good	
Financial circumstances										
Very good	0	0,0%	0	0,0%	1	0,0%	14	4,0%	6	23,0%
good	2	29,0%	11	50,0%	121	59,0%	256	81,0%	17	65,0%
bad	4	57,0%	9	41,0%	72	35,0%	44	14,0%	2	8,0%
Very bad	1	14,0%	2	9,0%	4	2,0%	1	0,0%	0	0,0%
Complaints:										
He/she is sensing complaints	7	100,0%	19	86,0%	161	79,0%	225	71,0%	10	38,0%
He/she is sensing no complaints	0	0,0%	3	14,0%	43	21,0%	91	29,0%	16	62,0%
Compared with representatives of other competition										
Nurses are earning •:	6	86,0%	17	77,0%	127	62,0%	200	63,0%	15	58,0%
far less	0	0,0%	3	14,0%	32	16,0%	57	18,0%	5	19,0%
a bit less	0	0,0%	0	0,0%	10	5,0%	15	5,0%	0	0,0%
the same number	0	0,0%	0	0,0%	5	2,0%	3	1,0%	0	0,0%
far more	0	0,0%	0	0,0%	2	1,0%	2	1,0%	0	0,0%
somemore										
worse chances have •, possibilities in the life of competition different from representatives:	5	71,0%	12	55,0%	85	42,0%	121	38,0%	10	38,0%
yes	2	29,0%	5	23,0%	61	30,0%	97	31,0%	2	8,0%
rather yes	0	0,0%	1	5,0%	30	15,0%	50	16,0%	3	12,0%
rather not	0	0,0%	0	0,0%	14	7,0%	26	8,0%	6	23,0%
not	0	0,0%	4	18,0%	14	7,0%	22	7,0%	5	19,0%
I don'tknow										
Nurses are beingdiscriminated:	6	86,0%	11	50,0%	74	36,0%	112	35,0%	10	38,0%
yes	0	0,0%	6	27,0%	78	38,0%	103	33,0%	5	19,0%
rather yes	1	14,0%	2	9,0%	24	12,0%	59	19,0%	5	19,0%
no	0	0,0%	1	5,0%	9	4,0%	15	5,0%	1	4,0%
I don’t know	0	0,0%	2	9,0%	19	9,0%	27	9,0%	5	19,0%
The participation of nurses on managerial positions towards the participation of nurses among the whole of employees in the workplace is:										
higher	0	0,0%	1	5,0%	21	10,0%	41	13,0%	5	19,0%
the same	1	14,0%	2	9,0%	22	11,0%	22	7,0%	5	19,0%
Lower than	5	71,0%	15	68,0%	101	50,0%	157	50,0%	7	27,0%
I don't know	1	14,0%	4	18,0%	52	25,0%	84	27,0%	7	27,0%
The fact that he/she is having a career job, bringing to family circumstances:										
of more benefit than losses	1	14,0%	4	18,0%	76	37,0%	141	45,0%	14	54,0%
of the same number benefit as losses	3	43,0%	9	41,0%	67	33,0%	80	25,0%	5	19,0%
less benefit but more losses	2	29,0%	6	27,0%	18	9,0%	25	8,0%	0	0,0%
the work isn't affecting family circumstances	1	14,0%	3	14,0%	38	19,0%	62	20,0%	6	23,0%
They would give the career up, if husband (partner) brought home the bacon enough on the satisfactory level										
Yes	3	43,0%	7	32,0%	37	18,0%	63	20,0%	3	12,0%
not	4	57,0%	15	68,0%	160	78,0%	248	78,0%	22	85,0%
No data	0	0,0%	0	0,0%	7	3,0%	5	2,0%	1	4,0%

Discussion

Examining the quality of life causes, that the man has more and more greater participation in the health and practical evaluation of one's situation what is supporting of him not only the subject in the process of curing [18], but also in the working life and social. The quality of life remains the important aim of every social development, particularly the social policy which behind the important aim is accepting the common wealth. The man pleased with his life better notices his meaning, better is also functioning in the society [3]. A profession of the nurse is most often pursued by women what results achieved in own examinations confirmed [19]. In own examinations nurses higher have more often assessed the quality of their life and have more often declared satisfaction from its health in comparing to results achieved in WHO examinations amongst the population from 23 countries world [20]. However in the somatic, psychological and environmental sphere they achieved a little bit lower results, and in the social class disscusion examining WHO[20]. The quality of life remains the important aim of every social development, particularly the social policy which behind the important aim is accepting the common wealth. The man pleased with his life better notices his meaning, better is also functioning in the society [3]. A profession of the nurse is most often pursued by women what results achieved in own examinations confirmed [19]. In own examinations nurses higher have more often assessed the quality of their life and have more often declared satisfaction from its health in comparing to results achieved in WHO examinations amongst the population from 23 countries world [20].

However in the somatic, psychological and environmental sphere a little bit lower results, but a criticism in the social class got qualities of life amongst declaring persons bad financial circumstances [24], of feeling complaints [25], is confirming results achieved by other authors and meaning of these factors in the improvement of quality of life of also nurses. Feeling the unequal treatment on the labour market, smaller remuneration for the work, worse chances in the life, and workload, of which less benefit is a result and more losses because of the work, not only negatively are having an influence to the productivity and exploiting the potential lying in this occupational group [26], but is also supporting worsening for her qualities of life and requires entertaining nurses by the government, employing entities and the self-government, of appropriate corrective actions and preventive. Also keeping an eye on it is essential, whether nurses for the performed work are honestly and just rewarded?

Conclusions

1. The majority of nurses positively are assessing the quality of its life.

2. Nurses in comparing to the clerical staff worse are assessing the quality of their life.
3. The evaluation of the quality of life of nurses is made conditional on the influence of many factors.

References

1. Wnuk M., Marcinkowski J.: Quality of life as a pluralistic and multidisciplinary construct. Probl. Hig. Epidemiol., 2012, 93, 21-26.
2. Nowy Leksykon. PWN, Warszawa, 1998.
3. Skrzypek E. : Economic aspects of quality of life. Quality Problems, 2001,1, 8-14.
4. Adamiec M., Popiołek K.: Quality of life - between freedom and a hoax. Movement of Jurists, Economics and Sociology, 1993, 2, 92-117.
5. Kaleta A.: Quality of life of rural youth. UMK, Toruń, 1988.
6. Tomaszewski T:. Trails and patterns. WSiP, Warszawa, 1976.
7. Saxena S., Orley J.: (on behalf of the WHOQOL Group). Quality of life assessment:the World Health Organization perspective.Eur. Psychiatry 1997, 12, Suppl.3, 263-266.
8. Jaeschke R., Guyatt G., Cook D., Miller J.: The definition and measurement of quality of life related to health. Medicine Med. Prakt., http://www.mp.pl/ artykuly/10534, data pobrania 15.03.2014
9. Oliver J., Huxley P., Bridges K., Mohamad H.: Quality of life and Mental Health Services. Rontledge, London, 1996, 31.
10. Gawlina Z.: Quality of life as a category of human existence description used in the social sciences. Materials of the International Scientific Conference "Nursing and quality of life" Krakow, 7-8 september 2000.
11. De Walden-Gałuszko K., Majkowicz M., Trojanowski L.: Role of social functioning, mental and spiritual sphere in the global assessment of the quality of life. Pychoonkologia, 1997, 1, 78-85.
12. Trzebiatowski J.: Quality of life in the perspective of social and medical sciences – classification of definitions. Hygeia Public Health, 2011, 46, 25-31.
13. Kane R.A.: The concept of quality of life of people with mental retardation in some facets of contemporary theoretical. ZawiślakA. UMCS, Lublin, 2006, 151.
14. Kane R.A.: Quality of life w Breslow L. [in:] Encyclopaedia of Public Health. Vol. 3 , Macmillan Reference USA, New York 2002,1003-1006.

15. Wrześniewski K.: How to assess quality of life of cardiological patients? Kardiol. Pol. 2009, 67, 790-794.
16. Wołowicka L., Jaracz K.: Polish version WHOQOL – WHOQOL 100 i WHOQOL-BREF [w:] Quality of life in medical science, Wołowicka L. (ed.), AM, Poznań, 2001, 276-280.
17. Turska W., Skowron A.: Methodology for assessing quality of life. Pharmacoeconomics, 2009, 65, 572- 579.
18. De Walden-Gałuszko K.: Quality of life - general considerations [in:] Quality of life in cancer., De Walden-Gałuszko K. Majkowicz M. (ed.), UG, Gdańsk, 1994, 13–39.
19. Abramczyk A., Franek G., Olechowska U., Guzak B.: The prestige of the nursing profession in the opinion of nurses in Poland (communication studies) [in:] Health promotion, prevention and care for chronic diseases - contemporary problems. Abramczyk A. et al.ed, T.1, A & A Optimed, Wrocław, 2011, 13-20.
20. Skevington S.M., Lotfy M., O'Connell K.A.: The World Health Organization's WHOQOL-BREF quality of life assessment: Psychometric properties and results of the international field trial A Report from the WHOQOL Group. Quality of Life Research. 2004, 13, 299–310.
21. Zaniewska R., Okurowska-Zawada B., Kułak W., Domian K.: analysis of quality of life in patiens with low back pain after receiving transcutaneous electrical nerve stimulation (TENS). Med. Pracy, 2012, 63, 295–302.
22. Majkowicz M., Zdun-Ryżewska A.: Quality of life in mental disorders - concepts, research, measurement tools. Psychiatry Clin. Pract., 2009, 2, 100–114.
23. Lisiński P., Małgowska M.: Quality of life and pain syndrome spine against the overload. Chir. Narządów Ruchu Ortop. Pol., 2005, 70, 361–365.
24. Glasgow R.E., Ruggiero L., Eakin E.G., et al.: Quality of life and associated characteristics in a large national sample of adults with diabetes. Diabetes Care, 1997, 20, 562-567.
25. Bury M.: The sociology of chronic illness : a review of research and prospekts. Sociology of Health & Illnes, 2006, 13, 451-468.
26. Lisowska E.: Monitoring gender equality in the workplace, EQUAL, UNDP, Warszawa, 2007.

THREATS
IN THE WORKPLACE

Danusewicz Anna[1], Czujko Oksana [1], Abramczyk Anna[2], Orzechowski Stanisław [1]

Preventive behaviour and the risk of lifestyle diseases among nurses

1. Students' Scientific Research in Public Health, Faculty of Medical Sciences, University of Warmia and Mazury in Olsztyn
2. Department of Public Health, Faculty of Medical Sciences, University of Warmia and Mazury in Olsztyn (carer of the Students Scientific Society)

Introduction

As in other industrial countries, the major reason causing deaths of women as well as of men constitute cardiovascular diseases [1]. Premature deaths caused by cardiovascular diseases are much serious problem for women and men in Poland than in the UE countries [2], and the level of mortality caused by these diseases in Poland is higher than average in the UE [2]. In spite of general decreasing tendency of mortality level caused by arteriosclerosis there is still two-fold increase of mortality in Warmińsko-Mazurski region. Other health threats are malignancies, which is second-largest cause of death. Among malignancies the most dangerous for Polish citizens are rhinotrachetis, bronchus and lung tumors, causing problem of mortality in Warmińsko-Mazurski region for people general, as well as for the persons between 25-64 years of age [2]. Analysis show that style of life is responsible for health condition of populations and societies. In case of cardiovascular diseases 54%, tumors 37%, and general mortality 50% [2]. The most important factors causing mortality in Poland are considered: smoking cigarettes, hypertension and elevated cholesterol level, overweight and obesity, excessive consumption of alcohol, low consumption of fruit and vegetables and low physical activity [1,2].

As nurses make the largest occupation al group, by performed functions and tasks and long-term contact with a patient they influence healthy behavior of the society. Thus, they are expected not only to have knowledge,but also proper manner and health behavior [3].

Determination of selected prevention behavior among nurses was obtained through answer to the following questions: sleep, rest, physical activity, eating, weight control, smoking, following doctor’s advice.

Aim of the work was to study of nursing selected behavior in terms of prevention concerning civilization diseases.

For the aim of this work the following research problems were adopted:

- At what degree the nurses apply preventive behaviours in their everyday life?
- What preventive behaviors are nurses characterized by?

Materials and methods

Results of the research come from 158 nurses of Warmińsko-Mazurski region. Almost half of selected population were secondary schools and medical studies graduates (postsecondary schools) (48,7%). Majority of the respondents were MA graduates (28,5%) and undergraduates (22,8%). The research was made on the basis of questionnaire survey in consideration of modified index version of health behavior [5].

Respondents' participation in the research was voluntary and confidential.

Results

The persons participating in the research were mostly inhabitants of urban environment (85%), were married (63%), and worked in public health care unit (80%). Most respondents had higher education, worked over 10 years in their profession (70%). For most respondents livelihood was permanent job (61%). The data is shown in Table 1.

From analysis of declared behavior, with preventive meaning, appears that almost one in five respondents almost never or rarely: care for proper nutrition (19%), limits sweets consumption, animal fats (20%), limits salt consumption and heavy salted food (19%), consume wholegrain bread (17%).

Almost always declare expression of expected preventive behavior from 8 to 25 % of respondents. Most of the time enquired respondents consume much vegetables and fruit (25%) and most rarely they almost always limit consumption of sweets and animal fats (8%). Slightly more often expected behavior was declared by graduates of master's studies, in comparison to secondary schools and medical studies graduates.

Limit salt consumption (22.2%), preserved foods (15.6%) most often graduates of master's studies (13.3%) and most rarely graduates of secondary and postsecondary schools (26%). Almost always consume many fruit and vegetables graduates of master's studies (37.8%) and most rarely graduates of undergraduates' studies. Data are shown in Table 2.

Table 1. Characteristics of the study population.

	N	[%]
Sex:		
woman	155	98,0%
man	3	2,0%
Age:		
Age range 22-40	63	40,0%
Age range 41-60	77	49,0%
Age range 61 and more	2	1,0%
No data	16	10%
Place of residence:		
rural	23	15,0%
urban up to 5 thousand habitants	8	5,0%
urban up to 5 thousand to 10 thousand habitants	12	8,0%
urban up to 10 thousand to 20 thousand habitants	22	14,0%
urban up to 20 thousand to 100 thousand habitants	37	23,0%
urban over 100 thousand habitants	56	35,0%
Status:		
single	29	18,0%
married	99	62,0%
widow/widower	5	3,0%
divorced	22	14,0%
separated	5	3,0%
Education :		
Medical secondary school	43	27,0%
Postsecondary medical school	34	22,0%
Undergraduate studies of I degree at nursing faculty	36	23,0%
Master’s studies (II degree), at nursing faculty	45	28,0%
Master’s studies (II degree) at faculty	3	2,0%
Specialization:		
Possesses	44	28%
Not possesses	114	72,0%
Work environment:		
Public health Care Unit	127	80,0%
Non-Public health care unit	37	23,0%
Public Hospital	125	79,0%
Non-Public hospital	16	10,0%
Ambulatory of Public health care Unit	1	1,0%
Ambulatory of Non-Public health care Unit	4	3,0%
Public Higher Education Institution	2	1,0%
Work training in profession:		
1-5 years	32	20,0%
6-10 years	16	10,0%
11-20 years	33	21,0%
21-30 years	57	36,0%
over 30 years	20	13,0%
Main Source of income:		
Permanent work	97	61,0%
Part time work	52	33,0%
Contract of order/ or contract for service	1	1,0%
Contract work	10	6,0%
Self-employment	3	2,0%

Table 2. Behavior regarding nutrition among the study population.

Feature tested:	Total		Level of education:					
			Secondary school and postsecondary medical schools graduates		Undergraduate studies graduates		Master's studies graduates	
Behavior regarding nutrition	158	100%	77	48,7	36	22,8	45	28,5
Eats much fruit, vegetables:								
a) almost never	6	4,0%	2	2,5,0%	2	6,0%	2	4,4%
b) rarely	9	6,0%	3	4,0%	3	8,0%	3	6,7%
c) from time to time	42	26,0%	22	28,5%	8	22,0%	12	26,7%
d) often	52	33,0%	29	38,0%	14	39,0%	9	20,0%
e) almost always	41	26,0%	17	22,0%	7	19,0%	17	37,8%
the lack of data	8	5,0%	4	5,0%	2	6,0%	2	4,4%
Limits consumption of animal fats, sugar:								
a) almost never	4	3,0%	1	1,0%	2	6,0%	1	2,2%
b) rarely	27	17,0%	16	21,0%	8	22,0%	3	6,7%
c) from time to time	51	32,0%	23	30,0%	9	25,0%	19	42,3%
d) often	51	32,0%	27	35,0%	9	25,0%	15	33,3%
e) almost always	13	8,50%	3	4,0%	5	14,0%	5	11,1%
the lack of data	12	7,5%	7	9%	3	8%	2	4,4%
Cares for proper nutrition:								
a) almost never	5	3,0%	4	5,0%	1	3,0%	0	0,0%
b) rarely	25	16,0%	16	21,0%	4	11,0%	5	11,1%
c) from time to time	41	26,0%	18	23,0%	8	22,0%	15	33,3%
d) often	58	36,5%	26	34,0%	16	45,0%	16	35,6%
e) almost always	17	11,0%	7	9,0%	4	11,0%	6	13,3%
the lack of data	12	7,5%	6	8%	3	8%	3	6,7%
Avoids consumption of food with preservatives:								
a) almost never	9	6,0%	5	6,5%	2	6,0%	2	4,4%
b) rarely	24	15,0%	13	17,0%	7	19,5%	4	8,9%
c) from time to time	52	33,0%	25	32,0%	9	25,0%	18	40,0%
d) often	41	26,0%	17	22,0%	12	33,5%	12	26,7%
e) almost always	18	11,0%	8	10,5%	3	8,0%	7	15,6%
the lack of data	14	9%	9	12%	3	8,0%	2	4,4%
Avoids salt and heavy salted food:								
a) almost never	3	2,0%	1	1,5%	1	3,0%	1	2,2%
b) rarely	27	17,0%	14	18,5%	7	19,0%	6	13,3%
c) from time to time	47	30,0%	25	32,0%	11	31,0%	11	24,4%
d) often	40	25,0%	17	22,0%	9	25,0%	14	31,1%
e) almost always	25	16,0%	10	13,0%	5	14,0%	10	22,2%
the lack of data	16	10%	10	13,0%	3	8,0%	3	6,8
Eats fully grain bread:								
a) almost never	6	4,0%	4	5,0%	1	3,0%	1	2,2%
b) rarely	20	13,0%	9	12,0%	5	14,0%	6	13,4%
c) from time to time	44	28,0%	19	25,0%	11	31,0%	14	31,1%
d) often	40	25,0%	21	27,0%	7	19,0%	12	26,7%
e) almost always	36	22,5%	18	23,0%	8	22,0%	10	22,2%
the lack of data	12	7,5%	6	8%	4	11%	2	4,4%

From analysis of respondents' statements appears that never or rarely limit smoking cigarettes one in five respondents (22%), and almost always 41%. Graduates of undergraduate studies slightly more often declare limiting smoking cigarettes (47%). 22% of respondents try to control their weight. The weight is usually controlled by graduates of undergraduate studies (25%) and most rarely graduates of secondary and postsecondary schools (31%).

Enough sleep has only one in ten respondents (11%), more often graduates of master's studies (22%). Almost always tries to obtain medical information on health situation and diseases only 18% of respondents, slightly more often graduates of secondary and postsecondary schools (23%). Only one in five respondents almost always try to find out how others avoid diseases (20%). Almost one in three respondents never or rarely tries to avoid physical activity (28%) and almost always tries to avoid one in ten of respondents (9%). Almost always enough rest have (9%) of nurses. Almost never or rarely have enough rest most often graduates of secondary and postsecondary schools (33%). 16% of respondents almost always follows doctors recommendations and almost never or rarely only 17% of respondents. Data are shown in Table 3.

Table 3. Preventive behavior among the study population.

Feature tested:	Total		Level of education:					
			Secondary school and postsecondary medical schools graduates		Undergraduate studies graduates		Master's studies graduates	
	158	100%	77	48,7	36	22,8	45	28,5
Limits smoking cigarettes:								
a) almost never	22	14,0%	11	14,0%	5	14,0%	6	13,3%
b) rarely	13	8,0%	7	9,5%	4	11,0%	2	4,4%
c) from time to time	17	11,0%	8	10,5%	1	3,0%	8	17,8%
d) often	19	12,0%	11	14,0%	3	8,0%	5	11,1%
e) almost always	64	40,5%	30	39,0%	17	47,0%	17	37,8%
the lack of data	23	14,5%	10	13,0%	6	17%	7	15,6%
Controls weight:								
a) almost never	7	4,0%	6	8,0%	0	0,0%	1	2,2%
b) rarely	29	18,5%	18	23,0%	8	22,5%	3	6,7%
c) from time to time	44	28,0%	22	29,0%	7	19,5%	15	33,3%
d) often	41	26,0%	14	18,0%	9	25,0%	18	40,0%
e) almost always	26	16,5%	12	16,0%	9	25,0%	5	11,1%
the lack of data	11	7%	5	6%	3	8%	3	6,7
Has enough sleep:								
a) almost never	8	5,0%	4	5,0%	1	3,0%	3	6,7%
b) rarely	28	17,5%	13	17,0%	11	30,5%	4	8,9%
c) from time to time	53	34,0%	30	39,0%	5	14,0%	18	40,0%
d) often	41	26,0%	19	25,0%	15	41,5%	7	15,5%
e) almost always	17	10,5%	6	8,0%	1	3,0%	10	22,2%
the lack of data	11	7%	5	6%	3	8%	3	6,7%
Avoids excessive physical activity:								
a) almost never	12	8,0%	8	10,0%	3	8,0%	1	2,2%
b) rarely	32	20,0%	17	22,0%	8	22,0%	7	15,6%

c) from time to time	52	33,0%	20	26,0%	12	33,5%	20	44,4%
d) often	39	25,0%	21	27,5%	8	22,5%	10	22,2%
e) almost always	14	9,0%	7	9,0%	2	6,0%	5	11,2%
the lack of data	9	5%	4	5,5%	3	8,0%	2	4,4%
Rests enough:								
a) almost never	9	6,0%	3	4,0%	1	3,0%	5	11,1%
b) rarely	37	23,0%	22	28,5%	9	25,0%	6	13,3%
c) from time to time	51	32,0%	21	27,0%	13	36,0%	17	37,8%
d) often	34	22,0%	19	24,5%	5	14,0%	10	22,2%
e) almost always	14	9,0%	6	8,0%	4	11,0%	4	8,9%
the lack of data	13	8%	6	8,0%	4	11,0%	3	6,7%
Follows doctors' recommendations ensuing from my research:								
a) almost never	10	6,5%	4	5,0%	2	6,0%	4	8,9%
b) rarely	18	11,5%	11	14,0%	3	8,0%	4	8,9%
c) from time to time	37	23,5%	18	23,5%	5	14,0%	14	31,1%
d) often	54	34,0%	25	32,5%	14	39,0%	15	33,3%
e) almost always	26	16,5%	12	16,0%	8	22,0%	6	13,3%
the lack of data	13	8%	7	9%	4	11%	2	4,5%
Regularly does medical examinations:								
a) almost never	11	7,0%	6	8,0%	2	6,0%	3	6,7%
b) rarely	32	20,0%	16	20,5%	7	19,0%	9	20,0%
c) from time to time	34	22,0%	16	20,5%	8	22,0%	10	22,2%
d) often	37	23,0%	13	17,0%	11	31,0%	13	28,9%
e) almost always	30	19,0%	17	22,0%	5	14,0%	8	17,8%
the lack of data	14	9%	9	12%	3	8%	2	4,4%
Tries to obtain medical information and understand what causes diseases and health:								
a) almost never	10	6,5%	5	6,5%	4	11,0%	1	2,2%
b) rarely	13	8,0%	5	6,5%	3	8,4%	5	11,1%
c) from time to time	37	23,0%	20	26,0%	7	19,2%	10	22,2%
d) often	58	37,0%	23	30,0%	15	42,0%	20	44,4%
e) almost always	28	18,0%	18	23,0%	4	11,0%	6	13,3%
the lack of data	12	7,5%	6	8%	3	8,4%	3	6,8%
Tries to find out how others avoid diseases:								
a) almost never	0	0,0%	6	8,0%	5	14,0%	2	4,4%
b) rarely	13	8,0%	10	13,0%	9	25,0%	11	24,4%
c) from time to time	30	19,0%	30	39,0%	8	22,0%	12	26,7%
d) often	50	32,0%	16	21,0%	5	14,0%	11	24,4%
e) almost always	32	20,0%	7	9,0%	6	17,0%	6	13,3%
the lack of data	33	21%	8	10%	3	8%	3	6,8%

Discussion

Many authors draw attention to lack of care regarding health among nurses [3], which may be caused by: conditions and specific of work, workload and perform functions in work and privet life [4]. Obtained results from private research confirmed a lack of care regarding health among nurses [3,4].

One of the diagnosed health threats among nurses is smoking, which is considered most significant cause of deaths in the world and one of the main risk factors of many chronic diseases such as: some of malignancies, lung diseases or coronary vascular diseases [6]. Smoking, each year, causes death of 5 million people. In Poland 33,5% adult men smokes cigarettes (5,2 million) and 21% adult women (3,5 million) [7], percentage of smoking Polish middle age women is the highest in the European Union [7].In spite of number of initiatives aiming to reduce the problem, obtained results in our study confirm the risk of smoking cigarettes [2,7,8] among this medical personnel [3,8].

Although overweight and obesity are important risk factors of number of chronic diseases [9,10] (hypertension, heart diseases, respiratory system, diabetes type 2), and premature death one in five respondents almost never control their weight or very rarely and one in ten almost always consider this factor. An important element of life style significant from the perspective of prevention regarding cancer and cardiovascular diseasesis consumption ofvegetable and fruit. In order to provide, vitamins, minerals and fibre the vegetables should be consumed in 4 portions daily, whereas fruit – source of vitamins, minerals, antioxidants and fibre should be consumed in 3 portions daily [11].Obtained results confirmed maintaining deficit regarding fruit and vegetables consumption [2], because one in three research participating nurses eat them from time to time or less.

Under the prevention of cardiovascular diseases, in healthy persons diet, limitation of fats consumption is recommended especially saturated fats [11]. Among questioning respondents a small percentage (8%) almost always limit this nutrient. Carbohydrates, which are important source of energy, play significant role in weight control, diabetes, cardiovascular diseases, colorectal cancer, aging and many more [11], one in five of respondents rarely or almost never limits this product.

Important role to maintain a good health play food fibre regarding total cholesterol reduction and LDL fractions in blood, positive influence on intestinal motility, postprandial plasma glucose, insulin level. Fibre consumption among adults at the level of 25g/per day has positive effect not only to maintain proper weight but also reduce the risk of diet derived diseases. The main source of fibre in Poland come from grain products (54%) and the best of its source is whole meal rye bread, mixed bread with addition of grain and various kinds of cereals [11] In accordance with healthy nutrition habits the wholegrain products should be the main source of energy, eaten in amount of five portions daily, best in form of wholegrain products. In spite of recommendations and positive health influence also because of fibre, wholegrain bread is consumed only one in five respondents (17%).

Although the diet is too rich in sodium chloride (salt), which may cause hypertension, stroke and stomach cancer [11]only one respondents in five avoids consumption of over salted food and similar percentage almost never avoids this kind of food. In this situation most people of tested population is in risk group of diseases caused by exceeding salt consumption. Proper nutrition of adult person in the light of literature, its among other things nutrition which provides zero energetic balance, where main source of energy are complex carbohydrates(50-70%), amount of monosaccharides does not exceed 12%, fats provide 20-35% of energy, protein 10-15% and a number of meals amounts from 4-5 daily [11].Almost 20% of respondents in our study nearly never or rarely cares for healthy nutrition and almost always cares for it only 11%. As in research carried out among nurses only one in four claims that from time to time cares for proper nutrition [3].

Although important element of prevention against diseases causing by incorrect nutrition is regular physical activity with moderate intensity [11], excessive physical activity almost always avoid only 9% respondents and almost never or rarely 28% respondents. Maintaining balance between excessive physical activity, work and rest and sleep plays significant role in keeping healthy [12]. Results of number of research proof that long term sleep deficit makes a risk factor of cardiovascular diseases, cancer and psychosomatic diseases [13,14,15] and metabolic disorders [16]. A risk caused by sleep deficit was confirmed by the results obtained in our study. Almost always enough amount of sleep declare only 11% of nurses, and one in five (23%) claims that almost never or rarely sleeps much enough

Care deficit for health among questioned nurses also stems from their lack of respect doctors' recommendations in comparison to results obtained by other authors [3]. Only 18% of nurses almost always try to obtain medical information on health improvement and diseases prevention.

In our study, more often was found a deficit, which is significant behavior in health protection and diseases prevention in comparison to the one obtained among plant workers in Lublin [17], a participant of the third age university, elderly persons [18,19] and diabetics [20] and nursing personnel at the beginning of the year 2000 [4].

Established behavioral deficit among persons representing the medical profession confirms authors' opinion about low behavior satisfaction despite the fact; they are expected to do better because of their profession [21]. Established results in our study show that recommendations regarding prevention against civilization diseases, maintaining health, healthy nutritions among questioned population are not followed satisfactorily and the respondents in various degrees are exposed to negative consequences of deficit expected behavior and required thorough and directed education in this respect. As healthy behavior and health care depend on various kinds of factors among which, apart from level of knowledge and skills, are economic, social and political conditions [22], also there is necessary to draw attention to working and life conditions of this kind of medical personnel.

Conclusions

1. Nurses show different levels of behaviours relevant to the prevention of lifestyle diseases in their everyday life.
2. The majority of nurses can be characterized by a significant deficit in prevention behaviours.
3. Irregularities regarding behavior are connected with lack of balance between activity and rest as well as the limitation of sweets and animal fats consumption.

References

1. Golinowska S.: Outline of health Care System Poland 2012. Warszawa, 2012.
2. Wojtyniak B., Goryński P., Moskalewicz B.: Health Situation of Polish People and its Conditions. PHZ, Warszawa, 2012.
3. Warchoł-Sławińska E., Włoch K.: Health Behaviour of Nurses. Public Health, 2003, 113, 156-159.
4. Kowalczyk–Sroka B., Marmurowska-Michałowska H., Cieślik A., Lelonek B.: Health Behavior Among Diabetics and Medical Personnel, Ann. UMCS Sect. D, 2003, 58, suppl. 13, 125, 105-110.
5. Juczyński Z.: Measuring Tools in Promotion and Health Psychology, Workstation of Psychological Tests of Polish Psychological Association, Warszawa, 2001, 116- 122
6. GUS. Health and Health Care in 2011. Warszawa, 2012.
7. WHO. Global Survey Regarding Smoking Cigarettes by Adult Persons (GATS) Poland 2009-2010.
8. WHO. Threat of Smoking Cigarettes Epidemic in Poland WHO 2009.
9. Matuszak M., Suliburska J.: Significance of reduction of Weight in Metabolic Diseases Treatment. Metabolic Disorders Forum, 2012, 3, 104–109.
10. Pacholczyk M., Ferenc T., Kowalski J.: Metabolic Syndrome. Part I: Definitions and Criterion of Metabolic Syndrome Diagnosis. Epidemiology and Connection to

Cardiovascular Diseases and Type 2 Diabetes. Post. Hig. Med. Dośw., 2008, 62, 530-542.

11. Jarosz M.: Nutrition Standards for Polish Population – Revision. IŻŻ, Warszawa, 2012.
12. WHO „Health Impact of Psychosocial Hazards at Work: An Overview". World Health Organisation, 2010.
13. Kasperczyk J., Kasperczyk J., Jośko-Ochojska J.: Evaluation of Relation Between Sleep and Selected Achievements and Duties of Students. Ann. Acad. Med. Stetin., , 2013, 67, 3.
14. Jurkowski M.K., Bobek-Billewicz B.: Influence of Sleep Deprivation on Organism Resistance. Sleep, 2002, 2, 95–98.
15. Zawilska J.B., Półchłopek P., Wojcieszak J., Andrzejczak D.: Chronobiological Disorders of Sleep. Farm. Pol., 2010, 66, 179-186.
16. Rabe-Jabłońska J.: Metabolic Disorders in Psychiatry and Neurology, Farmakoter Psychiatr Neurol., 2011, 1, 12–16.
17. Ślusarska B., Nowicki G.: Health Behavior in Prevention of Cardiovascular Diseases Among Working People. Problems of Epidemiological Hygiene, 2010, 91, 34-40.
18. Kozieł D., Kaczmarczyk M., Naszydłowska E., Gałuszka R.: Influence of Education in The Third Age University on Health Behavior of Elderly People. Med. Stud., 2008, 12, 23–28.
19. Muszalik M., Zielińska-Więczkowska H., Kędziora-Kornatowska K., Kornatowski T.: Evaluation of Selected Behavior Affecting Health Among Elderly People on the Basis of Inventory Health Behavior by Juczyński in the Question of Socio-Demographic Factors. Problems of Epidemiological Hygiene, 2013, 94, 509-513.
20. Kurowska K., Szomszor M.: Influence of Health behavior on Life Quality in People with Diabetes Type 2 Diagnosed. Practical Diabetology, 2011, 12, 142-150.
21. Baran A., Stocka A.: Studies Faculty as Determinant of Health Behavior. Medical Review of Rzeszów University, 2008, 4, 326-331.
22. Maszorek-Szymala A.: Health behavior of Women and Men Professionally Active. Now. Lek., 2012, 81,360–365.

Danusewicz Anna[1], Czujko Oksana [1], Abramczyk Anna[2], Orzechowski Stanisław[1]

Work conditions for nursing staff – selected aspects

1. Students' Scientific Research in Public Health, Faculty of Medical Sciences, University of Warmia and Mazury in Olsztyn
2. Department of Public Health, Faculty of Medical Sciences, University of Warmia and Mazury in Olsztyn (carer of the Students Scientific Society)

Introduction

Numerous research proves that psychosocial threats at work have a harmful influence on health (physical, social) and sanity of working people [1,2,3]. What is more, they are a cause of increasing costs of medical care. More than 40 million of European citizens suffer from occupational stress. The estimated data shows that at least 10% of adults at working age in Poland, USA, Great Britain and Germany suffers from clinically detected depression, fear (anxiety), stress or the occupational burnout. Vascular diseases, damages to musculoskeletal system and mental illnesses are the main reasons mentioned as causing the working ability loss [4,5]. Occupational stress, violence, mobbing are currently main challenges in the field of occupational safety and health [6]. Moreover, psychosocial factors occurring at the working place and stress connected with them were recognized as significant threats for to health and safety of working people [7]. In industrialized countries psychosocial risks are increasingly major public health problem. In modern conditions of healthcare system functioning, the work of a nurse is recognized as one of most stressful [9,10]. The aim of this dissertation is to acquaint with the opinions of nurses on their working conditions.

For the aim of this work the following research problems were adopted:

- How does the nurses assess their chosen elements at the place of work?
- What is the source of the greatest load at nurses work?

Materials and methods

The results of the study come from 158 people working in a profession of a nurse on Warmia and Mazury. Almost half of the examined group was graduates of medical studies and high schools. The major part of people asked consisted of graduates of master studies (28,5%) and bachelor studies (22,8%). The study was based on a questionnaire complemented by the scale of job satisfaction and the categories of psychosocial factors. It was assumed that with its help it will be possible to know the opinion of the nurses on the conditions, nuisance and stress at work, and psychosocial work environment factors that are their source. The participation of respondents in the study was voluntary and anonymous.

Results

People participating in the study mostly lived in urban areas (85%), were married (63%) and worked in a public health care (80%). Most of the respondents had a university degree, worked in the profession for over 10 years (70%). The source of livelihood for the majority of respondents was full-time job (61%). The data is shown in Table 1.

The account of respondents indicates that they are mostly critical of remuneration and social benefits. Dissatisfaction with salary declares 55% of respondents. Every third nurse indicates dissatisfaction with career opportunities (33%) and a fourth critically evaluate the conditions under which the job runs (26%) and organization of work (25%).

Participants found the most positive interpersonal contacts (75%). The vast majority of respondents indicated satisfaction with work (78%). Most nurses declare their satisfaction with the type of work (81%). The average score in the range of 1-1.5 is considered to be low, indicating dissatisfaction. Result in the range of 3.5-4 treated as high, indicates satisfaction with the work. The obtained results allow to say that nurses found chosen aspects of the work in a moderate way. Each of the evaluated elements of the work environment requires optimization, especially remuneration and social benefits. The data is presented in Table 2.
Nurses participating in the survey, the least likely though more often than every third, are exposed to the phenomenon of theft and providing services. Every second person indicates the risk, for which the reasons are: a little freedom in the process of deciding on the performance of duties (54%) and too small scope of authorizations necessary to perform the task (55%). The vast majority of respondents experience at work burden resulting from too low remuneration compared to the amount of work (79%) and exposure to verbal aggression (72%). The data is presented in Table 3.

An analysis of the factors determining the working relationship shows that nurses are often exposed to the negative consequences determined by the necessity to perform the tasks belonging to the responsibilities of other people (69%). A slightly smaller percentage of respondents indicates the threat of serious professional consequences as a result of mistakes at work (65%). Every second person pointed the presence of conflicts and disagreements with colleagues (54%) and excessive control by supervisors (53%). The least likely indicated factor was the competitiveness (28%). The data is presented in Table 3.

Table 1. Characteristics of the study population.

	N	[%]
Sex:		
woman	155	98,0%
man	3	2,0%
Age:		
Age range 22-40	63	40,0%
Age range 41-60	77	49,0%
Age range 61 and more	2	1,0%
No data	16	10%
Place of residence:		
rural	23	15,0%
urban up to 5 thousand habitants	8	5,0%
urban up to 5 thousand to 10 thousand habitants	12	8,0%
urban up to 10 thousand to 20 thousand habitants	22	14,0%
urban up to 20 thousand to 100 thousand habitants	37	23,0%
urban over 100 thousand habitants	56	35,0%
Status:		
single	29	18,0%
married	99	62,0%
widow/ widower	5	3,0%
divorced	22	14,0%
separated	5	3,0%
Education :		
Medical secondary school	43	27,0%
Postsecondary medical school	34	22,0%
Undergraduate studies of I degree at nursing faculty	36	23,0%
Master's studies (II degree), at nursing faculty	45	28,0%
Master's studies (II degree) at faculty	3	2,0%
Specialization:		
Possesses	44	28%
Not possesses	114	72,0%
Work environment:		
Public health Care Unit	127	80,0%
Non-Public health care unit	37	23,0%
Public Hospital	125	79,0%
Non-Public hospital	16	10,0%
Ambulatory of Public health care Unit	1	1,0%
Ambulatory of Non-Public health care Unit	4	3,0%
Public Higher Education Institution	2	1,0%
Work training in profession:		
1-5 years	32	20,0%
6-10 years	16	10,0%
11-20 years	33	21,0%
21-30 years	57	36,0%
over 30 years	20	13,0%
Main Source of income:		
Permanent work	97	61,0%
Part time work	52	33,0%
Contract of order/ or contract for service	1	1,0%
Contract work	10	6,0%
Self-employment	3	2,0%

Table 2 . Job satisfaction in the opinion of the respondents.

Tested feature	The average for population	a) very dissatisfied		b) rather dissatisfied		c) rather satisfied		d) very satisfied	
Working conditions	2,7	11	7,0%	30	19,0%	98	62,0%	15	9,0%
Work organization	2,7	10	6,0%	30	19,0%	101	64,0%	13	8,0%
Type of job	2,9	9	6,0%	12	8,0%	79	50,0%	49	31,0%
Remuneration and benefits	2,1	33	21,0%	53	34,0%	61	39,0%	2	1,0%
Professional development opportunities	2,6	9	6,0%	42	27,0%	88	56,0%	13	8,0%
Interpersonal relations	2,8	7	4,0%	23	15,0%	90	57,0%	29	18,0%
General satisfaction	2,8	5	3,0%	22	14,0%	105	66,0%	19	12,0%

Table 3 Psychosocial working conditions in the opinion of the respondents.

Tested feature Total N = 158	Appears	
	N	[%]
Working conditions:		
Deterioration or shortage of technical equipment used for work	96	61,0%
Problems with sufficient privacy to my clients in areas at the workplace	93	59,0%
Exposure to verbal aggression	114	72,0%
Exposure to assault, injury	83	53,0%
Exposure to theft and / or destruction of property	72	46,0%
The necessity to work alone, when there is a threat to my safety	68	43,0%
Little freedom in deciding how to perform my duties	85	54,0%
Too small range of powers needed for effective action to people under your charge	87	55,0%
Too low wages in relation to the workload	125	79,0%
Relations at work:		
Excessive control by superiors	83	53,0%
Excessive control by officials	66	42,0%
The threat of serious professional consequences for making mistakes at work	102	65,0%
Difficulties in obtaining support from the immediate supervisor in difficult professional situations	67	42,0%
Conflicts, misunderstandings with my supervisor	66	42,0%
Lack of recognition and respect from superiors	62	39,0%
Conflicts, misunderstandings with my colleagues	86	54,0%
The necessity to compete with colleagues	45	28,0%
The necessity to perform the tasks belonging to the responsibilities of other people	109	69,0%
Limited opportunities for improvement of professional competence	67	42,0%
Work with client:		
The necessity to reconcile the many conflicting interests	93	59,0%
Attempts to manipulation by patients	108	68,0%
The necessity to help clients who do not engage in cooperation with me	107	68,0%
Conflicts, misunderstandings with my clients / patients	97	61,0%
The necessity of helping clients whose families do not engage in cooperation with me, even when it is necessary	114	72,0%
Conflicts, misunderstandings with the families of my clients / patients	103	65,0%
Necessity to use ambiguous laws in force in my work	81	51,0%
The necessity for using legislation and procedures unsuited to the realities	97	61,0%
The rules, procedures impeding cooperation with other institutions, organizations	91	58,0%
Complex and / or tedious procedures related to the granting of aid to the clients	103	65,0%
Low effectiveness of existing procedures and professional instruments to solve problems	92	58,0%
The necessity to spend time doing unnecessary "paperwork" job	133	84,0%
The necessity to perform tasks within the deadlines, while there are serious obstacles to their adherence	100	63,0%
Shocking unplanned tasks that I have to do	115	73,0%

Among the factors indicating the relationships at work analysis of research material revealed that nurses most often experience the overload due to having to spend time doing unnecessary "paperwork" job (84%). Detailed data are shown in Table 3. Comprehensive analysis of workload showed that the largest source of load for the respondents were relationships at work (39%). The smallest load was caused by working conditions. In relation to 73% of the respondents found a low level of stress. The data is presented in Table 4.

An overall analysis of the stress load (based on 33 factors) shows that more than one of ten nursesexperience high job stress (16%) because of "almost all the time" co-occurrence of the analyzed factors. Detailed data are presented in Table 4.

Table 4 The overall burden of stress at work among respondents.

The grading scale, based on the stens*	N	%
Working with the client:		
1-4 stens Low stress level (0-24 pkt.)	105	66,5%
5-6 stens Medium stress level (25-34 pkt.)	35	22,0%
7-10 sten High stress level (35 and more)	18	11,5%
Relations at work:		
1-4 stens Low stress level (0-2 pkt.)	33	21,0%
5-6 stens Medium stress level(3-9 pkt.)	63	40,0%
7-10 stens High stress level (10 pkt. And more)	62	39,0%
Working conditions:		
1-4 stens Low stress level (0-16 pkt.)	116	73,5%
5-6 stens Medium stress level (17-24 pkt.)	32	20,5%
7-10 stens High stress level (25 pkt. and more)	10	6,0%
General stress level:		
Low (0-41 pkt.)	91	57,0%
Medium (42-63 pkt.)	42	27,0%
High (64 and more)	25	16,0%

*The result within 1-4 mean low score, in the range 5-6 - average, 7-10 – high [7].

Discussion

Various methods and scales used in the assessment of working conditions, stress and workload make it difficult to fully address the results obtained in the present study, conducted among nurses working in different positions and in different workplaces. Numerous studies have shown that the performance of the nursing profession is accompanied by the presence of factors such as excess labor, role ambiguity, conflict, resource deficits, which have a significant impact on job satisfaction, commitment to work and contribute to the occurrence of health, psychosomatic problems and staff turnover [9].

Results obtained in the present study indicated a critical evaluation of the work and moderate satisfaction, and confirmed opinions about the existence of load and stress [11] connected to the performance of the profession of nurse [9,10,12].

More than every third nurse provided its services even at the risk of her own life and health. A moderate level of satisfaction with the type of work show that they chose the profession consciously and want to be engaged in the roles, functions and tasks for which they received professional preparation [10]. Nevertheless, the work is a source of much tension and stress, which makes its evaluation not fully satisfactory. Too low wages in relation to the workload proved among the majority of respondents disadvantage in this aspect of the financial situation of this group of workers and puts it among the people in a special way predisposed to disease risk as a result of high stress because of this factor [13].

Too small scope of authorizations, little freedom to decide mean that every other nurse in varied degrees is exposed to stress, anxiety, depression, apathy, fatigue, low self-esteem and experiencing cardiac symptoms [14,15]. Conflicts and disagreements with colleagues and superiors, and lack of support from immediate supervisors, especially in situations where existing procedures are not effective enough caused that participants were vulnerable to high levels of anxiety, emotional exhaustion, low job satisfaction and increased risk of cardiovascular disease [16].

Conflict resolution and reducing or eliminating misunderstandings in the work of nurses, require a clear definition of their role [9]. The ambiguity of the role, which indicates the delegation of tasks inconsistent with qualifications, in our study, the necessity to perform tasks of other people, not only leads to reduced job satisfaction, but increases the tension, a sense of hopelessness and a reduction of self-confidence and risk of hypertension [17].

Although working conditions are one of the factors allowing for the delivery of high quality medical services [18], nurses participating in the study due to deterioration or shortage of technical equipment used for work, are forced to realize the tasks using the scarce equipment, and to experience stress and the risk of its adverse effects in the field of psychosomatic health [19]. Established in the study, the deficit in terms of workplace equipment relates to a higher proportion of nurses than in studies conducted among operating nurses [19].

Nurses participating in the study, compared to operating nurses, often valued more critically remuneration and social benefits, professional development opportunities, contacts, conditions in which the work takes place and declared lower satisfaction with the type of work, and lower overall job satisfaction. In the same degree they were satisfied with the organization of work. Nevertheless, its evaluation determined the need of optimalization [19].

Results obtained in the present study of nurses relations at work indicated that the surveyed nurses had a higher stress level than the one experienced in this area by the social workers [7].

Moderate job satisfaction, and significant satisfaction deficit discovered for 17% of the respondents, in a serious way predisposes persons working as a nurse for the development of disorders in terms of a mental health [20]. The necessity to perform tasks within the deadlines, while there are serious obstacles to their adherence, according to this study confirms the results obtained in the study of white-collar workers and predisposes a person engaged in the occupation to a deficit of healthy behavior [21].

The results of research show that the experiencing of many stressful factors by the people tested, specially predispose this professional group to occur many medical problems (somatic and psychosomatic disorders), psychological (family problems, sleep disorders, depression) and behavioral (increased smoking, violence, vulnerability to accidents, increased consumption of alcohol and psychoactive substances, etc.) [22].

The prevalence of endangering the health psychosocial factors among the nurses make it necessary to take the appropriate measures to reduce workload, increase its efficiency and to better protect the health of workers, and thus increase the health safety of patients [19].

Conclusions

1. Nurses are moderately satisfied with their work.
2. Interpersonal relations at work are the source of highest burden for a nurse.

References

1. Bonde J.P.: Psychosocial factors at work and risk of depression: A systematic review of the epidemiological evidence. OEM, 2008, 65, 438-445.
2. Kivimäki M., Virtanen M., Elovainio M., et al.: Work stress in the aetiology of coronary heart disease – a meta-analysis. Scand. J. Work Environ. Health., 2006, 32, 431-442.

3. EuroFound. The Fourth Working Conditions Survey. Dublin 2007: Office for Official Publications of the European Communities,
4. ILO. Mental health in the workplace. Geneva 2000: International Labour Organization
5. WHO Authored by S. Leka A, Cox T. Work Organization and Stress. Protecting Workers' Health Series, No. 3. Geneva, 2003,
6. EU-OSHA. Expert forecast on emerging psychosocial risks related to occupational safety and health. Luxembourg 2007: Office for Official Publications of the European Communities,
7. Waszkowska M,, Potocka A,, Wojtaszczyk P.: Miejsce pracy na miarę oczekiwań. IMP, Łódź, 2010.
8. Leka S., Cox T.: The European Framework for Psychosocial Risk Management. Nottingham 2008: I-WHO publications.
9. Jamal M.: Relationship of job stress and type-a behavior to employees' job satisfaction, organizational commitment, psychosomatic health problems, and turnover motivation. Human Relations., 1990, 43, 727–738.
10. Kulczycka K., Stychno E.: Analiza obciążenia psychicznego na stanowisku pracy pielęgniarki. Pielęg. XXI w., 2012, 3, 65-69.
11. Cox T., Griffiths A., Rial-Gonzales E.: Research on work-related stress. Report -2000. European Agency for Safety and Health at Work. Luxembourg, 2009.
12. Kuriata E.: Warunki pracy. Mag. Pielęg. Poł., 2013, 1-2, 40-41.
13. Siegrist J., Starke D., Chandola T., et al. :The measurement of effort-reward imbalance at work: European comparisons. Social Science & Medicine, 2004, 58, 1483-1499.
14. Ganster D.C.: Worker control and well-being: A review of research in the workplace. [w:] Sauter S.L., Hurrell J.J., Cooper Jr. i C.L. (red.), Job control and worker health, New York: Wiley, 1989, 3-24.
15. Terry D.J, Jimmieson N.L.: Work control and employee well-being: A decade review. [w:] Cooper C.L., Robertson I. (red.), International Review of Industrial and Organizational Psychology. Chichester: American Ethnological Press, 1999, 14,
16. Warr P.B.: Job features and excessive stress. W: R. Jenkins i N. Coney (ed.), Prevention of Mental Ill Health at Work. London 1992: HMSO.
17. French J.R.P., Caplan R.D.: Psychosocial factors in coronary heart disease. Industrial Medicine, 1970, 39, 383-397.

18. Rozporządzenie Ministra Zdrowia z dnia 22 czerwca 2005 r. w sprawie wymagań, jakim powinny odpowiadać pod względem fachowym i sanitarnym pomieszczenia i urządzenia Zakładu Opieki Zdrowotnej. Dz..U. z 2005 r. nr 116, poz. 985.
19. Ngozi Iyoha E., Abramczyk A.: Bezpieczeństwo zdrowotne pacjentów a warunki pracy pielęgniarek operacyjnych [w:] W drodze do brzegu życia, Krajewska-Kułak E., Łukaszuk C., Lewko J., Kułak W., 2013, 11, 1461-1475.
20. Ramirez A.J., Graham J., Richards M.A.: Mental health of hospital consultants: The effects of stress and satisfaction at work. The Lancet, 1996,347, 724-728.
21. Koukoulaki T.: Stress prevention in Europe: Trade union activities. [w:] Iavicoli S. (ed.), Stress at Work in Enlarging Europe. Rome 2004: National Institute for Occupational Safety and Prevention (ISPESL).
22. Quick J.D., Quick J.C., Horn R.S.: Health consequences of stress. J. Organ. Behav. Manage., 1986, 8, 19–36.

Naumov Igor Alekseevich, Esis Ekaterina Leonidovna , Sivakova Svetlana Pavlovna, Aleksandrovich Aleksandr Sulejmanovich

Condition of reproductive health of working women on chemical production

Education establishment, Grodno State Medical University», Grodno, Republic of Belarus

Introduction

Now improvement of a condition of reproductive health and birth rate rising are surveyed as one of mainstreams of the state policy defining the further development of Byelorussia. Moreover, the special place is occupied with questions of maintenance of safe working conditions and health protection of working women in connection with the high social importance of the yielded contingent and necessity of conservation of reproductive potential. It corresponds to original position of global strategy of the World Health Organization according to which «to everyone should be given possibility activly to participate in work without risk of a tresspass health and working capacity» [1].

The professional risk for reproductive health is defined by researchers as probability of causing of injury of reproductive function of the worker, to a prenatal fetation and health of the newborn in connection with labour activity of parents. Moreover, character and degree of clinical implications and their medico-social importance depend of a class of working conditions and a risk category: the more harmfully the class of working conditions, the is more significant the medico-social injury caused to health, including reproductive [2].

Following disturbances of reproductive health of women concern number professionally caused: nonspecific inflammatory illnesses of pelvic organs (N60–N73, N76–N77) at work in the conditions of a cooling microclimate; a dysplasia and a leukoplakia of nick of a uterus (N87–N88), neoplasms of genitals (D25–D28) at influence of the factors possessing mutagen and cancerogenic action, and also hormones and hormono-similar substances; disturbance of menstrual function (N91.1, N91.4, N92, N94), a habitual abortion and sterility (N96–N97.0) at the women who are exposed to influence of the general vibration and excessive sensorno-emotional loads in the course of industrial activity (intense character of work, work in a night shift) [3,4].

In connection with the above-stated, disturbance condition of reproductive health admits experts the yielded area to one of integrated indexes of sanitary-and-epidemiologic trouble of territory and reflects degree of aggressiveness surrounding, including industrial, mediums [5]. Moreover, the World Health Organization carries women fertility age and pregnant women to groups of the raised risk on adverse influence of chemical, physical and biological agents, physical gravity and nervously emotional intensity of work, and anthropogenous pollution of the occupied places [1].

Thus, now the special attention is given by researchers to a state of the women's health of occupied on chemical production, that, first of all, is caused enough by high danger of initial products, and also formation of toxic ingredients in a process of manufacture [6]. It is shown, that for the present stage of development of the chemical industry at constant perfection of technological processes characteristicly action of factors of the small intensity, result ining to augmentation of number of "nonspecific" polyetiological diseases [7] which arise not only at influence of harmful and dangerous factors immediately in the course of industrial activity, but also as a whole under the influence of an adverse ecological situation as in large industrial centres appreciable exhausts of chemical toxicants in environment are registered [8]. However till now dynamics of a condition of reproductive health of working women of chemical production still remains insufficiently studied, that does not allow to explain the basic patterns and the mechanism of influence of a different sort of the reasons on levels of a case rate, a mortality and reproduction processes, a parity and their interrelation among themselves and, finally, to develop necessary preventive actions that causes an urgency of the present research.

Research objective: to study dynamics of a case rate of reproductive system of the women who are carrying out industrial activity in the conditions of chemical production.

Materials and methods. Research is executed within the limits of research of chair of the general hygiene and a bionomics «The estimation of a state of health of workers of the enterprises and the organisations of of Grodno and the Grodno area on the basis of data of socially-hygienic monitoring and working out of preventive actions for its conservation and strengthening» (№ state registration 20121940 from 20.06.2012).

On the basis of the yielded periodic medical inspections and the official statistical documentation dynamics of a case rate of organs of reproductive system of working women fertility age of Open Society «Grodno Nitrogen» (Republic of Belarus) which were carrying out in 2008–2012 industrial activity (224 patients), and also women fertility the age, living in 2008–2012 in Grodno is studied.

Results are processed with use of a package of applied programs STATISTICA 6.0.

Results of research and discussion

It is positioned, that in 2008–2012 in the course of industrial activity of the working woman of Open Society «Grodno Nitrogen» which is the chemical production largest in Belarus with a selfcontained work cycle, were exposed to chronic influence of chemicals which are toxicants 2, 3, 4 classes: a methanol, white damp, the ammonia, a different sort of alkali in concentration which, however, did not exceed marginal concentration. Thus influence of chemicals on an organism of patients was combined with damaging action and other production factors (hum, the vibration, seasonally changing parametres of a microclimate), and high intensity of work [9].

It is positioned, that in 2008–2012 level of a primary case rate by illnesses of reproductive system at working women of chemical synthesis unlike women fertility the age living in Grodno has increased. Thus the average index of a primary case rate for the fifth anniversary has made 198,1±24,47 on 10 thousand population and was on 10 % above, than among women fertility the age, living in Grodno (Fig. 1).

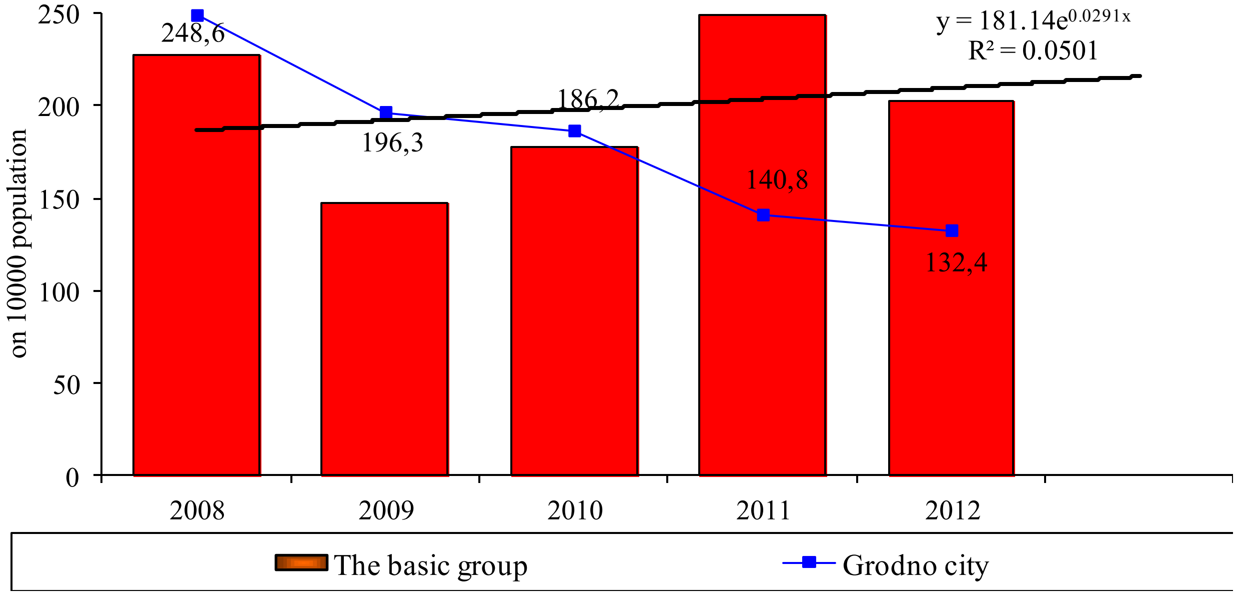


Fig. 1 – Dynamics of a primary case rate diseases of reproductive system in 2008–2012.

The index of the general case rate illnesses of reproductive system at working women of chemical synthesis in 2008–2012 also was with more expressed positive dynamics. In the surveyed fifth anniversary value of an index has decreased with 1340 for 10 thousand population in 2008 to 2312 on 10 thousand population in 2012 and an average index of a primary case rate during this period has made 1226±342,2 on 10 thousand population and was more than in 3 times above, than among women of control group (Fig. 2).

As is known, the earliest and frequent implications of influence of chemical toxicants (further – ChT) on female reproductive system are development of noninflammatory diseases of genitals [10] among which the leading place is occupied with disturbances of a menstrual cycle [11]. Moreover, the last can be used as criterion of ecological trouble in region [2]. In this connection, we had been studied dynamics of a case rate the yielded pathology.

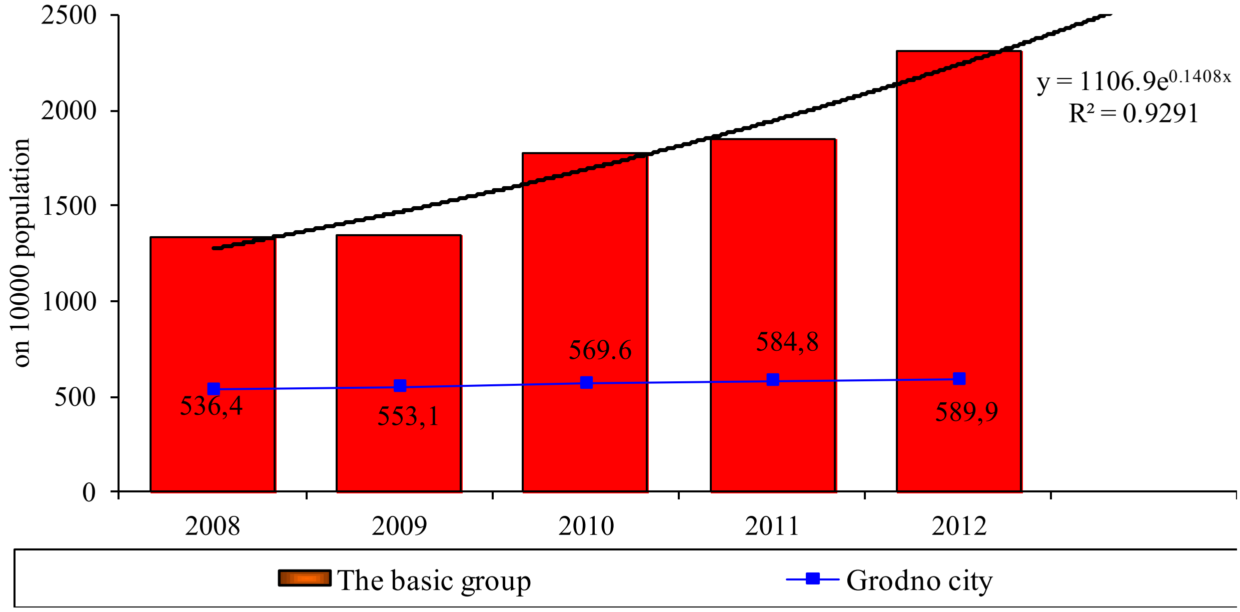


Fig. 2 – Dynamics of the general case rate diseases of reproductive system in 2008–2012.

It is positioned, that the index of a primary case rate disturbances of a menstrual cycle at working women of chemical synthesis in 2008–2012 was characterised by positive dynamics and has decreased with 71,8 for 10 thousand population in 2008 to 42,7 on 10 thousand population to the extremity of the surveyed period. It is necessary to notice, that the index of a primary case rate disturbances of a menstrual cycle of the female population of of Grodno has increased with 11,4 on 10 thousand population in 2008 to 19,7 on 10 thousand population in 2012

Nevertheless, the average index of a primary case rate disturbances of a menstrual cycle at the women who were carrying out professional work in the conditions of chemical production, for the fifth anniversary has made 50,13±13,13 on 10 thousand population and was almost in 3 times above, than among women fertility age, living in Grodno (Fig. 3).

The index of the general case rate disturbances of a menstrual cycle at working women of chemical synthesis in 2008–2012 was positive dynamics, though and less expressed. During the surveyed period value of an index has decreased with 105,9 for 10 thousand population in 2008 to 93,6 on 10 thousand population in 2012 and an average index of a primary case rate disturbances of a menstrual cycle at the women who were carrying out professional work in the conditions of chemical production, for the fifth anniversary has made 86,47±9,52 on 10 thousand population and was almost in 5 times above, than among women of control group (Fig. 4).

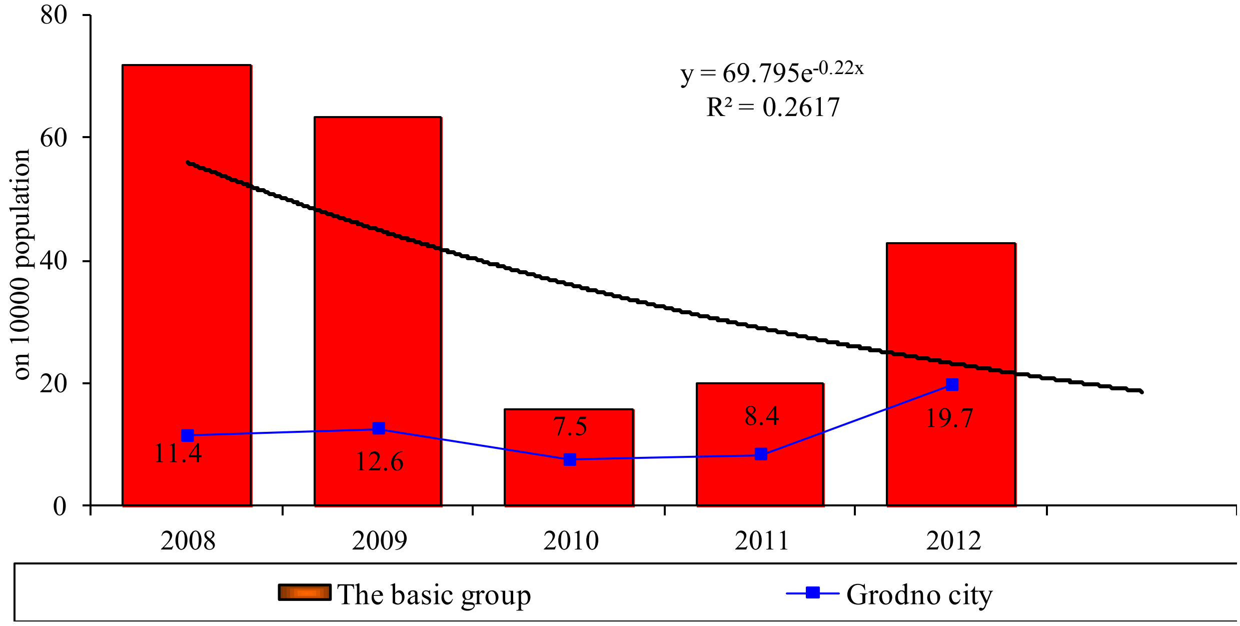


Fig.3 – Dynamics of a primary case rate disturbances of a menstrual cycle in 2008–2012.

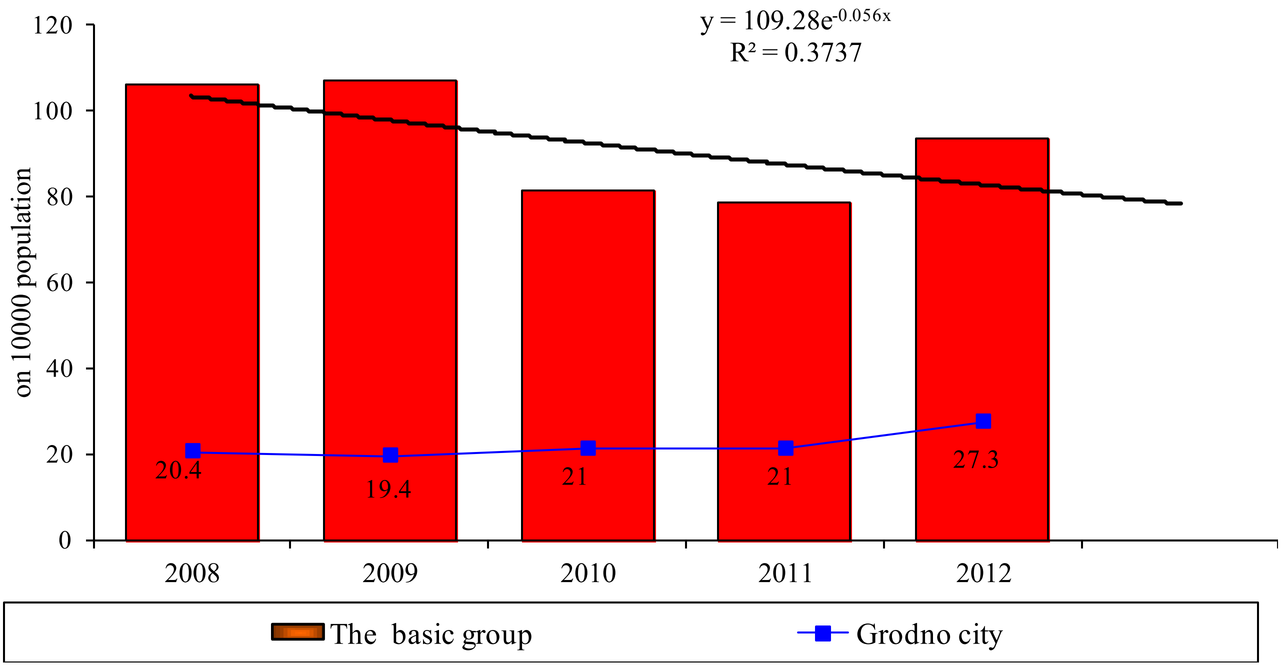


Fig. 4 – Dynamics of the general case rate disturbances of a menstrual cycle in 2008–2012.

The data obtained by us will be compounded with results T. Wang, S. Charette, M.I. Smith (2006), testifying that the female organism, in comparison with man's, is more sensitive to ChT, and disturbances of reproductive health as during pregnancy so in non pregnant a condition can arise and without any signs of poisonings [12].

Considering, that number ChT attack a metabolism of sexual steroid hormones or stimulate their action on organs-targets that is the possible reason of development of tumours of certain localisations [13], we had been studied dynamics of a case rate of leiomyoma uterus of the patients working on Open Society «Grodno Nitrogen», and also women fertility the age, living in Grodno.

It is positioned, that the index of a primary case rate of leiomyoma uterus at working women of chemical synthesis in 2008–2012 was characterised by positive dynamics and has decreased with 143,7 for 10 thousand population in 2008 to 123,3 on 10 thousand population to the extremity of the surveyed period. The average level of an index of a primary case rate of leiomyoma uterus at working women of chemical synthesis in 2008–2012 has made 112,7±18,78 on 10 thousand population and was almost in 4 times above, than among women fertility age of of Grodno. Thus, it is necessary to notice especially, that the index of a primary case rate a leiomyoma of a uterus of the female population of of Grodno for considered 5 years practically has not changed (Fig. 5).

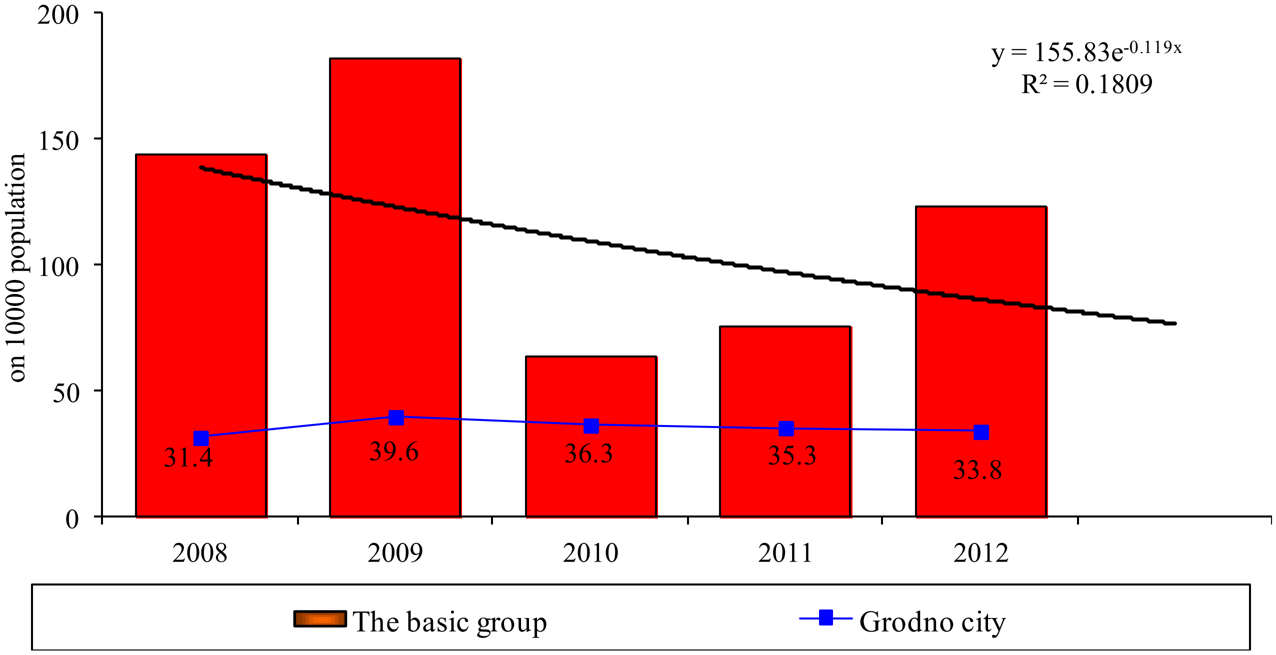


Fig. 5 – Dynamics of a primary case rate of leiomyoma uterus in 2008–2012.

As well as the previous surveyed index, level of the general case rate of leiomyoma uterus at working women of chemical synthesis in period 2008–2012 has decreased: with 1130 on 10 thousand population in 2008 to 1006 on 10 thousand population in 2012 the average level of an index of the general case rate of leiomyoma uterus at working women of chemical synthesis in 2008–2012 has made 1002,4±11,6 on 10 thousand population and was more than in 4 times above, than among other patients living in Grodno (Fig. 6).

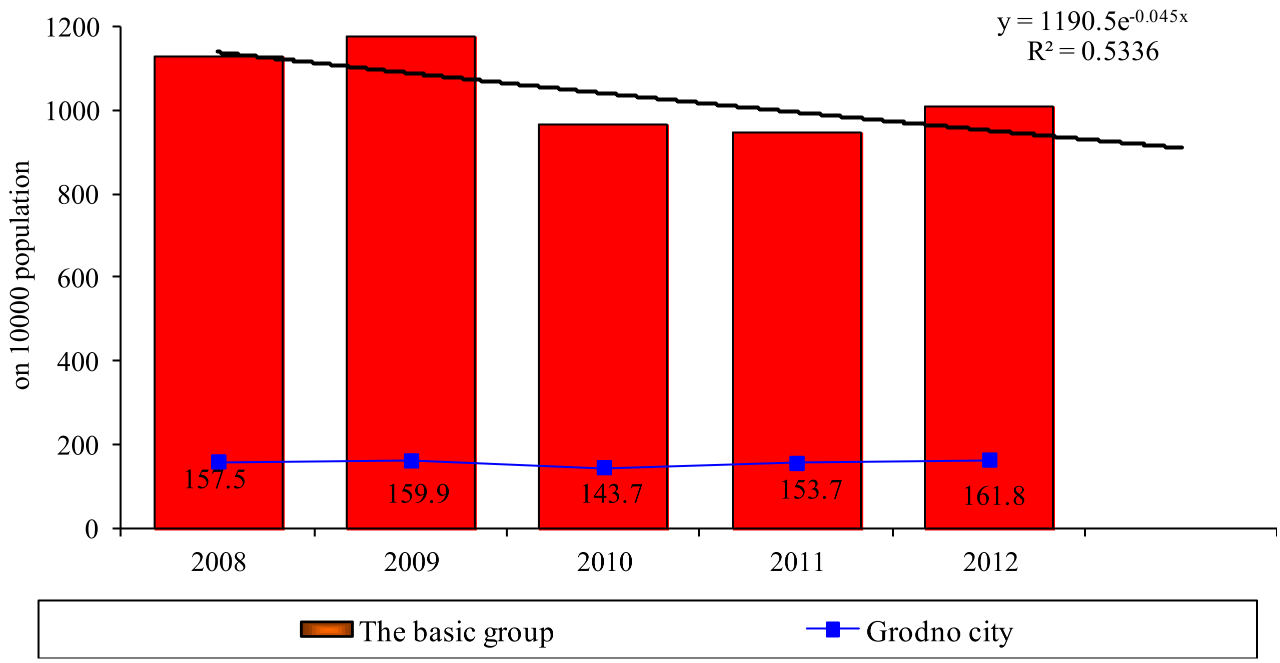


Fig. 6 – Dynamics of the general case rate of leiomyoma uterus in 2008–2012.

Because number ChT, formed in the course of a production cycle Open Societies «Grodno Nitrogen», are carried to a class 1A (known reproductive toxicant or development toxicant) [14], we had been studied dynamics of a case rate of newborns congenital anomalies (developmental anomalies), deformations and chromosomal disturbances.

It is positioned, that for surveyed 5 years it was not observed essential dynamics of an index of a primary case rate of newborns by congenital anomalies (developmental anomalies), deformations and chromosomal disturbances, which have been born by the patients who were carrying out industrial activity on Open Society «Grodno Nitrogen». However, the average level of an index of a primary case rate the yielded pathology in 2008–2012 considerably exceeded a similar index of newborns in Grodno and made 25,84±2,63 on 10 thousand population (Fig. 7).

In surveyed 5 years, dynamics of the general case rate congenital anomalies (developmental anomalies), deformations, and chromosomal disturbances had another character. So, at children who have been born by the patients who were carrying out industrial activity on Open Society «Grodno Nitrogen», index level has considerably increased: with 30,25 on 10 thousand population in 2008 to 52,97 on 10 thousand population in 2012 Thus among the children's population of Grodno dynamics of the yielded index was positive, that has led to depression of the general case rate with 14,32 on 10 thousand population in 2008 to 52,97 on 10,02 thousand population in 2012 it is necessary to notice, that the average level of index of the general case rate the yielded pathology of children which have been born by working women of chemical synthesis, in 2008–2012 almost in 5 times exceeded a similar index on Grodno and made 329,62±34,9 on 10 thousand population (Fig. 8).

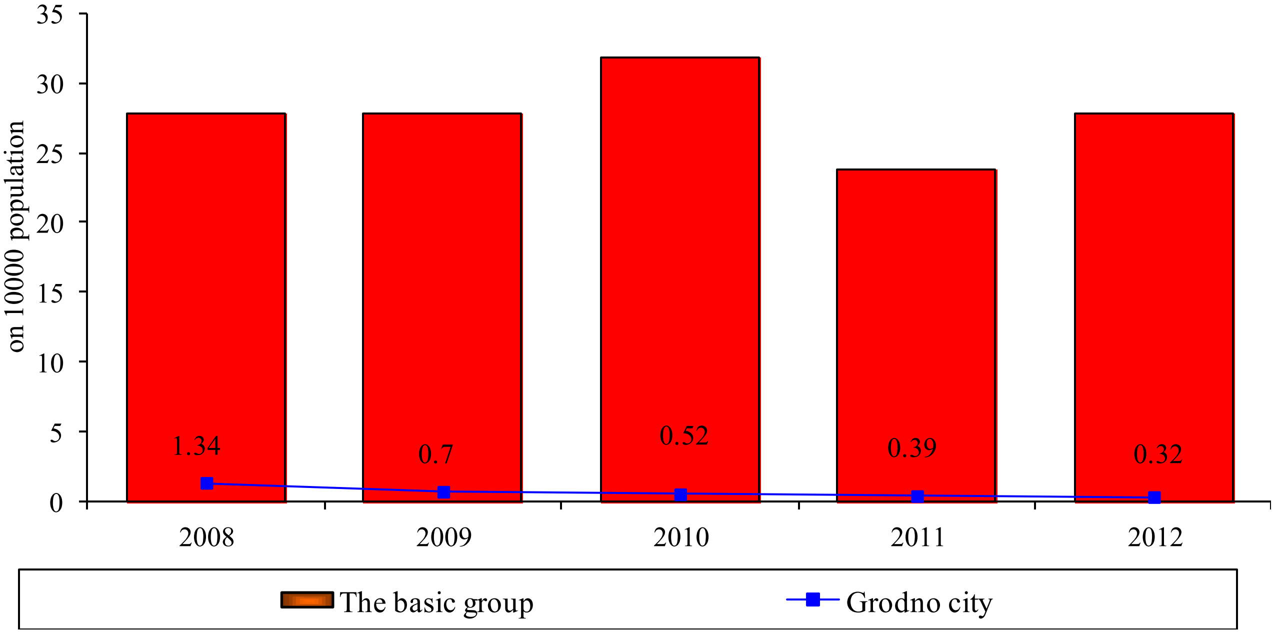


Fig. 7 – Dynamics of a primary case rate of newborns congenital anomalies (developmental anomalies), deformations and chromosomal disturbances in 2008–2012.

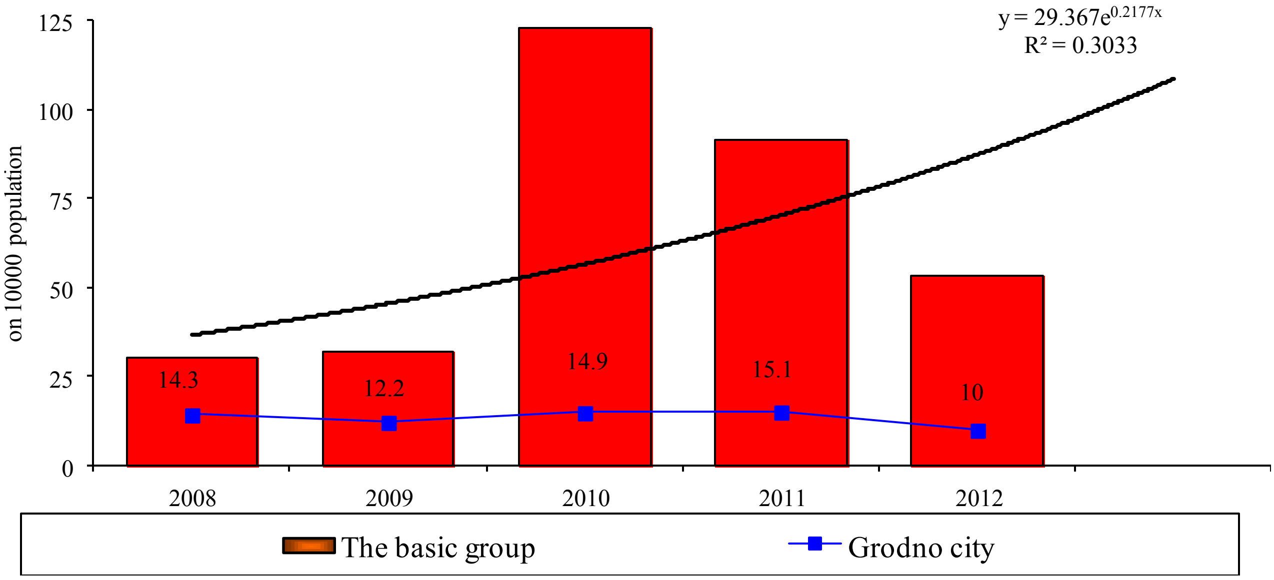


Fig. 8 – Dynamics of the general case rate congenital anomalies (developmental anomalies), deformations and chromosomal disturbances in 2008–2012.

Conclusion

We positioned, that ChT makes the expressed negative impact on functioning of female reproductive system. In this connection to an estimation of potential of reproductive health of the women who are carrying out industrial activity in ecologically adverse conditions, special significance should be attached, and the obtained data should become a basis for creation of technologies of prophylaxis.

References

1. Bonzini M., Coggon D., Palmer K.: Risk of prematurity, low birthweight and preeclampsia in relation to working hours and physical activities: a systematic review. Occup. Environ. Med. 2007, 64, 219–238.
2. Sivochalova O.V.: Risk of disturbances of reproductive health of women at influence of harmful factors. Mag. of obstet. and fem. illnesses. 2005, 55, 42–56.
3. Esis E.L.: Hygienic risk factors of disturbances of a state of health of the working women occupied on chemical production / E.A. Esis, I.A. Naumov // Education, medicine, physical training and sports in preventive maintenance of illnesses of a century: the collection of scientific articles of participants of the Int. scient.–pract. conf. «EMF–2013», devoted to the 65 ann. the depart. of physical training and sports BSU, Minsk, 21–23 nov.2013 / an edit. board: V.A. Koleda (editor-in-chief) [etc.]. – Minsk: Publish. centre BSU, 2013, 41–45.

4. ACOG Committee Opinion No. 349, November 2006: Menstruation in girls and adolescents: using the menstrual cycle as a vital sign., ACOG Committee on Adolescent Health Care., Obstet Gynecol. 2006, 108, 1323-1328.
5. Global strategy WHO on professional hygiene for all. The resolution of 49 sessions of the World Assembly of public health services, WHO, Geneva, 1996, 46.
6. Bakirov A.B.: Toxicology of products of the petrochemical industry. Part 2. Aromatic hydrocarbons: the manual for doctors / A.B. Bakirov, O.M. Dubinin, N.J. Hunsutdinova. – Ufa, 2010, 52.
7. Dautov F.F., Tuhvatullina L.M., Tcherepanov E.N.: Reproductive health of women in territories of a city with different level of an anthropogenous load / Gig. and sanit. 2009, 1, 17–19.
8. Chan A., Keane R.J.: Prevalence of induced abortion in reproductive lifetime. Am. J. Epidemiol. 2004, 159, 475–480.
9. Chashchin V.P., Svidovyj V.I., Frolov N.M.: Influence of factors of industrial environment on reproductive health working. SPb, 2004, P. 4–23.
10. Kennedy M.S.: Pregnancy and Chemicals Don't Mix. Amer. J. Nursing. 2005, 105, 16–20.
11. Philip R.B.: Ecosystems and human health: Toxicology and environmental hazards. Lewis Pabl., 2001, 328.
12. Wang T., Charette S., Smith M.I.: An Unintended Consequence: Atal Amidarone Pulmonary Toxicity in a Older Woman. J. Am. Med. Dir. Assoc. 2006, 7, 510–513.
13. de Paula F.C.S., Nicacio S.J., Goncalves J.R.: Avaliacao do acida trans, trans-muconico urinario-como biomarcador de exposicao ao benzene. Rev. Saud. Publ. 2003, 37, 780–785.
14. Chernjak J.I. Grassman D.A., Kolesnikov S.I.: Influence of proof organic contaminants on biotranstformation xenobiotics– Novosibirsk: Science, 2007, 34.

PROBLEMS
OF
SOCIAL MEDICINE

Chmielewska – Ignatowicz Tomira

Communication between a doctor and a patient – from paternalism to patient's autonomy

University of Cardinal Stefan Wyszynski in Warsaw

Introduction

At the base of reflecting upon the reasons for asymmetries in the doctor-patient relations, as well as upon the core of paternalism in this kind of interpersonal relation, the range of rights of a doctor given to him based on the role he plays should be considered first – the rights that decide about the power and authority of a doctor.

As Tobiasz-Adamczyk notices [1] the power of a role and social position of a doctor comes from the fact that only a doctor has an officially recognized healing ability in the society, what also makes him an expert in a certain area, privileged to claim either health or sickness. Additionally, the decisions of doctors can influence the qualifications of different behaviors (e. g. in case of crimes a doctor has the right to, based on his medical knowledge, change the qualification of a crime or influence a change in perceiving a criminal. A decision of a doctor can influence a change of patient's social status, e. g. claiming him disabled can distance the patient from certain activities and fulfilling some social functions).

Therefore, the definition of a doctor could mean that he’s not only entitled to interfere with a patient’s life in regard to his medical knowledge and present abilities (sometimes deciding or co-deciding about said life), but he also manages the tools making him able to make certain social decisions regarding a patient.

The assumption of asymmetry present in a patient-doctor relation, the base of which consists of the reason why a meeting between a patient and a doctor happens, also influences the view of such relation. The patient takes on a role in which he manifests his need to use a doctor's knowledge, abilities and help (at the same time admitting to himself and a doctor that he cannot solve the problem alone and needs help), what undoubtedly *a priori* influences the balance of a patient-doctor relation. The patient also usually represents only himself and his own current, subjective feelings, while the doctor has the prestige of medical knowledge and the aforementioned health institution system to his advantage. This kind of relativity influences the fact that the patient usually gives up a part of his own autonomy to a doctor and fulfills different tasks given by him, sometimes regarding matters he would prefer to decide himself in a different context [2]. In other words, he gives up a part of his autonomy in order to recover to full health quickly and improve the ability of performing social functions.

Taking the understanding of autonomy as: freedom, dignity, integrity, individuality, independence and responsibility after Dworkin [3] or claiming that autonomy is the right of self-determination, independence and freedom of making a choice after Mill giving it up seems to be – even if executed partially – some sort of acceptance of a certain kind of slavery.

The aspect of „giving up" a certain part of autonomy by a patient and submitting oneself to the will and actions of a doctor has already been regarded by the aforementioned T. Parsons. According to him, even if a clear asymmetry becomes unique to this relation, the role of a doctor is always complementary to the role of a patient. The health of a patient is an ultimate goal that unifies both parties, regardless of different characteristic of their part in the goal [4]. A doctor, aiming to realize a goal that is bringing someone sick back to their health, concentrates on the sickness first, not on the patient himself, at the same time undertaking instrumental activities. The concentration on a doctor's instrumental actions can cause fluctuations in patient's emotional behavior. In his theory Parsons gives big importance to the need of existence of a thread of understanding between a doctor and a patient. Nevertheless – in his own opinion – both sides, while realizing an overriding goal (the patient's health) should understand their mutual tasks, especially since the role of a patient has a passing and socially undesirable nature. It places upon a patient an obligation to recover quickly, what is possible while authoritatively respecting the orders of a doctor.

Materials and methods

Parsons' theory implies a model situation where both the doctor and a patient show perfect compatibility in pursuing the goal that is the patient's full recovery [1], and the doctor's authority is recognized by the patient focused on reaching the goal. The model of a doctor-patient relation suggested by Parsons underlines the understanding of such relation in categories of defining paternalism as „claiming absolute knowledge of one's well-being by another person" [5].

In sociological and psychological literature regarding the subject of doctor-patient relations mostly negative paternalism evaluations and a doctor-patient model based on it dominate. As Łuków notices the reason for such criticism may be the fact that its authors use an axiologically unnatural definition of paternalism as a violation of patient's autonomy. Still, at the same time a situation where a patient's autonomy is violated can occur mostly in a situation of urgent medical need, threatening the life of a patient (severe trauma, lack of consciousness), where knowledge and medical (instrumental) actions of a doctor are of the utmost importance. Accepting Beauchamp's theory [6] regarding the definition of „autonomy" of an individual (in the context of this contemplation – a patient), it is essential to differentiate between the autonomy of a person and the autonomy of an action, because it's highly possible that the ability to act autonomously does not guarantee that an action itself is, by all means, autonomic. A situation where an autonomic individual makes not autonomic choices – such as while using medical help – may serve as an example.

Patients themselves repeatedly strive to realize a paternal relation model by a doctor since the role of being incapacitated by an illness, not burdened with the weight of choices regarding their own health is very convenient for them. In such situations a patient himself subjectively makes a decision to transfer a great part of his autonomy to a doctor [2].

It is, however, without a doubt that paternalism showing interference with an individual's actions or the individual's access to information regarding his health or deliberate spreading of false information, when an alleged reason of interference or misleading is the fact that it's for the good of the person who is being misled [5], should be condemned. Yet it's still important to notice that this kind of paternal model is rarely realized during actual medical consult that does not concern direct threat to a patient's life.

It has been pointed out for example in the 50's of the 20th century by T. Szasz and M. Hollender who, developing Parsons' model, pointed out that mutual relations between a doctor and a patient have to run differently based on the patient's health and his ability to actively take part in the decision-making process. Taking into account the level of both sides of this communication's activity they have distinguished three basic types of patient-doctor relations: active-passive, guidance-cooperation and mutual participation.

In the model suggested by them it's possible to see three types of doctor-patient relations. The first type, called "active-passive", is the one closest to T. Parsons' paternalism theory since it's mostly being used in acute conditions, e. g. an unconscious patient, which means a situation where complete submission of a patient undergoing therapy is essential for the entire process of diagnosis and treatment.

The second type of relation, „guidance-cooperation", happens in the situations when a patient is able to cooperate. The origin of this relation is a "parent-child" relation. The patient is aware, but subjects himself to therapy in a very passive way, which serves as confirmation for the fact that most patients waive part of their autonomy for confidence in the knowledge and experience of a doctor and for waiving the responsibility for decisions regarding fast recovery and social life. The doctor, in this model, still remains the dominant side authoritatively deciding on the patient's treatment options.

The third type of relation is „mutual participation" based on the fact that the patient himself continues treatment with specific medical indications, consulting a doctor if necessary. In this relation the patient takes on a role of a participant and partner, and at the same time the role of a doctor is limited to detailed indication of some general rules that the patient has to follow in order to help himself. In this place, in theory of models of effective communication and relation between a doctor and a patient, the aspect of the patient's autonomy is clearly present.

The model developed by T. Szasz and M. Hollender indicated that the doctor-patient relation isn't only based on influencing a fully subjected and passive patient. Still, their approach implied expert dominance of a doctor and passiveness of a patient as a factor necessary for aiming their mutual goal, which is of course returning a sick person to full health [7].

After all, already E. Friedson noticed the fact that realization of a *stricte* paternalistic communication model between a doctor and a patient is impossible in a medical consult, which is a communicative and social setup. He indicated the fact that there is always a potential conflict at the base of a doctor-patient relation. In his opinion the diversity of their social roles implies difference of interests between them. Between the sides of this relation exists a potential conflict called a „perspective clash". In this model a dominant role of a doctor comes from a fact that he controls the access to all benefits of the medical system not usually available to the patient, and also from the differences between the level of medical knowledge of a doctor ant this of a patient. Even if with Parsons the patient was „following" the authority of a doctor respecting his authority, knowledge and experience to come back to his life from before the illness fast, with the Friedson model – according to Tobiasz-Adamczyk – we are being proven the divergence between the patient's expectations and what the doctor can actually offer. Although the doctor uses part of his authority to meet the expectations of a patient, he before all cares about keeping an insitutionalized dominance. It means that the course of illness depends on external conditions and on the doctor's attitude. This model includes interactive and dynamic aspects of a doctor-patient relation [1].

The aforementioned doctor-patient relation models (Parsons, Szasz, Hollender and Friedson) are considered as ones showing paternalistic dominance of a doctor over a patient by the literature of research on such communication. Despite the fact that paternalism is shown and realized as actions for the sake of another person's well-being taken without the person's consent only in justified cases in those concepts (either when it's impossible to maintain contact with the patient or the patient authorizes the doctor to decide about his health), the suggestions still underline and explain the asymmetric nature of a doctor-patient relation. The doctor is mostly the leader of the action, he decides about its course and shape, and the role of the patient is limited to communicating the type and quantity of information connected with the illness that is necessary for giving a diagnose. The doctor has authority over the patient.

Although the asymmetry of a doctor-patient relation coming from an institutional context of a meeting (hospital, clinic) and from the doctor's knowledge and experience (which the patient lacks and which he needs in order to receive help) seems to be understandable and justified, nowadays the paternalistic acts of doctors on the ground of communication cause a lot of controversy and dissatisfaction, for it proves to be the area subjected to patient's evaluation first and also the area in which the patient has to feel like an equal partner.

The European Social Survey conducted in 2004 shows that in the area of questions regarding estimating the level of partnership and paternalism between doctors and patients, Poland has shown the lowest indicators in the scale of readiness to admit mistakes in front of patients [8]. According to A. Ostrowska, who was interpreting the results of said survey, in Poland the dependance between a material status of a patient and a perceived level of partnership is not visible and no social-demographical-health variable co-related with an achieved level of communication in a significant way [8], what can serve as proof that tools of improvement of the doctor-patient relation are being conditioned mainly based on the doctor's work organization.

The authority of a doctor, and also the strategy of realizing a paternalistic relation model, is being shown – according to Mishler [9] – mostly in controlling the patient in the aspects of:

- **statement message** – because during a medical consult a sequence of three statements is considered the basic communication unit: the doctor's question, the patient's answer and the doctor's reaction to the patient's answer, covering the evaluation of said answer or another question. The basic function of such unit is to control the course of conversation. This control can be maintained by a doctor by deciding on the order and content of questions, and also on when and if to give the patient the „right to speak”. The nature of questions, for example closed ones, allows him to react to questions selectively, ignoring some parts of the patient's statement (e. g. life stories, subjective feelings) and paying attention to the others (e. g. only the answers influencing a diagnosis). It's important to notice that questions are a very important authority strategy, because they force the receiver to react in a certain way, limit the freedom of said reaction and sometimes contain the expectation to let the person asking the question speak after it has been answered. Using the „question-answer" pattern doesn't yet contribute to the increase of asymmetry in the doctor-patient relation, since the questions of a doctor are necessary for gathering all information to give a diagnose and choose a treatment. The asymmetry more likely comes from such control of the conversation maintained by a doctor that ignores subjective experience of a patient in favor of medical order represented by a doctor. While asking certain questions he is driven by logic that is usually hidden from the patient and that could influence the mazing of the patient with the order and nature of questions of a doctor, and also is a selective reaction to the patient's answers or is no reaction at all. Apart from gathering information from a patient, the doctors also provide the patients with information, among which the most important one is diagnosis – in the form of a name of a specific illness or that of a patient's medical assessment. Rigid requirements of a hospital or a clinic (audits, inspections regarding the transparency of actions/medical and administration procedures) can cause many defensive communication behaviors for doctors, resulting in the kind of questions asked to a patient, which in turn can indicate a stronger desire to meet the procedural requirements than to induce trust in a patient.

- **relation** - [9] – in the process of communication during a medical consult a doctor and a patient enter two different kinds of relation: the relation of authority, when the difference in social status is being used and which clearly points to a doctor as the dominant one, and the second type – the relation of solidarity and communication symmetry, natural for the partnership model of a doctor-patient relation.
- **performed roles** – according to Goffman [10], an individual in presence of other individuals can have different communicational goals (e. g. wants the others to have a good opinion of them or for the others to know what they actually feel, they might want to create a friendly atmosphere, induce a fight or insult someone). Regardless of the chosen goal, control over the communication behavior of others lays in the interest of an individual. Goffman thinks that at the base of all interaction lays the desire to control the reactions of other participants of the communication and controlling their behaviors. This control is being accomplished by projecting one's own definition of a situation, by expressing oneself in such a way that impressions received by others lead them to an involuntary action compatible with the controlling one's plans. However, if we assume that an individual present among others tries to influence the definition of a

situation created by one's partner, we also have to assume that the partner is also going to project his own definition by reacting and undertaking certain actions [11]. At the same time the interaction partner does not have to agree to the definition of a situation presented by the second participant of the communication act, although he also can not completely ignore it if he desires to continue the interaction.

„Placing" someone in a role, what in turn is connected with communicating roles imposed on a partner, and in case of a medical consult placing the patient in the role of a „sick one" functions similarly. Receiving and creating roles implies that what one of the participants of an act of communication (a doctor) does in a certain situation results in implications for the role of the second interaction partner (a patient). Since the roles are mutual, identifying a partner of a patient's interaction entails certain ways of executing the role by a doctor. By treating the interaction partner (patient) as if he was just executing such a role, the person placed in the role of a doctor places him in a role chosen by the doctor. Placing someone in a role is a result of exerting pressure on the interaction partner, but does not determine the actions of a partner. The interaction partner (patient) is entitled to not accept the role and start negotiating the roles, but he cannot deny the role completely – he has to act based on it if the interaction needs to be sustained. However, placing in roles always significantly limits the choice of action of a partner and blocks a certain situation definition [9]. Designating and accepting roles given by the participants of a communication act decide on the nature and course of said communication act and determine the strategy of engaging communication partakers in acting out proper roles. Similar to a director placing an actor in a certain role, one of the communication participants can place his co-participant in a chosen role. Placing in roles can concern both conversational roles, which is a speaker and a listener, and social roles and other showing up in the interaction.

Communication authority of one of the participants of a communication act allows him to „place" both one of his communication partners or himself in a role. It becomes an important tool of controlling the course of verbal communication (a person coming to a medical consult starts to act out a role of the sick one after the doctor says the words connected with diagnosis) and also a tool for using the paternalistic model. Nevertheless a language action of giving a role to a communication act participant is an interactive action and is effective only when acceptance of such verbal action is shown to all communication partners. The role suggested by one side can be accepted, denied or modified by the other side, what in turn requires an adequate reaction of the other side of the communication act. Acceptance of a role suggested by one of the participant of a communication act is to a large degree acknowledging (by the person undertaking a new role, e. g. a sick individual) and understanding the authority and superiority of another participant of the communication act.

The main power of symbolic authority, especially in case of a medical consult and a doctor-patient relation, is language "efficacy", because authority does not exist next to the language, but is being realized through the language and is reflected in it by using forms regarded by the receiver as an indicator of a higher or lower position of the sender. Language communication is not a direct source of authority used for example in a paternalistic doctor-patient relation model. It's both a reason for and a result of differences between communication participants in the social hierarchy, and in turn social asymmetry. Authority of a person higher in hierarchy seems to be the degree to which one of the communication participants can realize his own goals at the expense of another: a doctor can give orders to the patient and the patient has to obey them.

A conclusion can be drawn from the above considerations that communication behavior of a man should always be considered as a result of interaction between communication participants, at the same time taking into consideration the situation in which such act occurs.

Results

Gradual change in the approach to the doctor-patient relation from passive submission to active and negotiating approach of a patient has been made possible by the perspective of symbolic interaction. It institutes that the patient has his own vision of his problem and expectations that do not have to comply with what the doctor suggests as treatment. During the negotiations both sides elaborate on a common problem definition and determine the most optimal solution [12]. However, it is still impossible to avoid confrontation in understanding the illness that a doctor with non-medical image of a patient's illness has in mind.

Ever since it has been shown in the 60's and 70's of the 20th century that next to the patient's examination and using medical procedures a conversation with the patient is of much bigger value in terms of diagnosis and treatment numerous studies on doctor-patient communication try to explain how exactly doctors talk to their patients and what influence does it have on the patient's satisfaction and actually following the directions, understanding the medical terms and, eventually, the results of treatment.

Interest in the role of sociological and psychological factors in the course of treatment has appeared with a change of paradigm in the medical science at the end of the 60's of the 20th century. The psychological approach to medical consults highlighted the fact that the contact with a doctor has an interpersonal meaning to the patient, becomes an interpersonal circuit in which different psychological variables are involved (e. g. the doctor's consciousness regarding the meaning of certain actions, motives encouraging the patient to look for a doctor's help and following the doctor's recommendations [13]. Medical sociology in turn assumes that the contact between a doctor and a patient never happens in the void, but is a social phenomenon, exists as part of a social system and happened in a wider context of conditions and social norms. It analyzes the doctor-patient relation as a mutually-nominated setup of influences of two or more units, happening according to permanent patterns. It also analyzes the influence of the general system on the doctor-patient specifics, so the position of a doctor depending on the position of scientific medicine in a general system of medical beliefs and defines the roles of a doctor and a patient in a defined cultural circle [1].

This kind of approach regarding the doctor-patient relation brings the attention to the role of humanistic factors in the evaluation of medical practice, emphasizing the fact that those can't be opposed to the effectiveness of communication. Humanism is mostly understood as giving priority to the voice of everyday life as the base to understand, diagnose and solve medical problems of patients. The specifics of a medical consult are being evaluated based on the strength of the voice of everyday life and the doctor's orientation on this voice, while the doctor's orientation should also consider the value of subjective and non-medical experience of illness by the patient. Taking the difference of (non-medical) approach of a patient to understand his illness into account becomes one of the factors conditioning the possibility of realizing a partner cooperation model between a doctor and a patient.

Discussion

The issue of patients participating in medical decisions is associated with two principles: *salus aegroti suprema lex est* (the health of a sick man is the highest right) and *voluntas aegroti suprema lex est* (the health of a patient is the highest right) [14], while sometimes during clinical situations a doctor is often faced with a dilemma: the patient's autonomy or his health. Introducing the need to receive a conscious agreement of a patient to commence medical actions connected with his health was a crucial moment for giving the patient an autonomic possibility of self-determination. The need to receive an agreement to undertake medical actions towards a patient is the realization of autonomy postulates, the right to decide about oneself and respect for carnality of every human being [14]. In this context the patient's will to cooperate with a doctor, the doctor's communication competence, the ability to communicate a diagnose and pros and cons of a treatment to a patient in an accessible way seems to be crucial for the doctor-patient relation.

The 70's of the 20th century is the period when in research regarding communication between a doctor and a patient researchers derive from the paternalistic and mechanical understanding of a relation in favor of a model that holds a procedural, interactional and partner meaning. The belief in the need to consider communication acts between participants as dynamic and changeable acts was the base of the approach to the doctor-patient relation, succumbing to subjective interpretations of such communication even after the process itself has been finished. Miller and Steinberg emphasize that treating communication as a process brings acknowledging a thesis that the communication participants cannot grasp the entirety of a communication situation while it lasts because the situation itself lasts even after the communication event is over.

The specificity of such communication type is connected with the fact that communication partners influence each other, project onto each other a defined image of the situation, define themselves and react to the image of them created by their communication partner. Communication happens when someone's behavior is subjected to observation and interpretation, while the sender and receiver don't always have to agree in terms of intentions. Even situations where one of the sides gives a specified intention to a statement are possible, what has already been mentioned by Goffman [10], who emphasized the importance of statements given (intentional) and compared them to given-off statements. However, not reading or not reading the intention of a statement receiver correctly is not lack of communication. It's an alternative approach to a coded (linear) communication model, in which the central place is given to the sender, and who is also given an active role in giving the statement. The role of a receiver was to decode thoughts, words and intentions of the sender and by this to gain access to his thoughts. Emphasis was put on the technical side of communication in this model – on the elements such as channels, codes, coding/decoding and information noise.

A partner, interactive model changes the accents a little bit [9], because it assumes that the sender communicates intentions that the receiver is able to read thanks to a demountable and cultural code and similar communication standards. Provided, however, that in the paternalistic model the main sender of information (a doctor) was always in the middle of communication interest, in the partner model the receiver plays the main role – he can (but does not have to) acknowledge some behaviors of the sender as important and try to give them possible intentions. The focus of communication is being moved from analysis of the sender's intentions to the analysis of a strategy undertaken by him, deduced based on observable communication behaviors of the receiver.

Partner approach to a receiver (patient) of the sender's (doctor) statements places the patient in a situation when he is able to consciously choose therapy and doubt a doctor's decisions. The sources of such approach to the role of a patient who has a say in terms of ways of treatment can be found in consumer movements of the 20th century [12]. The goal of such kind of medical relation is to create a good interpersonal relation, enable information exchange between two participants of a communication act (also including non-medical ones, but able to influence the diagnosis and choice of therapy), to make decisions and to provide therapy on every stage of the patient's recovery. This type of doctor-patient cooperation model is clearly influenced by holistic medicine, taking into account not only the medical problem of a patient, but also his psychological and communication expectations connected with consults, doctors and illnesses, his abilities, life goals and individual needs.

Sources of such holistic interpretation of a patient can, for instance, be found in the 20th century consumerism, which implied that the relation between a doctor and a patient is a relation between a consultant and a client. The doctor's function in such relation model is the role of an adviser. He is a partner with professional authority, but no power over the patient. In this place it's important to distinguish between the definition of an „authority of a doctor" and very well known interpretation of a paternalistic „power of a doctor". As much as the „power of a doctor" comes from respect regarding doctor's knowledge and experience, authority is something gained by a doctor based on knowledge, experience, efficiency, empathy, motivation and abilities (including communication ones).

According to main implications of the consumerism theory, health requires an active attitude and the doctor-patient relations are something the consumer (a patient) has to learn based on guides from an expert doctor to function healthily and effectively. So the role of a doctor changes - he takes, to some point, a role of the patient's educator and adviser and at the same time takes responsibility for enriching the patient's medical knowledge, strengthening his sense of autonomy and control over decisions regarding treatment [14], which in turn influence the patient's comfort and his motivation to live healthily or fight an illness.

As doctors A. K. Jankowska and K. Frieman notice, clinic experience indicates that not always are authoritative (paternalistic) decisions of a doctor correct, yet the consequences of incorrect diagnosis is always on the patient [14]. Partnership in the relation between a doctor and a patient, proving to be an answer the need of defending the patient's autonomy, changes the role of a patient, bringing back his dignity and freedom. The patient's participation in the desicive process that is about him gives him the right to self-determination, at the same time bearing the weight of mutual responsibility for the decision [14]. In respect to that it's worth to notice that a doctor's decisions made during a medical consult and connected with highlighting the role and importance of the patient's autonomy and decision very much depend on the patient's will, his consciousness , readiness and communication skills. Not once do taking upon oneself the mutual responsibility for the choice of therapy and partnership with a doctor require emotional maturity from a patient. The degree to which the patient is prepared for the role of a mutually responsible partner greatly depends on the doctor's communication competence, his will to educate the patient and give him the right to mutually decide about actions taken during his illness and therapy.

Conclusion

Research shows that the closes to the doctor's the patient's social position is, the highest chance there is to create partner relations between them. University education, better medical knowledge help with shaping rational behaviors against the illness; they also have great influence on the doctor-patient relations and the communication expectations the patients hold towards the doctors. But is it entirely true?

Halik's research from the year 2000 shows in turn that it's the doctors themselves who sometimes make creating a partner relation with a patient impossible, assuming his insufficient cognitive and analytic competence [15]. This phenomenon is accompanied by gradual decrease of the doctor's role as an expert. At the same time the risk of numbers of patients who change the doctor's guides according to their own opinion grows. Modifying and decoupling one's therapy decided by a doctor is, however, not an effect of the negotiations with a doctor, but merely an act of willfulness.

In regard to the reality of Polish health industry it has to be noted that after gradual changes of health consciousness in the society changes of the medical care system never follow, and so they fail to fully realize the social needs especially in terms of a cooperation relation and partnership with a doctor. Difficulties with creating a doctor-patient relation satisfactory for both sides also come from the disadvantages of the health care system. In the years 2002-2005 up to 46-59% of respondents in our country (data from a CBOS BS/5/2006 report) have spoken of Polish medical care negatively, which was not without any influence on the evaluation of a doctor-patient relation.

The post-modernistic approach to reality has also left its mark. Sociologists analyzing contemporary specifics have indicated the decreasing role of tradition and authorities in general [16], consequently also the doctor's authority. The doctor-patient relation also had to be influenced by evolving criticism of medicine, the increase of people with higher education, access to different sources of medical knowledge on the Internet and negative statements about doctors and health service in the media, always informing about medical mistakes and negligence in medicine.

Yet it's still important to notice that sometimes the patients themselves aim for realization of a paternalistic model upon contact with a doctor. Some of them enjoy the role of someone not burdened with the weight of decisions regarding one's own health. In such situations the patient himself subjectively makes the choice of ceding part of his autonomy to a doctor. Nevertheless, as we can deliberate from the research conducted by the Institute of Philosophy and Sociology in the year 1999 [17] on a representative, nationwide group of 1323 Polish people and research of the Institute of Rheumatology in Warsaw (2001), conducted on a group of 2167 people, the paternalistic model is still the dominating relation model in the health industry, yet the realization of this model is not the will of patients, but a kind of communication schemes adopted by the doctors. The reactions of patients indicate one-sided decision making by doctors who don't usually suggest alternative treatment, don't offer accessible, but different in price alternative drugs and the majority of doctors rarely informs patients about the benefits of an additional, commissioned consult or explains the way prescribed medicine works. This has also been confirmed by research conducted among doctors in 2010 by the Department of Psychology of Consumer Behaviour Management and the Institute of Organization and Management of Wrocław University of Technology regarding satisfaction from working in the profession with a social mission. Conclusions of the research shows that doctors realizing such a missionary role (not always in a fully conscious way) also have some kinds of shortages in the area of soft competence that improves the relations with others (results of professional interests, emotional intelligence or optimism). It can be a manifestation of a hierarchical vision of the world of sorts. The doctors clearly see their social role, but it's not the role of a partner for others – more of an authority dominant over others with one's detailed knowledge [18]. This type of conviction among doctors is surely a serious, if not the most important barrier in the desire and possibility to establish any partner relation with a patient and in building a positive image of the Polish health industry among patients.

References

1. Tobiasz-Adamczyk B.: Relacje lekarz-pacjent w perspektywie socjologii medycyny. Wyd. Uniwersytetu Jagiellońskiego, Kraków, 2002.
2. Ostrowska A.: Socjologiczne i etyczne uwarunkowania relacji lekarzy z pacjentami. [in:] Etyczne aspekty decyzji medycznych, Hartman J., Waligóra M. ed.; Wyd. Wolters Kluwer Polska Sp. z o.o., Warszawa, 2012.

3. Dworkin G.: The Theory and Practice of Autonomy. Cambrige University Press, 1988.
4. Barański J.: Interakcja lekarz-pacjent [In:] Zdrowie i choroba. Wybrane problemy socjologii medycyny, Barański J., Piątkowski W. (ed.), Wrocławskie Wydawnictwo Oświatowe, Wrocław, 2002, 200-236.
5. Łuków P.: Granice zgody: autonomia zasad i dobro pacjenta. Wyd. Naukowe Scholar, Warszawa, 2005.
6. Beauchamp T.L,. Choldres J.F.: Zasady etyki medycznej. Wyd. Książka i Wiedza, 1996.
7. Jakubowska-Winecka A., Włodarczyk D.: Psychologia w praktyce medycznej, Wyd. lekarskie PZWL, Warszawa, 2007.
8. Barański J., Steciwko A.: Wzajemne zrozumienie oraz współpraca lekarza i pacjenta – panorama problemów [In:] Relacja lekarz-pacjent. Zrozumienie i współpraca. Barański J. Steciwko A. ed., Wyd. Elsevier Urban & Partner, Wrocław, 2013, 180.
9. Stefaniak K.: Władza i tożsamość w komunikacji lekarz-pacjent, Wyd. Atut, Wrocław, 2011.
10. Goffman E.: Człowiek w teatrze życia codziennego, Wydawnictwo KR, Warszawa, 2000.
11. Hałas E.: Interakcjonizm symboliczny. Polskie Wydawnictwo Naukowe, Warszawa, 2006.
12. Ostrowska A.: Modele relacji lekarz-pacjent [In:] Wstęp do socjologii medycyny. Ostrowska A. ed., Wyd. Polskiej Akademii Nauk, Warszawa, 1990, 186.
13. Heszen-Niejodek I.: Lekarz-pacjent. Badania psychologiczne, Wyd. Zakonu Pijarów, Kraków, 1992.
14. Jankowska A.K., Frieman K.: Udział pacjenta w podejmowaniu decyzji medycznych. [In:] Relacja lekarz-pacjent. Zrozumienie i współpraca, Barański J, Steciwko A. ed.. Wyd. Elsevier Urban & Partner, Wrocława, 2013, 109-118.
15. Halik J.: Społeczne różnice w stanie zdrowia i dostępie doświadczeń medycznych – główne mechanizmy i uwarunkowania., Prom. Zdr. Nauki Społ. Med. 2000, 19, 103-112.
16. Giddens A.: Socjologia, Wyd. Naukowe PWN, Warszawa, 2005.
17. Bartkowiak G.: Kompetencje interpersonalne w relacji lekarz-pacjent [In:] Promocja zdrowia. Kontekst społeczno-kulturowy, Głowacka M.D. ed., Wyd. Wolumin, Poznań, 2000, 145-160.
18. Bajcar B., Borkowska A., Czerw A., Gąsiorowska A.: Satysfakcja z pracy w zawodach

z misją społeczną. Psychologiczne uwarunkowania., Gdańskie Wyd. Psychol., Gdańsk, 2011.

Chmiel Izabela [1,2], Czekaj Janusz[1,2], Iwaszczyszyn Jan[2]

Ethics and contemporary nursing

1. Faculty of Health Sciences of the Jagiellonian University Medical College in Krakow
2. Care and Treatment Center in Krakow

Introduction

Work determines our existence in the surrounding world. It affects the way we learn about reality and the way we transform it according to our needs. We perceive work in two facets – material and social. The material dimension of work relates to the possibility of satisfying our needs from the most basic to the most sophisticated ones. The psychological dimension is a source of satisfaction and a way to find our place in society [1].

Nursing is a specific occupation that belongs to a group of professions that have gained high trust in society. Research conducted by the Centre for Public Opinion Research in 2013 showed that nurses were rated fourth – after firefighters, university professors, and miners – in the ranking of high-trust professions. More than three-quarters of Poles (77%-78%) respect nurses [2]. This results not only from their professionalism, skills, knowledge, continuous learning, involvement in research and introducing changes aimed at the improvement of quality of care, but is mainly associated with their personalities, their familiarity with the principles of professional ethics, and most importantly complying with and applying these principles in contacts with patients. The essence of their work is to provide patients with the appropriate care [3].

Ethics, ethical principles, professional ethics

Acquiring the appropriate qualifications and skills is not sufficient for professional nursing since moral principles and strong will for incorporating these principles into practice are also necessary [4].

Ethics (Greek *éthikós* and *éthos*, which refer to customs, habits) [5], one of the branches of philosophy, is also referred to as moral philosophy. According to *A Small Dictionary of the Polish Language*, ethics is a set of principles and standards of conduct adopted in a certain period of time and in a given environment. It is the study of morality [6].

It should be kept in mind that ethics and morality are not the same. Morality, in short, is a set of principles and guidelines, which come down to certain prohibitions (e.g. do not steal, do not kill) and orders (e.g. be fair, act fair). Ethics is the basis for morality and involves the creation of thought systems, which generate moral principles not just the principles alone.

Compliance with ethical principles facilitates practicing a given profession, influences its prestige, helps solve problems, accelerates the process of decision-making, provides guidelines on morals and professional perfectionism, establishes and accounts for the limits of deviations from the general norms, as well as requires, in certain cases, to regard certain duties which are generally considered exceptional as primary ones [7].

Since ethics focuses on the term “good,” it shows us what “good” is and how to act in order to achieve it [8].

Professional nursing ethics is a specific sub-discipline of science dealing with the nursing profession. According to Wrońska, it is a set of standards and directives associated with the traditions of a profession, with the spirit of national culture, as well as with basic ethical guidelines adopted in a given society and used to practice a given profession [9].

The behavior of nurses performing their professional work is regulated by an ethical code, which has no formal legal status but is of an honorary character. Its regulations are usually respected by nurses, who treat this compliance not as a requirement but as a matter of honor and the opportunity to identify with their profession.

Ethical anti-standards

The Code of Medical Ethics reads as follows: *“The ethical principles apply to all human beings regardless of their condition, age, profession, position or post and regardless of their social background. Science, knowledge and experience are to serve the best interest, health, and happiness of each and every human being. All plans, acts, and creation leading to human death, physical and moral suffering is unethical and deserves universal condemnation”* [10]. Disobeying these guidelines results in a situation wherein order to justify ethical misconduct we begin to create our own standards of conduct, which differ from those generally accepted. In order to silence the voice of conscience, we try to artificially attribute moral correctness to actions which are not accepted by principles generally considered proper, moral, or good for our profession. We can find in our pseudo-considerations an explanation for our actions, and we create our own ethical anti-standards:

My behavior is not unethical as long as:

- I can name at least several colleagues who act exactly the same way I do,
- none of the patients have filed an official complaint against me,

- in my opinion, patients have no objections to my actions,
- patients are so difficult and troublesome that they simply "ask for" such treatment,
- I was feeling unwell on that day and could not be required to perform high quality work,
- I believe that the professional ethical principles were established by a person who does not understand the conditions at my job,
- I can earn more as a result,
- I find it more convenient,
- no one will ever know, and even if they did, they probably would not care,
- I comply with other ethical standards,
- I do not intend on hurting anyone,
- I wish to act this way only once,
- nobody can prove anything,
- I am tired and overworked [11].

Aspects to consider

Nowadays, there are different views on the concept of ethics, especially in medicine. The term rarely meets with approval and in some cases raises doubt, resentment, and indignation. Reports from the Internet, the press, radio or television concerning the unethical behavior of medical personnel resulting in danger or loss of human life have almost become part of daily life. Therefore, a discussion on ethical issues, on work free of ethical anti-standards, as well on the need for regular ethical reflection by nurses is very desired in this difficult time of struggle for patients' life and dignity as well as for the dignity of the nursing profession.

Discussion on the subject of ethics is very important, however, it should be kept in mind that the ethical anti-standards develop not through conversations with others but ourselves. Therefore, it is very commendable for each and every nurse to reflect upon ethical aspects and try to answer the following questions:

1. Do I happen to consider my patients as cases and not humans?
2. Do I consider my patients inferior to me, e.g. due to the fact that they are weaker and depend on me or need my help?
3. Do I perceive my patients only in terms of source of income?
4. Have I become indifferent to patients' trust?

5. Do I manage to keep a professional distance when empathizing with patients?
6. Do I take responsibility for my failures to the same extent as for my successes?
7. Do I tend to place responsibility for my failures onto others (colleagues or employer)?
8. Do I assume that as long as nobody files an official complaint against me I have fulfilled my professional ethos perfectly? [9].

Summary

The profession of nurse not only involves fulfilling the general duties, but it also requires a certain attitude, which determines a person's suitability to perform this type of work - work, which all nurses and midwives begin with the following words: *"With deep respect and reverence[...]"* [12].

Those first words of the pledge for nurses and midwives clearly indicate that providing care aimed at improving the lives and health of people is an exceptional challenge and that 'calling' is essential in this profession. Although the principles of nurses' professional ethics derive directly from the universal principles of ethics and require nurses and midwives both to respect the rights of patients and to act in the interest of professional dignity, the Code of Professional Ethics for Nurses and Midwives is a type of a master guide and a basis for establishing standards of conduct. What we do with this 'guide' depends only on us.

Conclusions

- Discussing issues related to ethics should become standard and an integral part of all types of professional training.
- Ethical reflection allows to avoid creating an own system of ethical anti-standards.

References

1. WWW.google.pl. *Antystandardy etyczne- mszw.edu.pl/wp-wyklady* [cited 23.02. 2014].
2. WWW.wyzszekwalifikacje.uni.lodz.pl.Prestiż zawodów. Badania CBOS [cited 23. 02.2014].
3. Poznańska S.: Pielęgniarka i pielęgnowanie w opiece nad zdrowiem [in:] Wprowadzenie do pielęgniarstwa. Zahradniczek K. (ed..), Warszawa, PZWL 1995, 30.
4. Tałaj T., Suchorzewska J.: Postawy pielęgniarek położnych wobec osób chorych i cierpiących w aspekcie obowiązujących norm prawnych i moralnych. Probl. Pielęg., 2007, 15, 32-36.
5. http://portalwiedzy.onet.pl/ - etyka [cited 23.02,2014].

6. http://sjp.pwn.pl/szukaj/etyka [cited 23.02,2014].
7. http://www.pozew.pl/Kodeks etyki zawodowej pracownika administracji [cited 23.02,2014].
8. Szwałkiewicz E.: Opiekun medyczny w praktyce. Wyd. Lek. PZWL, Warszawa, 2013.
9. Wrońska I.: Zasady etyczno-deontologiczne pracy pielęgniarki [In:] Wprowadzenie do pielęgniarstwa. Zahradniczek K. (red.) Wyd. PZWL, Warszawa, 1995, 54-58.
10. Kodeks Etyki Lekarskiej i ustawy z dnia 5 grudnia 1996 r. (Dz.U. z 2002 r. nr 21.)
11. Pope K., Vasquez M.;Ethics in psychotherapy and councelling. John Wiley and Sons, San Francisco, 1991.
12. Doreinger E.: Kodeks etyki zawodowej pielęgniarki i położnej Rzeczypospolitej Polskiej w odniesieniu do praw pacjenta, Materiały Szkoleniowe z III Konferencji Szkoleniowo-Naukowej Pacjent-Pielęgniarka Partnerzy w Działaniu, Kraków 2004.

Iwaszczyszyn Jan[1], Kliś-Kalinowska Anna[1,2*], Chmiel Izabela[1,2], Pieniążek Iwona[1], Czekaj Janusz[1,2]

Ethical comments on the commercialization of medical services

1. Care and Treatment Home, Cracow, Poland
2. Jagiellonian University, Collegium Medicum, Faculty of Health Sciences

Introduction

It is widely known that Hippocrates (460-377 BC), author of 'The Oath', was the primary founder of medical ethics in Europe. The Hippocratic Oath has been a source of moral rules for medical practice for over 2500 years, as it covered the subjects of medical vocation, the necessity of high morale and virtues in medical graduates, and emphasized a positive relationship between doctors and patients, clearly specifying the duties of physicians and the medical community. Therefore, it constituted the foundation of medical ethics. However, the Hippocratic Oath cannot answers for a number of current, specific and important issues in modern medicine, especially the challenges brought by the rapid development of biotechnology, huge advances in medical knowledge, and the development of bioethics in the second half of the twentieth century. At the same time, the rapidly spreading moral relativism, questioning of the objective truth, and uncritical pluralism - often referred to as 'tolerance' - have led to dangerous turmoil, skepticism and the emergence of questions on how to act so as to be consistent with the ethos of independent medicine and adequately fulfill the expectations of patients based on the art of medicine, which has evolved over the past two and a half millennia.

The fact that there are different views on the same issues within bioethics, just as in philosophy, with the best example of personalistic ethics and the utilitarian views opposed to it, creates specific circumstances, where it is difficult to tailor the Hippocratic '*ars medica*' to one, universal code of bioethics, especially when it comes to the most important issues, i.e. regarding the anthropological interpretation of the concept of human beings, their dignity, rights and autonomy, etc. [1,2].

Personalism perceives humans from a somewhat 'statistical' point of view, assuming that each human being is a person deserving full dignity (*dignitatis humanae*) from conception to natural death. Physical, mental and spiritual characteristics of an individual are secondary to being a person, therefore they do not determine it, and cannot exclude either unconscious patients who are unable to perform moral activities or human fetuses, even those with serious birth defects [2]. This idea generally corresponds with Hippocratic medicine.

Utilitarian anthropology is essentially based on "functionality" with the main idea of periodization and variability of the value of human life. According to this code of ethics, humans become persons once they acquire certain characteristics (e.g. awareness) [3].

In difficult ethical cases, it is recommended that decisions be based on a final consensus, having considered different views and having reached a collective negotiated position. This is known as negotiation ethics based not on absolute ethical principles but on a mutual agreement between parties presenting different views, who take part in the dispute.

This ethical pluralism, the divergence between the established law and the eternal ethical norms of natural law, may cause elderly and chronically ill or dying patients to feel anxiety about a possible decrease in the quality of their life or may feel that their personal dignity is threatened. These disabled and weak individuals may be easily hurt, often unintentionally, by healthy persons who take decisions regarding the allocation of resources for care and treatment [4].

Insufficient resources for healthcare services, which should be systematically increased due to a constant rise of costs and inflation, is an important current healthcare issue leading to tension and conflicts associated with the division of these funds among different medical specialties. Suggestions to reduce financial support for those who no longer can be cured (e.g. palliative patients) are disturbing. This issue is frequently discussed in the media. Twenty-first century patients receive more accurate information concerning the nature and symptoms of their diseases as well as the available treatment methods, the accompanying suffering and possible death, which also contribute to their anxiety.

In light of changes related to healthcare commercialization, the assumptions of traditional Hippocratic medicine, which is mainly based on personalistic bioethics and its independence from financial aspects, often cannot be implemented, despite a general belief that financial security for treatment should be a priority compared to other budget expenditures. However, there are proposals to modify, in the spirit of utilitarianism, the current Code of Medical Ethics, suggesting to limit resources for the treatment of patients with poor prognosis and dying patients

[5].

However, it appears that the commercialization of medical services in Western European countries and the US did not increase their profitability. It can be assumed that, similarly, in Poland and Central and Eastern European countries, the balance of payments associated with health services will not improve. Furthermore, Poland and neighboring countries have different historical, political, cultural and religious experiences. Therefore, we believe that the implementation of new organizational and ethical principles in Poland may result in a number of culture-related, ethical or religious dilemmas and cause financial collapse in an already insufficient healthcare budget. The negative consequences of these changes may pose a threat to palliative care centers and long-term care facilities, which provide care for terminally ill patients.

Controversies and ethical dilemmas

As already mentioned, traditional (Hippocratic) medicine is based mainly on personalistic assumptions regarding the philosophical status of a patient. A person is someone who cannot be characterized and limited to a certain category. They are a unique being, a carrier of values, who performs duties and deserves unconditional respect [6]. Dignity is therefore a priority criterion even in relation to human freedom. Thus, severe symptoms and a ‘low quality of life’ cannot result in decreased dignity or value of human life [7,8]. Hence, it is obvious that abortion, euthanasia or suicide are categorically unacceptable [9].

Commercial medicine is, by contrast, based on assumptions similar to those in utilitarianism, which recognizes the role of convenience as a superior paradigm of bioethics [1].

In utilitarianism, the term person is of a relative and subjective nature, which results from the fact that the value of human life is variable and dependent on symptoms [3]. As a result, the existence of patients with a low quality of life may be considered as less valuable and even in extreme cases ‘not worth living’ [10]. This may lead to a final conclusion that euthanasia is acceptable in these cases [3, 11].

The inferiority of patients’ dignity in relation to their freedom and autonomy may cause controversy when a patient demands medical services characterized by short-sighted, subjective or irrational purposes [8,12]. Personalistic medicine only accepts actions which are in accordance with ‘proper’ medical purposes, the main one being according to Pellegrino, to provide "*care and treatment for patients with different conditions as well as those who cannot be cured*" [12, 13].

Utilitarian medicine, in contrast, features a wider range of services and does not exclude so-called “improper” medical purposes such as meeting social or economic needs, attempts to change the nature of a patient, mutilating surgeries performed in, for example, patients with body dysmorphic disorder, sex reassignment surgeries (consistent genotype-phenotype correlation), stimulation or anabolic therapies, etc. [14]. When patients’ autonomy outweighs their dignity, doctors may find themselves forced to perform commercial services, which are often against the patient's objective interest, needless to say that the autonomy of a physician, who is able to predict the negative consequences of such decisions in a more appropriate manner, is violated [2]. Healthcare commercialization has brought unfortunate neologisms, which have never before occurred in medical terminology, e.g. the term ‘patient’ is being replaced with the terms ‘client’ or ‘beneficiary.’ The term ‘doctor’ is also being replaced with the term 'healthcare provider', and medical facility is referred to as ‘healthcare entity.’ Medical errors are referred to as ‘adverse events,’ etc.

The use of this terminology may imply that it is aimed at the dehumanization of both patients and doctors. Categorical avoidance of patient’s personal data which is frequently replaced with a barcode is yet another example. Although this new procedure seems reasonable in pediatric departments, it raises doubts in adult patients, who do not wish to have their personal data protected in this manner.

However, the depersonalization of patients by ‘destroying’ the concept of a person and replacing it with functional terms, typical of utilitarian ethics and commercial medicine, is a more fundamental problem. As already mentioned, attempts are made to replace the uniform term ‘person’ with somewhat peculiar terms such as a ‘future person,’ which involves human fetuses and small children (due to their psychological immaturity) and a ’past person’, that is ‘moral subjects,’ which involves severely mentally handicapped, unconscious or terminally ill patients, etc. The term ‘person’ would include healthy individuals, fully aware of moral actions [11].

Such periodization of life may cause differences in the valuation of human life.

These assumptions bring about other peculiar terms such as ‘a life not worth living’ or ‘wrongful birth,’ when a newborn is diagnosed with serious developmental disorders. Such an approach emphasizing the doctrine of a person's ‘quality of life’ may lead to the legalization of abortion and euthanasia, and is unacceptable in Hippocratic medicine [9].

Commercial services provided by a healthcare provider to a beneficiary as well as emphasizing patient autonomy are the major principles of commercial medicine, which creates a new reality where medical services may include activities referred to as ‘improper medical purposes’, as mentioned above, which often remain in contradiction with the objective interest of a patient [14].

Commercialization in generally based on expenditure minimization and profit maximization. Thus, healthcare becomes a commodity at the disposal of a healthcare provider (an alleged owner) and may be traded and sold at will.

However, health as well as other personal rights cannot be treated merely as a commodity since healthcare commercialization may lead to the commercialization of human persons, lowering their dignity and treating them like objects [2]. Regarding patients’ health and diseases in terms of profits and losses as well as the financial gains of a healthcare provider may also result in inefficient functioning of healthcare. This is confirmed by frequently prolonged waiting times for specialist consultations or planned or elective surgeries as well as the lack of reimbursement for some drugs, such as antineoplastic agents, which if not used due to high costs may result in therapy failure.

At the same time, the complex administrative structure, fragmentation of medical specialties, as well as a steady increase in healthcare documentation may in practice lead to diminished doctor responsibility for efficient diagnostics and therapy, as well as the loss of the overall vision of patient needs.

An excessive extension of patient autonomy accompanied by the questioning of the personal autonomy of physicians and other therapists is a negative aspect of healthcare service commercialization as it poses a threat to their conscience clause through expanding services to include procedures or pharmaceuticals required by patients that endanger a person’s dignity or belong to the above mentioned improper medical purposes [2]. Promoting neutral world views in applicants, students or doctors against their conscience clause is the best example of impairing doctors’ autonomy. The consequences of these actions may include, as already mentioned, the possible elimination of medical personnel with ethical views different than those of their employer. Students and doctors may therefore conceal their ethical views and feign the required neutrality, which in practice may lead to superficial and insincere interactions that may impair mutual trust between a patient and therapist.

It is worth noting that the medical knowledge of a doctor or therapist is not only their private possession. It is widely known that it also belongs to society and even to the whole of mankind [2]. This is associated with the privilege of students, doctors, and therapists to use academic achievements of many centuries and the experience of their predecessors. A medical education cannot be acquired without the ethical consent of society, as supported by allowing students to participate in post-mortem examinations (autopsy) of deceased patients or to participate, during studies or post-graduate internship, in diagnostic or therapeutic proceedings conducted by their teachers – experienced physicians.

Summary

In light of the growing commercialization of medical services, it appears that the inclusion of diagnostic and therapeutic activities in the principles of free market brings about major changes in doctor-patient relations. They also depend on the type of medical specialty which pertains to a given patient. Particular attention should be paid to specialties associated with the beginning and the end of life, where the subject receiving care is defenseless, weak, poor, or lonely, that is when patients are unable to demand their rights and may be easily hurt. Palliative medicine, which provides care for patients who are in almost every respect dependent on others, mainly on their family and palliative therapists, is one such specialty.

Commercialized medicine emphasizes the autonomy and freedom of a patient who becomes a 'client' and participates in a healthcare provider-beneficiary contract. Many years of experience in palliative care have taught us that most of these patients are unable to clearly state their wishes, are frequently characterized by verbal confusion and even lack awareness. It seems inappropriate to treat these patients as clients waiting for a service similar to a commercial transaction. The same is true for newborns, especially those with serious birth defects. Therefore, commercialization of such medical specialties is our greatest concern [10].

The practice of recent years has shown that commercialization has failed to increase medical service profitability; on the contrary, it increased the costs of these services. The patient-doctor relationship, which has hereto been based on trust, kindness and the patient's objective interest, is now impaired. The waiting time for consultations and planned surgeries has increased, and so has the number of medical services referred to as for improper medical purposes. Also, allegedly scientific arguments for the depersonalization of seriously ill patients as well as for valuing life based on its quality have occurred.

The clash between personalistic and commercial medicine has resulted in new challenges for doctors and medical personnel who in addition to treating patients and protecting their health are also expected to care for patients' objective interest by protecting them from their own ill-considered, subjective and even irrational decisions. Actions aimed at defending the independent ethos of clinical medicine, which has been developed and perfected over more than 2500 years, also seem necessary so as not to regret any hasty decisions or changes resulting from the economic condition of the state, such as 'experimenting with' euthanasia, abortion or eugenics, etc. In addition to defending *ars medica*, it also seems essential to protect doctors' autonomy as well as their clause of conscience despite a definite departure from paternalism in the patient-doctor relationship [5]. We believe that the principle of non-participation, under any circumstances, in deadly activities such as eugenics, cloning, abortion, assisted suicide, etc., should always remain the primary responsibility of a physician, regardless of the circumstances, financial difficulties, promotion of foreign examples and the wishes of patients, their family, or caretakers [5].

Conclusions

Summarizing the above dilemmas, it is our opinion that:

1. The rapid technological development of medical devices, the acceleration of scientific research, increased number of medical specialties, as well as the gradual increase in the number of specialist consultations during a patient's therapy are all positive consequences of commercialization.
2. Healthcare service commercialization gave rise to a new type of business and became a source of new trade corporations.
3. Despite being based on free market principles, healthcare service commercialization not only did not result in lower costs of healthcare services but it has led to a further increase in these costs.
4. In addition to standard therapeutic activity, therapists may be financially involved, as investors, in institutions that accompany the basic healthcare activity, where they may frequently be employed as consultants or advisors. This in turn may artificially increase

both the competitiveness and the costs of products or services, which is an obvious disadvantage for patients.

5. A doctor may in fact become an ‘independent entrepreneur’ or a ‘sales agent’ with goals other than just medical ethics, which may be limited merely to the legality of his/her actions and not to his/her virtues, duties, and the patient’s interest. The profits of a healthcare provider may dominate both concern for the patients’ health and their objective interest, which may result in a pointless prolongation of life in dying patients who pay for it on the one hand, and offering euthanasia to poor patients on the other.
6. We therefore believe that making excessive profits by private investors and healthcare providers using the resources allocated by the national budget for healthcare, which is achieved at the expense of patients, is likely to be one of the hidden purposes of commercialization.
7. It should be kept in mind that suffering patients cannot be treated as rational ‘clients’ who freely acquire products or services. These patients often find themselves in a difficult existential situation, which forces them to seek immediate help. Therefore, the freedom of choice, searching for advantageous therapeutic offers among those advertised, often proves to be an illusion.
8. There are serious concerns that the consequences of healthcare service commercialization may create situations where patients’ health and interests will no longer be treated as a primary goal and criterion for the actions of healthcare providers as they will have an opportunity to achieve undeserved financial gains.
9. A steady increase in the number of specialist tests (laboratory tests or consultations), not always essential for the purposes of treatment yet providing investors and healthcare providers with additional profit, may serve as an example of negative motivation for the actions of a healthcare provider.
10. The medical knowledge of a doctor or a therapist can neither be treated only as their private possession nor can it belong to a company providing medical services. Therapists and doctors, by benefiting from the experience of their predecessors as well as from society's consent to gain practical experience during their studies when they assist in physical examinations, become indebted to their ‘community.’

11. Peculiar and primitive innovations in medical terminology as well as a steady increase in documentation are also important. By innovations we mean replacing medical terminology with non-medical terms: patient becomes ‘client’; hospitals, medical centers, clinics and physicians become ‘healthcare providers’; and medical errors are referred to as ‘adverse effects.’
12. Postulates which may suggest attempts to depersonalize patients by non-statistical but functional terms describing a patient as well as the emergence of peculiar terms such as ‘a future person’ (i.e. fetuses and children) and ‘a past person’, i.e. patients with serious physical or psychological conditions, lacking consciousness or who are terminally ill, etc., are a major concern. This terminology may initiate the legalization of euthanasia or assisted suicide.
13. Similarly, the co-called ‘philosophy of life quality’, which is associated with utilitarian medicine, may also be used for the valuation of human life and, in the case of its low quality, suggest to end it by euthanasia or suicide.
14. Healthcare service commercialization may endanger the independent ethos of clinical medicine by replacing it with an agreement or a contract. As a result, *ars medica* will resemble trade.
15. Promoting ideological neutrality among doctors impairs their autonomy as well as their clause of conscience. It also may become a source of discrimination, which is unacceptable in civil societies.

References

1. Biesaga T.: Błąd antropologiczny i jego skutki w bioetyce w: Maryniarczyk A. Stępień K. red. Błąd antropologiczny. PTTA, Lublin, 2003, 191-199.
2. Biesaga T.: Elementy etyki lekarskiej. Med. Prakt., 2006, 57-68; 90-98.
3. Singer P.: Etyka praktyczna (tłum. Sagan A.), KIW, Warszawa, 2003.
4. Iwaszczyszyn J.: Filozofia dialogu i spotkania w opiece paliatywnej. Kraków 2012
5. Kodeks Etyki Lekarskiej (z dnia 02.01.2004) NRL 2004.
6. Słownik encyklopedyczny Collins. Vesey G. Foulkes P. Wydawnictwo RTW, Warszawa, 1997, 232-271.

7. Jan Paweł II: Evangelium vitae (encyklika). Wyd. M., Kraków, 1995, 21.
8. Papieska Rada „Cor Unum" Niektóre kwestie etyczne odnoszące się do ciężko chorych i umierających z dnia 27 sierpnia 1981.
9. Iwaszczyszyn J., Kliś-Kalinowska A., Lis M., Czekaj J.: Ethical aspect of quality of life of palliative care patients. Prog. Health Sci., 2013, 3, 162-165.
10. Iwaszczyszyn J., Kliś-Kalinowska A., Czekaj J., Chmiel J.: Ethical problems of palliative care in the period of its evalutionary transformation. Prog. Health Sci., 2012, 2, 153-157.
11. Szawarski Z.: Mądrość i sztuka leczenia. Słowo Obraz Terytoria, Gdańsk 2005, 258-271/
12. Pellegrino E.D.: The internal morality of clinical medicine: a paradigm for the ethics of the helping and healing professions. J. Med. Philos. 2001, 26, 559.
13. Pellegrino E.D.: Toward a virtue-based normative ethics for the health professions. Kennedy Ins. Ethics J. 1955, 267.
14. Kass L.R.: Toward a more natural science. Biology and human affairs NY Free Press 1985, 152, 159, 160, 162,163.

Mińko Maciej[1], Mińko Magdalena[2], Barańska Agnieszka[3], Siwczyńska Dorota[3]

The analysis the cross-border healthcare directive

1. Faculty Law and Administration, Maria Curie-Skłodowska University in Lublin
2. Department of Healthcare, Medical University of Warsaw
3. Collegium of Socio-Economics, Warsaw School of Economics

Cross-border directive introducing in all countries of the European Union cross-border health care enables citizens of one of the European countries, the implementation of health services in another country belonging to the European Union. The legal basis for cross-border healthcare is a directive of the European Parliament and of the Council Directive 2001/24/EU of 9th March 2011, which entered into force in all the countries of the European Union on 25th October 2013. It applies regardless of whether the Member States had to formally deploy in their area or not. Cross-border healthcare is using health benefits other EU countries if the waiting time for services in native country is too long. The provision of charge carried out abroad, will be reimbursed by the Health Fund on the basis of the amount of the rates applied by the NFZ (NHF). This includes services from the so-called basket of guaranteed benefits. The guarantor for the refund are to be the appropriate referrals in accordance with the principles set out in the Act of 27th August 2004 about health care benefits financed from public funds.

After the entry into force of the directive has not abolished the existing regulations already, and the European health insurance card. So why do we need new legislation? The new directive will not affect the benefits they provide citizens with social security regulations in force. Though the existing provisions that focus on the agreements on social security, and not on the rights of the patient- in effect since 1971, further clarification required rights for EU citizens to make use of healthcare in another Member State. In the case of hospital care, one of the most important achievements of the new directive is to allow patients to choose service providers. In the case of care outside of the hospital's patients will be able to take advantage of benefits abroad without prior permission and formalities are completed, and after returning home will be able to apply for reimbursement of costs of treatment. The directive includes not only public service providers, but also private. Patients will have access to information on the quality and safety benefits to be granted to them, both within and outside of hospital inpatient care. Using this directive to also solve other practical issues: where can I find information on quality standards used by the hospital? What reimbursement to patients? The Court of Justice confirmed that the right to the use of cross-border healthcare is already enshrined in the Treaty. In the newly adopted, directive was postponed; however, in a clear way to EU rules and are given a uniform and coherent legal framework for all European citizens. EHIC and guarantee a permanent medical assistance, such as the guarantee's directive cross-border. As we have already written directive can benefit those who plan to in the future to undergo treatment, and have made efforts to do so. It's all about putting on a particular type of benefit, and to ensure that the provision of these belong to the basket of benefits guaranteed by the NFZ. You must also keep in mind that the refund will depend primarily on the permission from the NHF, but only in some cases listed in the directive, which are, inter alia:

- in cases where the service requires a stay in the hospital for one night
- in the case of specialized and costly services
- in serious and specific situations related to the quality, or safety of care provided by the service provider.

In these three cases, patients should ask for approval for reimbursement, the national health authority. Member States are required to present to the public, which treatments are the subject of such authorization. National health authorities may refuse the authorisation if the treatment, can pose a risk for the patient or if you can provide health care in their home country within the limits of the medically justified. However, the Member States will have to explain why that refusal was necessary, and justify their assessment of what is "medically justified." That refusal, however, is not the final decision, because the Patients have the right to request a review of any administrative decision regarding cross-border healthcare.

This Directive shall not affect the benefits already offered to citizens by the existing regulations on social security, which have their basis in the articles of the EU Treaty on the free movement of persons. However, explains the patients ' rights, which are the basis for the free movement of services, and which have been referred to in various judgments of the European Court of Justice. In the case of hospital care, one of the main achievements of the new directive is that patients will be able to pick them up with your doctor. Another advantage of the new directive is that it introduces the wider possibilities in the provision of services because the directive covers all providers of health services in the EU. Reducing bureaucracy is another plus of new regulations as in the framework of Directive prior agreement of the national authority would rather than and not as it was so far the rule. Patients will receive all the information you need to make an informed choice, for example, on: the quality and safety of health care through the national contact points, which will be set up in all

Member States. Furthermore, the directive introduces new measures to help all patients how best to make use of the rights conferred on the basis of legal acts. The new law introduces procedural guarantees. The patient has the right to duly justified medical decisions, and to appeal against them, if it considers that its rights are not respected. All patients have the right to complain and to claim compensation. The proceeding must be covered by insurance against civil liability (OC) or a similar guarantee. Every patient has the right to a copy of your medical records.

What amount will be returned to the patient after the provision of overseas?

The patient will be returned the same the amount thereof referred to service in his country. Member States in which the care is free at the place of execution of the provision must inform the patients about their reimbursement tariffs. If the treatment abroad is cheaper than in the country of return will reflect the actual cost of treatment. Medical expenses are usually the patient paying a certain amount in advance, the refund shall be the appropriate State authority responsible for it as soon as possible. The law also gives Member States the option of earlier confirmation of return in writing. Member States also have the option of paying for health care directly, rather than in the form of a refund. Important issues raised At Medical Board in the post from 22. 02. 2013 year on cross-border healthcare "Foundation of the Bill provide that the reimbursement of the costs of cross-border healthcare will make the regional branch of NFZ, and in the event of refusal to return, the insured person will be able to submit a complaint to the provincial administrative court. The proposed mechanism does not correspond to the standards of the directive and the nature of the legal case for reimbursement. The insured person should be able to reference the path to the proceedings before the Court, since his claim for the reimbursement of expenditure incurred abroad is wealth and should be entrusted to an ordinary court cognition instead. The proposed law should at the same time ensure that the carrying case for reimbursement of cross-border healthcare was released from court costs."

An important problem is the inability to perform in the country and the possibility of it abroad. It is possible, however, will only be entitled to reimbursement if the data service you need to cart the health benefits of the patient in accordance with the provisions of laws or regulations in his country. The national contact point will be able to provide information, how to check whether the provision should be to your cart health benefits to which he is entitled to a particular patient.

Another issue is the question of medical records held by the doctor in the native country, fulfillment of the provision in another country should be sent there. The patient has the right to receive a copy of your medical records from their native country before undergoing treatment in another Member State. The documentation must also communicate to the service provider in the country where the treatment has been carried out, before returning to the country.

The Problem of failure of treatment abroad was also addressed in the directive. Namely, the national contact point in the Member State has an obligation to explain to the patient what is entitled to his right, and provide information about the laws in force in the country concerned. Their own patient is obliged to offer the same further treatment, as that from which the patient could benefit if treatment from the beginning takes place on its territory. What we do, so rest assured that treatment started abroad will be continued after his return to the country? Native country has a duty to ensure the same quality of further treatment the patient regardless of where in the EU a previous treatment.

Another interesting issue relating to the directive on cross-border is a matter of prescriptions issued in their home country. Recipe published in another EU country should be in the country of residence of the patient, and vice versa. Thanks to the treatment taken in another EU country will be continued after the patient's return home. The patient has the right to obtain prescribed medicine, provided that it is approved for sale and available in the country where it wishes to buy. Although these rules are not new, in practice, there are difficulties in implementing the prescription. The provisions of the directive, although it certainly did not kill the problem right away, should help a community pharmacists ' intervention in a better understanding and implementation of the prescriptions issued in another Member State.

The national contact points.

Cross-border healthcare any Member State of the European Union shall appoint at least one national point for cross-border healthcare.

The task of national contact points provide patients information:

1. services, including information about permissions specific to a service provider to provide services or of any restriction imposed on his practice;
2. standards and guidelines for quality and safety laid down by the Member State of treatment, including arrangements for the supervision of service providers and their evaluation, information on service providers who are subject to the standards and guidelines and information about the availability of hospitals for people with disabilities;

3. on the rights of the patients, procedures and complaints investigation mechanisms corrective measures, in accordance with the legislation of that Member State, as well as on existing legal and administrative options for the settlement of disputes, including in the case of damage caused in connection with the provision of cross-border healthcare;
4. rights and privileges of patients in relation to cross-border healthcare, procedures for accessing those entitlements and how they determine the conditions for the reimbursement of the costs of cross-border healthcare, procedures for appeal and redress, in cases when patients feel that their rights are not respected.

The above information to patients, for which coverage is country, Poland will provide provincial branches of the national health fund.

Point in the country, in which the patient treatment plans to inform the health care system in this country and how it guarantees the quality and safety of treatment, including:

- who sets the standards in this field and what is their scope
- who oversees compliance with the standards
- what are the consequences if the health care facility does not comply with the standards in force
- or a specific medical facility is registered and whether it has permission to offer a particular type of treatmentas well as the extent to which the quality control system and safety is covered by
- on the rights of the patient in this country and about what you can do if something goes wrong, or if you will not be satisfied with the treatment.

What scale of cross-border healthcare are we talking about?

Patients prefer to receive healthcare in their own country. That is why the demand for cross-border healthcare represents only around 1% of public spending on healthcare, which is currently around €10 billion. This estimate includes cross-border healthcare which patients had not planned in advance (such as emergency care for tourists). This means that, at present, considerably less of that 1% of the expenditure and movement of patients is for planned cross-border healthcare, like hip and knee operations or cataract surgery.

As I wrote in the introduction, the development will be done on a plane yet little-known medical tourism, not yet widespread enough. More fashion in Poland is the spa tourism, which involves the conscious and voluntary visiting any on a period of having the status of a non-working time, with a view to maintaining or improving the current state of health through physical and mental relaxation.

Spa tourism, despite the fact that more developed in terms of health tourism. Thanks to the directive on cross-border effects can be combined with the medical service some tourist. It will bring to both the tourist plane gains, financial and health.

References

1. http://europa.eu/rapid/press-release_MEMO-13-918_en.htm, [cited 23.04. 2014].
2. http://europa.eu/youreurope/citizens/health/planned-healthcare/hospitals/index_pl.htm, [cited 23.04. 2014].
3. http://inwestycje.pl/gospodarka/Transgraniczna-opieka-medyczna-8211-spoznione-i-nieadekwatne-do-dyrektywy-przepisy;227933;0.html, [cited 23.04. 2014].
4. http://www.bpp.gov.pl/dla-pacjenta/transgraniczna-opieka-zdrowotna/, [cited 23.04. 2014].
5. http://www.nil.org.pl/aktualnosci/transgraniczna-opieka-zdrowotna-stanowisko-naczelnej-rady- lekarskiej-z-22.02.2013-r., [cited 23.04. 2014].

Siwczyńska Dorota[1], **Psujek Magdalena**[2], **Mińko Maciej**[3]

The beginnings of the social security system in the UK in the 40's

1. Collegium of Socio-Economics, Warsaw School of Economics, Warsaw, Poland
2. II Faculty of Medicine with English Language Division, Medical University of Lublin, Poland
3. Faculty of Law and Administration, Maria Curie Skłodowska University, Poland

Introduction

With the development of capitalism, the existence of factors that are independent of employers and employees, and may adversely affect their health and life. Hence there is a need to protect the society in case of unforeseen occurrences, which included, among others: illness, accidents, unemployment or old age. Diagnosis of currently functioning system, whose plan was developed by Lloyd George, revealed that reforms implemented in 1911 addressed only individual solutions and did not form a coherent system of social security [1]. The National Insurance Act accepted by the Parliament ensured the introduction of "*insurance in case of loss of health, the prevention and treatment of diseases, the prevention of unemployment and the effects of accidents*" [2]. Such responsibilities of the state in social issues proved to be insufficient. The system protected the citizens from the effects of social risks, but it lacked universal health care insurance in case of maternity and funeral costs [1]. Therefore, in the process of insurance systems formation, particular attention began to be paid to the stakeholders. Among the participants in the system were both insured, employers and the state [1]. The view that the poor conditions of the working class concern not only themselves, but they have a huge impact on the whole society became more common.

Explication

Causes of the Beveridge Report

In 1942 Committee on Social Insurance and Related Benefits was created under the direction of William Beveridge. The aim of the Committee was "to examine, with special emphasis on internal relationships, existing patterns of social insurance and related benefits, including the system of benefits associated with the consequences of accidents at work and occupational diseases and to make appropriate recommendations" [3].

The main disadvantages of the fuctioning system included the exclusion of certain occupational groups from the social security system and the lack of universal criteria for all insured. In addition, the content of the report indicated that the current system is managed by a complicated and uncoordinated administrative apparatus absorbing significant financial resources [1].

All of these weaknesses of the current system were particularly enhanced during the Great Depression and World War II [4]. Rising unemployment, poverty and political reasons called for carrying out fundamental reforms. Beveridge believed that the lack of response to deteriorating conditions of life during the war could result in a threat of revolution.

The three main rules for the implementation

Beveridge report foresaw the introduction of many revolutionary changes in the field of social and health care in the UK. Therefore William Beveridge distinguished three main hints that were the basis to develop further recommendations on the proposed changes.

The first principle was that in case of planning any proposals for the future the expertise and experience gained in the past must be taken into considerations and that these proposals should not be limited by the group of interests. Beveridge said that " now, when the war is abolishing landmarks of every kind, is the opportunity for using experience in a clear field. A revolutionary moment in the world's history is a time for revolutions, not for patching" [3].

The second principle was that the organization of social insurance should be seen as one of the important parts of a complex policy of social progress. It spoke also about the security of income that would be a natural consequence of the universal insurance introduction. Moreover Beveridge distinguished five major obstacles - the giants on the road to reconstruction. Among them there were: disease, ignorance, squalor, idleness and want [3].

The third principle clearly states that the only way to create a social security system is the cooperation between the state and the individual. State should protect the contribution of funds from payers - defined as an interest in the report, as well as provide the service. Beveridge postulated “not to block initiative, opportunities and responsibility of citizens" [3] in the process of organizing social security. He stated that individuals should be encouraged to autonomous action ensuring themselves and their families more than the minimum guaranteed by the state.

Social security plan

In the face of worsening of the social situation of many people in the UK, Beveridge presented in his report a series of reforms that were supposed to eliminate poverty from social life. The uniform system was to ensure safety in the case of job loss and lack of funds for maintenance. This goal was to be achieved by a dual income redistribution. Vertical redistribution was to be implemented by the tax system, which would include social assistance, child allowances and partly healthcare and rehabilitation. In turn, the horizontal redistribution would oscillate between the insured during periods of better and worse financial situation, health and disease, as well as the working age and old age, and its implementation would be provided by the social insurance system [1].

Project of the social security system proposed by Beveridge also provided other methods of social protection for the citizens of Great Britain, including the introduction of benefits for children, social assistance and protection from unemployment. Another important element of the plan was the introduction of free, universal healthcare and rehabilitation. Because "*health is a dimension of both individual and social nature, high mortality and treatment deficiencies lead to higher social security costs, prolonged inability to work while diseases in addition to the losses that have been brought directly to individuals, causing loss of production*" [1]. In addition, Beveridge proposed solutions for social life, both for the poor strata of society, as well as the middle class [5]. Anticipating the growth of middle-class prosperity, Beveridge included a prerequisite for achieving objectives, which was voluntary insurance. The purpose of the voluntary insurance was to provide higher means than those guaranteed by the social security and to ensure the financial security of the situations uncovered by these insurance [1].

Assumptions

In order to ensure equal access to social security benefits to all citizens, essentials of system functioning was enhanced. These include:

1) Universality - understood as social security coverage for all citizens, regardless of economic status, gender or age.
2) Classification - due to the diversity of exposure to different risks of various occupational groups, there were distinguished six classes of insurance, which include:
   a. employees;
   b. self-employed;
   c. married women - distinguishing of the class let for inclusion of both marital and professional status of women [1];
   d. other persons of working age, i.e. students;
   e. persons beyond retirement age;
   f. persons in the pre-productive age.

3) Uniformity of insurance benefits - expressed in the equal amount of benefits, regardless of income.
4) Uniformity of insurance subscription - meaning an equal value of the contributions, excluding income. The only exception from this rule would be a greater burden on employers in vulnerable sectors of the economy.
5) The sufficiency of insurance benefits - both with regard to the value of benefits paid, as well as the payment period.
6) The harmonization of administrative responsibility - which should reduce administrative costs and increase the efficiency of insurance [1,6].

Functioning rules

The report indicated Ministry of Social Security as a major institution, which would administer the activities of the social security system. The newly formed entity would be responsible for the creation of regional and local offices as well as coordination of their activities at the central level. The appointment of the Statutory Committee of Social Security, which would work for the Ministry was also proposed. Its tasks would include: control over the Social Insurance Fund, recommending the amount of collected premiums and the value of paid benefits.

As to voluntary insurance, entrusting Trade Unions coordination of unemployment insurance was considered, while the Mutual Aid Societies was to be responsible for sickness insurance - all under the condition of operating under the social supervision in the form of state agencies and the exclusion of profit as the main aim in business.

The Beveridge's project assumed delegating issues of healthcare and rehabilitation to the Ministry of Health. However, the establishment of a special committee to ensure appropriate coordination of the two units was proposed.

Besides, as the unit of appeal in all matters of social security, working for the citizens, they proposed the institution of arbitration. It was also to act as a control over the functioning of the Ministry and its field units. As the supreme court defined Superreferee constituted by the Crown, whose decision would be final [1].

Conclusions

Reform plans initiated by William Beveridge have significantly contributed to the emergence and development of the social security system of UK citizens. Many of the solutions from the report are still operating today, or they created a solid foundation for building social security systems in other countries. So in addition to the historical value of the report, the practical value of this document should also be emphasizing. In the face of progressive social changes after World War II, it became a determinant of building a welfare state. In the postwar period, the United Kingdom, like many other countries, was struggling with serious financial problems. Therefore, in the proposed system of insurance division partition of costs between employees, employers and the State was so important. In the future it accounted for revenue protection for both citizens and government.

References

1. Magnuszewska-Otulak G.: Raport Beveridge'a. [w:] Rozwój systemu zabezpieczenia społecznego w Wielkiej Brytanii – Raport Beveridge'a, Trzepizur-Szmigiero (red.) Instytut Pracy i Spraw Socjalnych, Warszawa, 1992, 13-73.
2. Marsh D.C.: National insurance and assistance in Great Britain, London 1952, 29.
3. Beveridge W.H.: Social insurance and allied services – Report by sir William Beveridge, New York, 1942, 5 -7.
4. Johnson P.: The welfare state. [w:] The economic history of Britain since 1700 - 1939-1992, Floud R., McCloskey D. /red./: 3 t., Cambridge 1994, 314-315.
5. Harris J.: Political ideas and the debate on state welfare - 1940-1945. Smith H.L. /red./: War and the social change, Manchester, 1986, 238.
6. Johnson P.: The welfare state, income and living standards. [w:] The Cambridge economic history of modern Britain – Structural change and growth – 1939-2000, Floud R., Johnson P. (red.), Cambridge, 2004, 234-235.

Twardowski Mirosław

Doctor-Patient Relationship in the View of Islamic Bioethics

Faculty of Biology and Agriculture, University of Rzeszów

Introduction

Muslim ethics is of a thoroughly juridical character, which means that all moral standards take the character of the '*spiritual law'*, that is *shari'a.* [1,2] *Shari'a* (its literary meaning is '*the way to water'*) is a Muslim legal system ('*the spiritual law'*) which includes practical rules explaining and applying the precepts of Quran to everyday situations. *Shari'a* regulates the duties of Islam followers in all aspects of their lives, that is their duties toward God and religion, but also toward themselves and others. *Shari'a* is the law that is described by such qualities as infallibility, immutability, indisputability and universality. Apart from Quran, the following sources have affected the '*spiritual law'*: *sunnah* (the tradition transmitting Muhammad's words and teachings), *ijma* (the agreement among the scholars of the Muslim community), and *qiyas* (the process of deductive analogy).

Islam believes in absolute divine omnipotence [3]. That is why, in accordance with the explanations presented in Quran, suffering exists only in accordance with God's will [3]. However, God never makes people to carry intolerable burden. Islam is against excessive severity which weakens the body and limits natural instincts.

Illness and suffering have their share in atonement for sins and give rise to a more positive and cheerful attitude towards suffering, which is not perceived as curse or a meaningless experience anymore.

Islam exhorts the faithful to be sensitive to the ill and to take care of them in order to avoid the possible desire for death [3]. Society has the moral and religious duty to contribute to the costs of caring for a patient, stepping in for relatives who are unable to bear them; this action represents a post-mortem investment, and virtue has no price. Apologetically it is recalled that in Muslim societies, the seriously ill or terminal patient can still enjoy, socially and psychologically, a network that does not leave him unprotected and having to fend for himself as is the case in the West. However, if the Koran recommends perseverance in the face of pain, the absence of perseverance is not punished as Koran 2.45 recognizes that each individual possesses different capacities of suffering and therefore, also a different resistance to pain.

However, the unitary conception of the human being, who is made up of the physical and spiritual dimension, has become the central idea of Muslim medical anthropology. The dualism of the soul and body, which characterizes the Muslim philosophical tradition, is the result of the influence of the Western philosophy, especially Plato's philosophy. For Plato, the soul and body are irreducible; the soul is the body and constitutes a separate and distinct entity. [3].

This is an inevitable consequence: both illness and health are not exclusive to the physical-biological sphere but also include the psychological-spiritual sphere. Both well-being and physical illness are eventually, in some way, well-being and illness of the whole organism and the whole person. As healing is, to some extent, simultaneously physical and spiritual and as the mind and body are complementary to one another [3].

In the world of Islam in relation to the doctor-patient relationship, the principle of public good and of help and care for the needy and ill is in effect [3]. It has taken on preponderant importance, deeply affecting values and medical practice. As a result, in Islam medicine has become a social and moral practice and this activity has been conveyed above all by the hospitals.

The contrast between Islamic medical ethics (and practice) and the Muslim law in the (Muslim)doctor-(Muslim-non-Muslim)patient relation

In the times of the Prophet there were no hospitals in Arabia [3]. These were established on a wide scale in the Abbasid period. The first Muslim hospital director was Bakr al-Razi. The Muslim hospitals existing in the period from 9th to 12th century were the largest and best organised in the world. A description of the aims of the activity in the most important Egyptian hospital of those centuries, the Mansuri hospital, is presented in one of its founding documents. It was a place of treatment for the ill, independently of their gender, economic conditions, region of residence, race and religion. Major or minor disorders were treated there, including both physical or mental problems, as the protection of mental health is one of the aims of the *Shari'a*. The greatest attention was to be devoted to those who had suffered from the loss of their minds and honour, and individuals were to be admitted as well as entire groups until they were perfectly healed. All the costs were borne by the Hospital. The insistence on mental illnesses is to be underlined with the connection to physical disease, showing the importance of psychosomatic medicine in classic Islam. No patient could be rejected on the basis of race, religious faith, gender, etc.; there was a mosque and also a chapel for Christians.

This "egalitarian" trend for patients of different faiths can be accompanied by a different attitude well rooted in Muslim law, according to which the *dhimmis*, whilst protected, remain in a state of juridical inferiority compared to Muslims. This can be found in a historical episode. The head of the doctors of Baghdad, Sinan Ibn Thabit, questioned the Grand Vizir or Plenipotentiary Minister or lieutenant of the Prince, on the conduct to be followed by doctors concerning the majority of the inhabitants of Sawad who were Jews, recalling that in Baghdad Muslim and non-Muslim patients were treated in the same way. The Vizir replied that animals, Christians and Jews have to be treated but following a specific order: first Muslims are treated, then non- Muslims and lastly animals. Following the strictly juridical order, the Muslim doctor could first protect the faithful of the "*true religion*" [3]. For example, according to al-Qaradawi, "if there is a Muslim and a non-Muslim and both are in need of organ or blood donation, the Muslim must be given priority for Allah Almighty says in the Koran 9.71: '*The Believers, men and women, are protectors one of another'" [4]. Obviously, this juridical approach may go against the medical ethical approach, for example art. 3 of the last Islamic Code for Medical and Health Ethics of the IOMS (2004) which maintains that the physician should treat all his patients "without any discrimination based on . . . their religion . . . or their gender, nationality, or color*" [3].

These aspects highlight a contrast between Islamic medical ethics and Muslim law, which in turn is rooted in the Koran where both interpretations are present at the same time:

- the equality of the faithful and/or men before God
- the structural juridical distinction between Muslims, dhimmis and infidels.

The Muslim-doctor vs. the incurably and/or terminally ill Muslim patient

In Muslim law, the individual affected by a fatal disease is seen as equivalent to:

- a woman close to childbirth, i.e. who has reached the sixth month of pregnancy or, according to more recent opinion, the woman who is suffering labour pains
- the soldier in battle
- the prisoner condemned to death
- a person injured in an accident is the injury implies a danger of death [3].

The Muslim doctor has the task of making every effort to give the incurable patient moral support and relieve physical and psychological pain, i.e. acting on the whole sphere of the person [3]. Every attempt to save a dying person, if the probabilities of success appear significant, should be made. On the contrary, artificially prolonging the vegetative state of a patient who is definitively unconscious is unlawful as it is consciousness that makes an individual responsible; otherwise dignity is violated beyond the divine will. If it is certain that a person will not live, it is useless keeping them in a vegetative state with heroic attempts at resuscitation or other artificial equipment.

In all developing countries, the majority of patients with serious pathologies seek treatment when the pathology is too advanced and incurable. In Muslim countries it is still likely that the incurable patient will die in his own home, where several generations may live together and where the impression is that the terminal patient can tolerate his suffering better. This inclination is not without problematic consequences, when hospitals have modern clinical equipment. In fact, "letting the patients go home" often means forgoing direct care by doctors and medical staff and hospital equipment and, at the same time placing a considerable "*burden*" on families that are not always in a position to take on a similar commitment, either on the material or psychological level. The law in many Muslim countries allows transferring a patient whose life is in danger to his home if he himself or his family so request.

Palliative care

Speaking of care for the terminally ill patient means speaking of palliative care, i. e. what to do when no more can be done for the patient [3]. Recourse to hospices in the Middle East and North Africa is hindered by multiple reasons: in the first place those of an economic and social order as they require a complex and expensive structure; the inefficiency of nurses and the poor qualification of health personnel; the low salaries of the latter and, lastly, the general preference for home care.

Since the early 1990s, a palliative care department has been active in Saudi Arabia at the KFSH in Riyadh for the purpose of providing physical, psychological and social care to the terminally ill patient and his or her relatives either at home or in hospital by an inter-disciplinary team of professionals and expert nurses. This is believed to be the most complete Palliative Care Service in the whole of the Arab world.

In Europe and North America, care for the patient for whom therapy is useless is increasingly evaluated as a specialisation exercised by health personnel competent in clinical pharmacology and the specific pathologies. In the dominant social environment in Saudi Arabia, the strong family unity and the strong religious bond are some of the factors that help the patient to die at home, accompanied by relatives [3].

Numerous socio-cultural obstacles oppose the programmes of palliative care in these countries [3]. In the first place, there is a widespread lack of knowledge of modern pharmacological instruments to control and reduce pain.

Information and consent of the seriously and terminally ill patient

By quoting the Muslim law, Islamic bioethicists invoke the rule according to which the subject *optimo iure* of rights and duties is the free, pubescent male who is healthy in mind and body and with an irreproachable life [3]. Only the possession of these requisites gives full juridical capacity. The absence of one or more of them entails the diminution of the right of disposal. These limitations are called "*impediments*" or "*restraints*". In the Muslim law there are several categories of such limitations, including: sex; age; illness and certain pathological, physical and mental conditions; special and transitory circumstances; apostasy and other deprivations that suppress juridical capacity [3]. Therefore, the psychophysical infirmities cause limitations of the capacity to act. Some infirmities are temporary, others are chronic. The individual affected by a fatal illness is "*bound*" or "*impeded*", i.e. he has a limited capacity because it is believed that his psychophysical state does not allow him to be fully aware in providing for his own interests.

In Muslim countries the patient is first and foremost a member of the family which feels responsible for him; the consent of the seriously ill and/or incurable patient is easily taken over by that of the family in order to avoid emotional problems for him [3]. Similarly, in Muslim countries it is preferable to avoid any negative consequences for the patient at the psycho-physical level that can be caused by the information about the state of health. The serious illness of one member of the family tends to emotionally involve all the others. For this reason the Doctors prefer to communicate with chosen members of the family.

An interesting study was carried out in the Arab Emirates in 1995 with the purpose of examining the information to be given to a terminally ill patient on a sample of 100 citizens and 50 local Doctors [3]. Two cases were analyzed:

- The death of the patient within six months is almost certain: Should the doctor tell him?
- A patient has a 50% chance of dying in the next six months: Should the doctor tell him? There were three possible answers: Yes, No, It depends.

Case 1. Forty-two per cent of citizens and 38% of Doctors answered NO; 27% and 8%, respectively YES; and 31% and 54%, IT DEPENDS. If the patient asks expressly for the truth then 38% of citizens and 36% of Doctors answer NO, and 59% and 42%, respectively, answer YES.

Case 2. Seventy per cent of Doctors answer NO, 0% YES and 30% IT DEPENDS. If the patient expressly asks for the truth only 28% of Doctors say YES and 54% continue to say NO. The majority of citizens are also contrary: NO 43%, YES 30%, IT DEPENDS 27%. In the case of explicit request, 59% of citizens answer YES and 54% NO.

Comment. When asked for the reasons for their choices, no citizen mentioned the patient's right to know the truth about his health or the duty of the doctor to tell him, but practical reasons were given, e.g. making a will or allowing the patient to seek treatment abroad. Religious reasons justified both silence and revealing the truth. In general, the Doctors seem much less in favour than the citizens of telling the truth. Amongst the consequences, 90% of citizens revealed that they did not completely trust what Doctors tell them about their state of health. Lastly, the majority of Doctors maintain that Western patients seem more inclined to want to know the truth about their condition.

The living will

The expression *living will* indicates a declaration made by a person in possession of his mental faculties, in which he specifies the limits within which he wants to be treated in the event of being in an extremely critical condition, without the possibility of recovery [3].

The term *al-wasiya* in Muslim law indicates the last wishes and, by extension, also a will. Their regulation is present in Koran 5.106: "*O ye who believe! Let there be witnesses between you when death draweth nigh unto one of you, at the time of bequest - two witnesses, just men from among you, or two others from another tribe, in case ye are campaigning in the land and the calamity of death befall you. Ye shall empanel them both after the prayer, and, if ye doubt, they shall be made to swear by Allah (saying): We will not take a bribe, even though it were (on behalf of) a near kinsman nor will we hide the testimony of Allah, for then indeed we should be of the sinful!*" [4].

The *living will* cannot be included in the will as what is included in a will can be executed only after the death of the testate [3]. For example, art. 184 of the Algerian Law on the Family no. 84-11 states that the *wasiya* is a transfer of property free of charge that takes effect after death.

However, according to some lawyers, a Muslim can draw up an alternative living will, without a binding value and which can be defined a wasiya mubahah and includes the following elements :

- Request to suspend treatment if this does not improve the quality of life according to the principle "*la darar wa la dirar*" (no harm and no harassment). In this case death is not accelerated as only excessive treatment is refused. However, hygiene and nutrition should be maintained
- Instructions to switch off life-supporting equipment after brain stem death has been diagnosed. This was allowed by the Council of the Islamic Jurisprudence Academy of the OIC in Amman, 1996, 5th Resolution
- Inclusion of the wish to donate organs according to the principle of public benefit (*maslaha*)
- It is worthwhile appointing an attorney, Arabic *wakalah* (pl.), to be expressly mentioned. When the patient's mental faculties are compromised, his legal representative (*wakil*) is morally obliged to communicate the dying patient's wishes to his relatives and Doctors.

According to Koran 2.282: "*The witnesses should not refuse when they are called on*" [4]. If none of the requests contained in the *living will* contradicts the teachings of the *Shari'a*, there is no justification for ignoring the directives it contains.

Islam vs. euthanasia: for or against?

For Islam, man is not his own master, therefore the termination of the treatment of a living individual on his request or on the request of his relatives in the event that the patient is unable to distinguish between right and wrong is prohibited [1,5]. From a religious perspective, the patient who shows strength of mind in facing up to, accepting and overcoming his suffering earns credit with God; euthanasia - amongst other things - would prevent him from obtaining this credit [3]. Again from a religious standpoint, it must be remembered that where there is life there is hope and a miracle can always happen.

A person is considered legally dead and all the Shari'a's principles can be applied when one of the following signs is established:

- complete stoppage of the heart and breathing, which is deemed irreversible by doctors
- complete stoppage of all vital functions of the brain, which is deemed irreversible by doctors, and the brain has started to degenerate [6].

Under these circumstances it is justified to disconnect life-support systems even though some organs continue to function automatically with these devices.

Euthanasia could be defined as an act which hastens the death of a human being or removes the obstacles that, for example, remove pain [3]. The modern *fatwas* do not dwell on the different types of euthanasia and generally do not go beyond the distinction between active and passive euthanasia, condemning them both as murder [6]. Active euthanasia (also known as positive euthanasia) is an action that aims to cause or speed up the patient's death. Passive euthanasia (also known as negative euthanasia), on the other hand, consists in not using or ceasing to use medical treatment to cause or speed up the patient's death [7]. However, it needs to be highlighted that the definitions and distinctions between suicide, murder and euthanasia are often confused and/or vary depending on their authors [3]. The traditional Islamic position on euthanasia was confirmed during the First International Muslim Medical Conference in Kuwait in 1981 [8].

However, according to a rigid approach, the Muslim doctor should not intervene directly to voluntarily take the life of the patient, not even out of pity; he must see whether the patient is curable or not, not whether he must continue to live [3]. Similarly, he must not administer drugs that accelerate death, even after an explicit request by relatives; acceleration of this kind would correspond to murder. Koran 3.145 states: "*Nor can a soul die except by God's leave, the term being fixed as by writing*" [4]; Koran 3.156 continues "*It is God that gives Life and Death, and God sees well all that ye do*" [4], resulting that God has fixed the length of each life, but leaves room for human efforts to save it when some hope exists [3].

The patient's request for his life to be ended has in part been evaluated by juridical doctrine in some aspects. The four "*canonical*" Sunnite juridical schools were not unanimous in their pronouncements. For all, the request or permission to be killed does not make the action, which remains a murder, lawful; however, the disagreement concerns the possibility of applying punishments to those that cause death: the *Hanafites* are in favour; the *Hanbalites*, the *Shafi'ites* and the *Malikites* are partly in favour and partly contrary to penal sanctions.

Following the traditional approach, contemporary juridical-religious documentation asserts that the spread of euthanasia in the West is the result of rife materialism, the dissolution of the family accompanied by the absence of affection between relatives therefore the seriously and terminally ill patient risks being left to fend for himself [3].

In the case of the suspension of treatment aimed exclusively at delaying inevitable death by means of a decision of the patient himself or of the Doctors or relatives, this attitude does not seem contrary to the principles of the *Shari'a*. Artificially delaying an inevitable death by means of support therapies is contrary to the interest of the patient, hindering the natural process of dying.

This principle is clear in the fatwa issued by the *Fatwa* Department of the South African *Jamiatul Ulama*, which states as prohibited active euthanasia where patients can end their lives, for example, by means of a lethal injection; vice versa, passive euthanasia where patients may withhold treatment or artificial life-support is only permissible if a trustworthy, reliable opinion and specialist feels that there is no hope of survival.

In June 1995 the Muslim Medical Doctors Conference in Malaysia (Kuala Lumpur) reasserted that euthanasia goes against the principles of Islam; this is also valid in the military context, prohibiting a seriously wounded soldier from committing suicide or asking other soldiers to kill him out of pity or to avoid falling into enemy hands [3].

The Islamic Code for Medical and Health Ethics (IOMS, 2004) in art. 62 does not consider as euthanasia the termination of treatment "*when its continuation is . . . useless, and this includes artificial respirators* . . . "; similarly, giving drugs to reduce severe pain does not come within the scope of "*mercy killing*" even if this drug may accelerate the patient's death [3],

Muslim law does not prohibit the refusal of useless and disproportionate treatment following the consent of relatives. Ajatollah Muhammad Hussain Fadlallah and Ajatollah Makarem Shirazi express their opinion on this matter in such a way. The former says: "*Killing someone because of unbearable pain or because of lack of resources for treatment is unacceptable. However, if the patient is in a coma and, technically speaking, is dead and it is impossible to restore them to their normal condition, there is not a duty to sustain their life. This decision should be made by the patient's family or guardian after receiving the doctor's approval*". Ajatollah Makarem Shirazi, on the other hand, admits that: "*killing a man is forbidden, even if it is made out of pity and even if it is at patient's request. Discontinuation of treatment which results in death is also forbidden. However, it is impossible for a patient who has been unconscious for years to regain consciousness and in such a case it is allowed to stop keeping the patient alive*" [9].

Death would not be attributed to the termination of the "therapies" but to the inexorable progress of the disease. Therefore, any comprehension seems reserved for the so-called passive euthanasia which may not be considered a crime if not considered equivalent to suicide; according to some authors passive euthanasia contributes to protecting the dignity of the life and death of the suffering patient. Koran (2.45) recalls that men show different capacities of perseverance even in the face of suffering in life. It is therefore conceivable that in specific cases a person suffering beyond every limit may choose to die to defend his dignity as compelling him to live has no positive effect on society or on the individual.

The law in some Muslim countries explicitly states what has been said so far about euthanasia. On the other hand, the social debate is at times more articulated.

The Penal Code of Turkey describes euthanasia as a crime. Article 14 of the Regulations of 1998 of the Ministry of Health on Patients' Rights prohibits euthanasia and specifies: "It shall be prohibited to take life, by medical methods or in any other manner whatsoever". This is prohibited both on the request of the patient and of others. Passive euthanasia seems to be a widespread practice. It is easy to discharge from hospital a terminally ill patient who is not informed of his condition and without his consent; the prescription of fatal doses of anaesthetics seems common. A study of 1995-1996 on 524 Doctors operating in the Ankara area showed that more than half were in favour of some form of passive euthanasia. The majority of those in favour limited this consent to those patients who consciously ask for it; moreover, precise rules and protocols on the subject were requested. 38.9% were against passive euthanasia.

Article 552 of the Lebanese Penal Law of 1943 can punish by up to 10 years imprisonment those who, out of compassion, put an end to a person's life on the latter's request. Article 27 (10) of the Code of Ethics (1994) specifies that, if the patient suffers from an incurable disease, the doctor must limit himself to relieving psychophysical suffering with treatment compatible with keeping the patient alive. The doctor does not have the right to voluntarily cause death but, it is added, it is preferable not to use excessively technical methods which prolong the patient's agony. The doctor must treat the patient until his death but without violating his dignity. In fact, there are indications of Doctors who have performed forms of active or passive assisted suicide with or without the consent of relatives or the patient [3]. This seems to respond to a less rigid attitude of society to the problem of euthanasia, an attitude shown by the approach of 135 judges in Beirut to hypothetical cases concerning withdrawal or withholding of life-sustaining devices and physician-assisted suicide. Fifty- six per cent of the judges express a different opinion from art. 552 of the Penal law and are in favour of the doctor assisting the terminal patient if the latter asks for death. The younger judges and the lawyers training to become judges seem to be the most in favour.

However, there are numerous examples of unanimous opinion of doctors-opponents of euthanasia. These are: In Sudan, a study was carried out on the attitude to euthanasia and assisted suicide on 248 doctors in the two main hospitals of Khartoum, all the Doctors who graduated in Sudan were strongly against both solutions, especially for religious reasons (90%) or as actions contrary to their duties as a doctor (85%) and similar considerations.

Ministerial Resolution no. 288/17/L of Saudi Arabia of 23 January 1990 in art. 21, dealing with the patient's consent, states that under no circumstances must a doctor put an end to a terminally ill patient's life even if requested by the patient himself or by his relatives.

Law no. 17 of the Libyan *Jamahiriyya* of 3 November 1986 on the responsibility of the doctor maintains that no patient's life may be taken, not even on his request, for the reason of deformity, incurable or terminal disease or acute pain, even when the patient's life depends on artificial life-support equipment.

Islamic bioethics on dying and death

Islamic bioethics places emphasis to the need to ensure that the dying patient receives all the necessary religious services [3]. Relatives and closest friends should be at the patient's side [10]. It is important to adapt, if it is possible, the hospital room to the religious culture of terminally ill Muslim patients in a non-Muslim environment [3]. A quiet prayer is permissible, but one should avoid crying, sobbing and making noise [10]. The dying patient's head should be turned towards Mecca, modifying the position of the bed at whose side the family and close friends gather [3]. The terminally ill patient is exhorted to pronounce the *Shahada* or the "profession of faith" and, if this is impossible, he must be made to repeat it slowly. If this is also not possible, the invocation of the name of God is sufficient. An imam, although not obliged, may be present at the death of a Muslim and officiates at the burial, the prayer is whispered in the ear of the deceased. Shrouds for the deceased should not be elaborate. According to the *Shari'a*, infidels may touch the corpse only with gloves and it should be the family that washes and lays out the body. The deceased must be buried as soon as possible whilst cremation of the corpse is traditionally prohibited.

In the Koran and in the Sunna there is no specific definition of the end of life, which is left to scientific study, human experience and inevitably reflects the medical knowledge available at the historical period of the various authors. When asked by the Iranian Ministry of Health what the criterion of death is according to the *Shari'a*, the *ayatollah* Tabrizi replied that it is essential to refer to a specialist to decide whether the first or second criterion corresponds to the definition of death adding, however, that it consists of the separation of the soul from the body [3].

Conclusion

The stimulus and impact of contemporary Western models are above all the factors that lead to a reinterpretation of Muslim medical ethics with the Holy Texts, especially Quran, as regards the doctor-patient relation. The new position can be summarized as follows:

- Illness always concerns the whole person and includes all dimensions of patient's suffering, that is the physical, mental and spiritual dimensions.
- The patient must be treated by doctor with respect and compassion.
- The physician understands the duty to strive to heal, acknowledging God as the ultimate healer as well as the Lord of life and death.
- The patient should be the doctor's guide and *vice versa.*
- The doctor's role should not be limited to the treatment alone.
- The doctor should not only treat, but also prezent ilnesses.
- The doctor has the duty to inform patient – if it is possible – about their state of health and at the same time respect their autonomy, decisions and whishes.

The protective attitude of society and the family to the seriously ill or terminal patient is accompanied by the paternalistic role of the doctor. Nevertheless, the trend by Doctors to inform the patient of his state of health is gaining ground in Muslim countries.

References

1. Ally M. ibn: Islam. In: Problemy etyczne w tradycjach sześciu religii. Trans. D. Chabrajska. IW Pax, Warszawa 2007, 311-365.
2. Wańka A.: Główne zasady moralności muzułmańskiej. H.D., 2002, 262, 1, 48-57.
3. Atighetchi D.: Islamic Bioethics: Problems and Perspectives. Springer, New York, 2007.
4. Koran. Trans. J. Bielawski, Warszawa, 1986.
5. Skura-Madziała A.: Religie świata i ich stanowisko wobec eutanazji. An., 2009, 12, 2, 25-34, http://www.annalesonline.uni.lodz.pl/archiwum/2009/ 2009_02_skura_madziala_25_34.pdf [updated 2014 Feb 24]
6. Filiz Ş.: The Place of Bioethics Principles in Islamic Ethics. In.: Islam and Bioethics, Arda B., Rispler-Chaim V. (eds.), Ankara, 2012, 12-37, acikarsiv.ankara.edu.tr/browse/23911/Microsoft%20Word%2012 [updated 2013 Sept 13]
7. Chańska W.: Eutanazja – głos filozofa. Cz.A., 2008, 173, 5, 40-51, http://www.cza.pl /pdf/cza2008-06-07-s40-51.pdf [updated 2014 Feb 24]
8. Klöcker M., Tworuschka M., Tworuschki U.: Etyka wielkich religii. Trans. M. M. Dziekan, M. Mejor, Verbinum, Warszawa, 2002.
9. Eutanazja. Czy pacjent albo lekarz może decydować o eutanazji?, http://www.al-islam.org.pl/fat%C5%82y/medycyna/106-eutanazja [updated 2014 Feb 24]
10. Ciechanowicz J.: Etyka wielkich cywilizacji. Polish Guide Publishing, New York, 2010.

Zdziebło Kazimiera[1,3], Zboina Bożena[2,3], Strojewska Wioletta[2], Stępień Renata[1,3], Wiraszka Grażyna[1,3]

The attitudes of nurses towards people at the end of life

1. The Jan Kochanowski University in Kielce, Faculty of Health Sciences
2. University of Business and Enterprise in Ostrowiec Świętokrzyski
3. Polish Nurses Association – the Branch in Kielce

Introduction

Ability to communicate with a patient at the end of life is often blocked by the medical staff using generalities like: we'll manage somehow; it will be better. Undoubtedly, this is a form of consolation, but it does not replace with reliable information on the actual condition of a patient. Patient may receive such information as underestimating his or her problems, lack of subjectivity, and his or her problems are beyond the professional opportunities of nurses, who do not know, what is a real state of patient and do not know how to deal with patient and how to give professional help. Another mistake of proper communication is instructing patients how to live and act. Terminal stage is not a good time to change the patient's views. It is best to tolerate and accept them [1].

Both medical staff and patient confirm knowledge of impending death by their behaviour. The staff are generally better realized in what patient is still waiting on until the end of life. They know the more data that are not available to patient. When the relationship with a patient becomes more open, the role of a patient from treated into dying one has been changing. The main objective will be the acceptance of this condition by patient, calming him or her and reducing physical suffering. In the context of open awareness, the ill is not alone, and he or she can prepare for death [2].

Patients with unfavorable prognosis suffer more because of communication problems associated with the disease than from any other cause except pain. They attempt to communicate in different ways, using ordinary communication, nonverbally or verbal language of symbols. In the first case, patients formulate a message directly on a conscious level. In the case of non-verbal communication, they demonstrate needs and concerns by their behaviour, rather than asking for something directly. The third method is included in symbols. Patient uses the images or symbols and checks the willingness of nurses to listen [3].

Attitude towards any object (thing, event, idea, another person) is called a constant tendency to human being's positive or negative behaviour towards this object [4].

De Walden-Gałuszko distinguishes positive and negative attitudes, which most often prevail among medical personnel:

- Negative – attitude of antipathy, indifference, protectionism. It is characterized by negative behaviours and emotions, that is instrumental treatment of patient, ignoring his or her needs and opinions.
- Positive – this attitude is partner and religious. Positive meeting the needs of patient, respect for his or her rights. Staff respects his or her decisions and opinions on matters of health [5].

In the Independent Ethics by Kotarbinski, the main role is played by the ideal of a reliable guardian [6]. This is a person genuinely considerate and caring, at that time when he or she inspires confidence, does not retreat in danger and is a strong support. In all circumstances, you can always count on his or her help. The basic principle of such a guardian is the maxim: first of all, do no harm *(Primum non nocere)*. Such a guardian can be only a human being with a good heart, sensitive to the needs of others, willing to provide assistance, courageous, fair and kindly oriented toward his or her charges [6].

If the patient is in a terminal stage, the structure of the hierarchy of needs and values is reversed. The most important are the biological needs such as food, sleep and physical comfort. The main need is to eliminate discomfort. Another very important necessity is the need of self-worth, which is associated with showing respect and emphasizing the subjectivity of patient and his or her dignity. Social needs of patient are often manifested by self-centered attitude, awaiting acceptance, fondness and love from the environment. While the needs for beauty and justice are decreased. An exception are religious needs, which in the case of illness become meaningful. In human being's spiritual sphere there are cognitive-evaluative assessments, which express desire for intangible things (truth, goodness, beauty) and the need for contact with the Highest Value called the Absolute or God. No satisfying these needs mainly results in sense of guilt, lack of impact on own lives and a sense of meaninglessness [7].

The terminally ill wants to be treated as a partner, needs respect for own person, and does not desire showing mercy. Dying patient should feel that he or she is among devoted people. During the talks one should remember that words are not so important as gestures, symbols, attitudes and looks. Any attempts to satisfy the needs of patient, based on his or her behaviour, are a basic skill of showing psychological help. One needs a lot of effort to gain patient's confidence and become a trustworthy person for patient who will be willing to talk about such important matters as forthcoming death. Ability to listen, inner peace, kindness and maturity play a big role in this case [8].

The aim of the study.

The main aim of this research is to know the opinion on the attitudes of nurses towards people at the end of life, and the determinants of these attitudes. To achieve such defined purpose, the following specific issues were formulated:

1. What emotions and feelings are experienced by nurses when dealing with death?
2. What are the expectations of patients and their families towards people who take care of the sick?
3. What is the role of support to the dying and family?
4. Does the age of the respondents have an impact on the attitude towards death?

Materials and methods

The questionnaire survey was conducted among 117 nurses working in different wards in the Holy Spirit Specialistic Hospital (Szpital Specjalistyczny Ducha Świętego) in Sandomierz.

The diagnostic survey was used as a research method, the questionnaire was used as a research technique and the questionnaire of survey – as an author's research tool.

Questions in the questionnaire of survey were compiled so that respondents could choose responses and also have the possibility of adding their own.

Results

1. Characteristics of the study group

Most of the respondents were at the age of 40-50 years old, i.e. 58.26%. Seniority in the profession over 20 years had 55.56% of respondents. Among the study population, the largest group were people with secondary medical education, i.e. 41.88% (Table 1.)

Table 1. Characteristics of the study group

Age	%	n	The seniority	%	n	Level of education	%	n
20-30	4,35%	5	5 lat	5,13%	6	Secondary medical	41,88%	49
30-40	22,61%	26	10 lat	12,82%	15	Bachelor	37,61%	44
40-50	58,26%	69	15 lat	26,50%	31	Master's degree in nursing	8,55%	10
More than 50	14,78%	17	More than 20	55,56%	65	Master's degree in different discipline	5,98%	14
Total	100.00%	117	Total	100.00%	117	Total	100.00%	117

2. Emotions and feelings experienced by nurses when dealing with death

When asked about the emotions when dealing with death, greatest number of respondents because as many as 58 persons, i.e. 16.52% of the responses were related to sadness and depression when dealing with death. 56 respondents, i.e. 15.95%, responses concerned the possibility of additional time off work to be able to relieve the stress associated with the death of patient (Table 2)

Table 2. Emotions experienced by nurses when dealing with death

Emotions experienced when dealing with death	Number of responses*	%
I am sad and depressed	58	16,52%
I do not want to continue to work	32	9,12%
I would like to have an extra break to be able to release	56	15,95%
Without negative emotions I do the following activities	30	8,55%
I have a depressed mood and transfer it outside work	30	9,69%
I admit failure	34	7,41%
I feel relieved	26	15,53%
I feel calm and belief in life after death	51	14,53%
I believe that I am a witness to the mystery	34	9,69%

* the surveyed nurses had possibility to choose more than one response

The nurses, participating in the research, indicated that dying patient is a suffering human being that requires assistance and greater commitment on their part. Such responses were overwhelming majority – 94 nurses, which represented 40.17% (Table 3).

Table 3. The perception of the dying person by nurses

The perception of the dying person by nurses	N*	%
The suffering person in need of assistance	94	40,17%
The subject of my actions	72	30,77%
I treat all patients equally	31	13,68%
I can not devote my time to only one patient	32	13,68%
Others	5	2,14%

*respondents could give two responses or add other own

For the examined persons, the contact with dying people, is a severe emotional experience. It causes that we take various views of the problem of dying and often think of the end of life. When asked about the feelings associated with death, greatest number of persons – 54 i.e. 46.15%. respondents answered that death is a natural part of life. 50 nurses, ie 42.74% of the respondents answered that they often think about their own death and appreciate every day of life (Fig. 1).

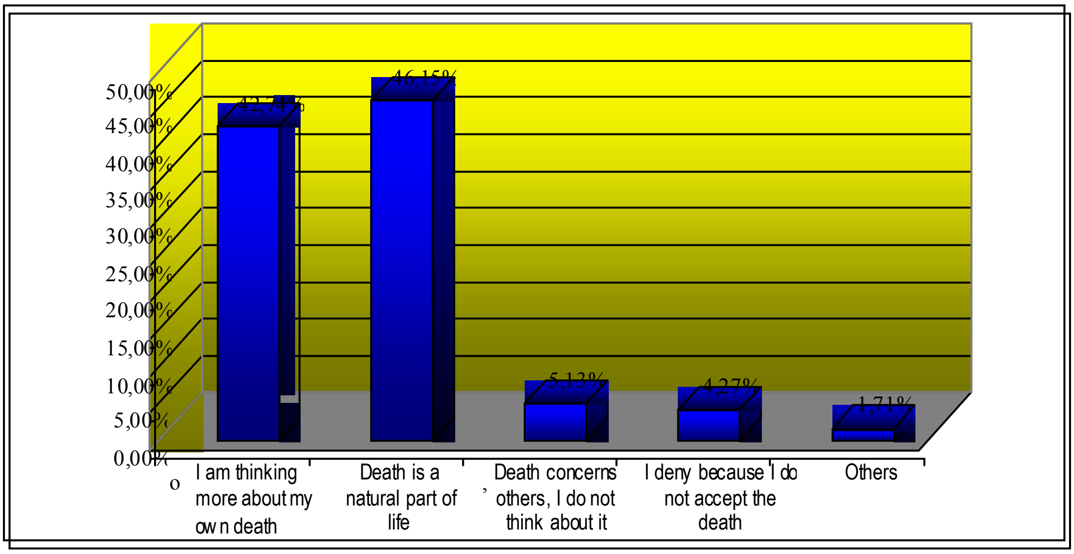


Fig. 1. Nurses' feelings associated with death

3. Expectations of patients and their families towards nurses caring for the terminally ill.

The vast majority – 90 persons, i.e. 25.64% of the responses indicated that the most desirable character trait is patience with people in terminal stage (Table 4).

Table 4. Character traits of persons caring for the terminally ill

Character traits of persons caring for the terminally ill	N*	%
Empathy	45	12,82%
Holism	12	3,42%
Patience	90	25,64%
Altruism	8	2,28%
Forbearance	60	17,09%
Kindness	70	19,94%
Communication skills	37	10,54%
Sympathy	28	7,98%
Others	1	0,28%

* the respondents had possibility to choose more than one response

Patient in terminal stage mainly expects respect for personal dignity from nurses, as reported 79 respondents i.e. 33.76% answers. Another important element, pointed out by investigated nurses is to provide peace and quiet for patient, such answered 65 respondents i.e. 27.78% of the responses. (Table 5).

Table 5. Expectations of the dying patient and family in the mental area

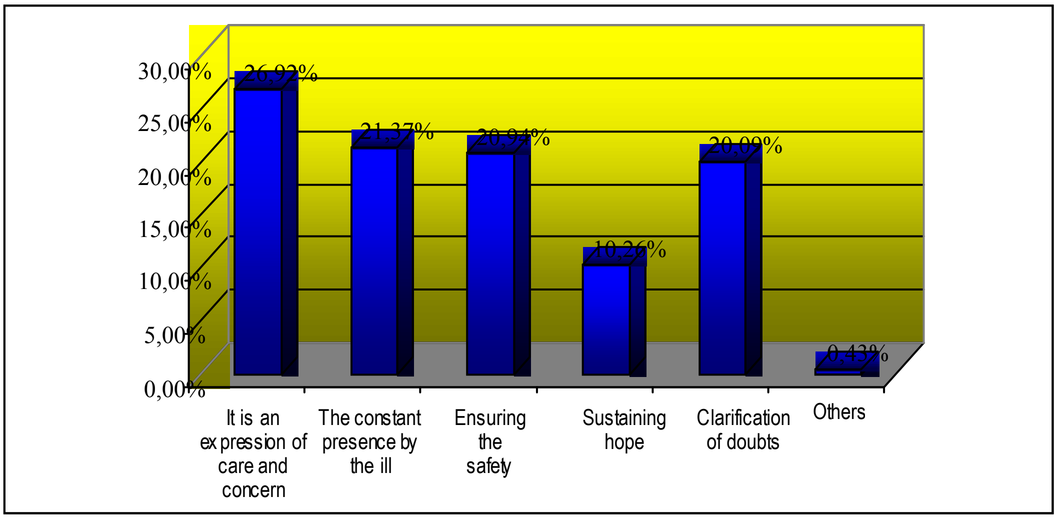
Expectations of the dying patient and family in the mental area	N*	%
Providing peace and quiet	65	27,78%
Ensuring intimacy	30	12,82%
Respecting for personal dignity	79	33,76%
Subjective treatment	29	12,39%
Constant presence of nurse	31	13,25%
Others	0	0,00%

* the respondents had possibility to choose two responses

Expectations connected with support for the terminally ill and to the patient's family, before all, express the care and concern, what admitted 63 persons i.e. 26.92% of the responses. On a constant presence near the sick person, indicated 50 respondents, i.e. 21.37% of the answers.

4. The role of support for the dying and the family.

Expectations, concerning support for the terminally ill and to the patient's family, above all, mean the expression of care and concern, as said 63 persons ie 26.92% of the respondents. 50 respondents, i.e. 21.37% of the answers, indicated the constant presence of nurse near the sick person. For 47 respondents, i.e. 20.09% of the responses, it is important to ensure safety and to clarify the doubts regarding the disease and the current state of the patient's health. The least of nurses pointed out that the family and the patient expect support of hope from them. This answer was given by 24 surveyed nurses i.e. 10.26% of all responses (Fig. 2).



* the respondents had possibility to choose two responses

Fig. 2. The role and kind of support for the terminally ill and family by nurse

Almost half of the 58 nurses, i.e. 49.57%. respondents stated that they understood patients, because they were once in a similar situation. One should show compassion to patient and his or her family, this is professional approach, as considered 51, i.e. 43.59% of the surveyed nurses. Showing compassion is very difficult only for 5 persons, i.e. 4.27% of the respondents (Fig. 3).

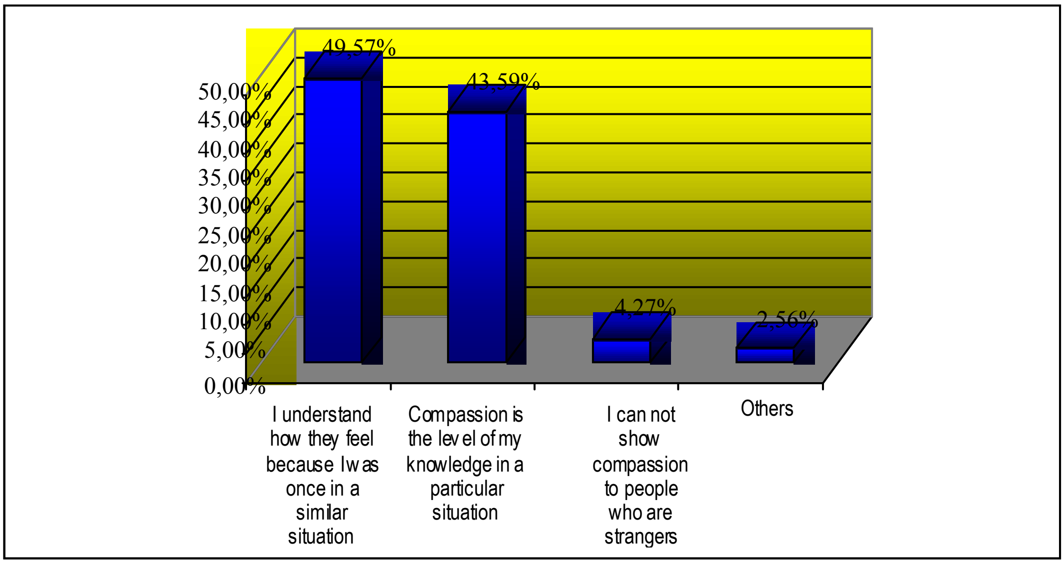


Fig. 3. Showing compassion to patient and family

Faith helps explain the dilemma that the death is not the end of everything, what was said by 48 nurses i.e. 41.03% of the respondents (Fig. 4).

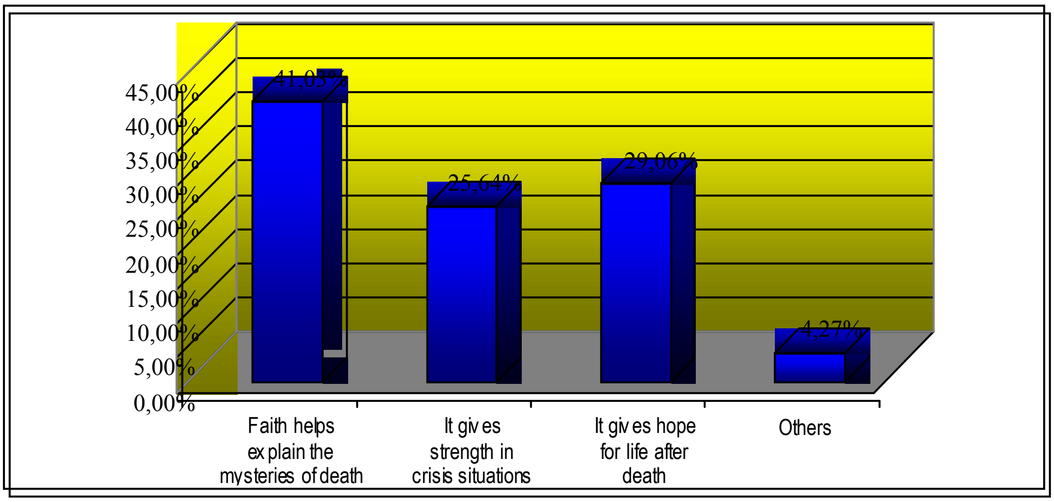


Fig. 4. The attitude towards death and professed faith

Age has a significant impact on the perception of death and attitudes of the surveyed nurses towards people at the end of life (Table 6).

Table 6. Determining the correlations between selected variables

Excitements when dealing with death	Age	df=8	Correlation found
Character traits of persons caring for the terminally ill	Age	df=8	Correlation found
Preparing nurses to accompany the patient at death	Age	df=4	Correlation found
The most common problems in the care of the terminally ill	Age	df=6	Correlation found
The role and kind of support for the terminally ill and family by nurse	Age	df=5	Correlation found
The perception of the dying person by nurses	Age	df=4	Correlation found
Assessment of the care level provided by nurses to terminally ill patients	Age	df=5	Correlation found

Discussion

The results of the research related to the attitudes represented by the nurses in contact with a human being at the end of life allow to draw conclusions, that there are different types of behaviour: a strong fear in contact with dying person and his or her family (in response to questions, looks, request of the patient); avoiding contact with the dying and his or her family and avoiding talks about death by medical personnel; denial, which is manifested by a lack of acceptance of own death, the struggle for life until the end, regardless of the incurred costs (denial of the negative feelings of patient and only giving information building hope); the mature acceptance of death as a natural phenomenon that must be taken into account and with whom one have to fight as long as possible, but at some point you have to also accept it if it is approaching inevitably [9].

The research, conducted on self-esteem of nurses towards death, show that during contact with the dying persons, the respondents mostly felt sadness and helplessness. They did not avoid contact with the dying, they did not feel fear. They manifested an attitude of denial associated with a complete lack of acceptance of death and the absolute struggle for life to the end. They maturely accepted death as a natural phenomenon that must be taken into account and with whom you have to fight as long as possible, but it also must be accepted, if it is inevitably approaching [10].

Another aim of the study was to investigate the types of attitudes related to the emotions experienced by the nurse in contact with the death of patients. Three types of attitudes were selected: 1) emotional type – persons highly experienced the death of patients, negative emotions of high intensity accompanied them and these emotions influenced the life and work; 2) distanced type – the tested presented indifferent attitude to death, arguing it longtime work experience, and they considered that the experience of negative emotions associated with death is an unprofessional behaviour; 3) neutral type – persons felt the negative emotions associated with the death of the patient but they controlled them and did not relocate them to private life. In this type, religion played a significant role, because it could be a kind of defense mechanism in discharging negative emotions [11].

Conclusions

The conducted research allowed to formulate the following conclusions:

1. Frequent contact of nurses with dying patients and their families makes them vulnerable to experiencing stress and destructive influence of negative emotions; they usually feel regret, sadness, depression, guilt, bitterness and despair.
2. The most desirable characteristics of nurses who care for the terminally ill are: expressing patience towards patient, his or her family, forbearance, kindness and empathy.
3. During the terminal stage, the patient feels many somatic disorders associated with dying. He or she mainly expects relief in pain, the abolition of breathlessness and from the staff he or she expects take care of the hygiene of the body as well as the need for change of position. In the mental sphere, above all, the patient expects respect for personal dignity, peace, quiet, intimacy, subjective treatment, and the constant presence of nurse.
4. Age has a significant impact on the perception of death and attitudes of the surveyed nurses towards people at the end of life.

References

1. Bańkowska-Polak D.: Relacje między lekarzem a pacjentem w stanie terminalnym. Nowa Medycyna, 2007, 1, 6-7.
2. Ostrowska A.: Śmierć i umieranie. Oficyna Wydawnicza Aknapress, Warszawa, 1991.
3. Keirse M.: Psychologiczne aspekty opieki paliatywnej. Polskie Wyd. Encyklopedyczne, Radom, 2007.
4. Wojcieszke B.: Postawy i ich znaczenie. Gdańskie Wyd. Psychologiczne, Gdańsk, 2005.

5. de Walden-Gałuszko K.: U kresu. Opieka psychopaliatywna, czyli jak pomóc choremu, rodzinie i personelowi środkami psychologicznymi. MAKmed, Gdańsk, 2000.
6. Kotarbiński T.: Medytacje o życiu godziwym. Wiedza Powszechna, Warszawa, 1986.
7. de Walden-Gałuszko K, Kaptacz A.: Pielęgniarstwo w opiece Paliatywnej i Hospicyjnej. PZWL, Warszawa, 2005.
8. Krakowiak P.: Hospicjum to też Życie. Biblioteka Fundacji Hospicyjnej, Gdańsk, 2008.
9. Muraczyńska B.: Problemy zawodowe pielęgniarek w opiece paliatywnej – wybrane zagadnienia. Ann UMCS Sect. I, 2001, 26, 202-206.
10. Krajewska-Kułak E., Mickiewicz J., Łukaszek C., Van Damme-Ostapowicz K., Bielmuk A., Rozwadowska E.: Samoocena postaw pielęgniarek wobec śmierci. Pielęg. XXI w., 2010, 1-2 , 43-49.
11. Dębska G, Merklinger-Soma M, Cepuch G.: Emocje jako element postawy towarzyszący pielęgniarce w kontakcie z pacjentem umierającym. Pielęg. XXI w., 2010, 1-2, 65-70.

HEALTH EDUCATION

The history of window of life idea - a place for leaving secretly an unwanted baby to protect his/her life and to provide him/her deserving conditions for the development

Bajek Anna[1], Marcinkowski Jerzy T.[2], Galewska Irena[1]

1. Ludwik Perzyna Regional Hospital in Kalisz
2. Department of Hygiene, Chair of Social Sciences, Poznan University of Medical Sciences in Poznan

The media very often inform about leaving babies in a rubbish container, staircases or in the forest. There are many reasons for such decisions, e.g. a lonely parenthood, difficult financial situation, homelessness, child disability, the lack of support for under-aged parents, life helplessness but the question is whether such decision approves of human’s dignity?

The right to live of each human being is the most important right. The windows of life were created to draw attention to the problem of abandoned children. In the windows of life a baby can be left safely without putting him/her in the jeopardy of death or other dangers. In a very short time it is taken under care of professional help and love of new parents.

What is the ‘window of life’?

The window of life is a specially prepared place that allows those mothers who cannot or do not want to take care of a newborn baby to leave it safely and anonymously inside it [1].

Are windows of life an invention of modern times?

The windows of life are not new, they have existed before, though in a different form. The idea of taking care of so called ‘foundling’ was applied in Medieval Ages. It was initiated by a French - blessed Gwidon from Montpellier. He was born in 1140 in France. He came from a rich ducal family of the Guillems. He was the youngest son of ten children of Guillem VI and Matilda - the countess from Burgundy. He sold all the properties he inherited from his parents and he spent this money to buy a hospital in the suburbs of Montpellier in 1175 in which he provided shelters for abandoned children, pregnant women, ill and poor people where he took care of them himself. His activity he devoted to the Holy Spirit and the Holy Trinity. He took a double cross with branches and a dove as a coat of arms for his community. The Pope Innocent III in Breve: *His praecipue* from 22 April 1198 approved the new community as Ordo. The pope wanted for the act of compassion to flow from Rome and that is why he built the hospital dedicated to the Holy Spirit and bulla Inter opera pietatis from 19 June 1204 in Saxia by the river Tybrus and he gave it to Gwidon and his brothers under their care. This hospital became the main house of the order and Gwidon became the supervisor of 'holy ghosts'. He died in Rome in 1208 [2].

In the hospital of Holy Spirit there was the first window of life created which was then known as 'the circle' (fig. 1). In the wall of the hospital there was a wooden drum layed-in that resembled a barrel. The person who carried the baby was able to put him/her inside and then to turn it this way signaling by a special ring to a person who was on night duty. The baby after being taken out from the drum then undertook some registration procedures which meant cutting a small double cross on his/her foot with a lance. It was the symbol of the order and the Holy Spirit Hospital. These procedures had two meanings as they emphasized belonging to hospital community and also they prevented such abuse as child trade or using them for earning money. After the registration procedures the child was carried to another cycle and it was given to a wet- nurse, who was taking care of the baby : washing, dressing up and feeding and then putting into a cradle with a holy name on it. There were also musicians employed to play the pipes in children's rooms so that they did not cry. Each abandoned baby was recorded in so called 'Wet-nurses' book' and in the other book, confident, not available to the hospital staff, so called 'Secret Book' in which there were some details concerning the baby's appearance or the things left with him/her. If there was not a birth certificate along with the baby, he/she was taken to hospital church after the registration procedures and it was baptized there. The children left in this window of life got to families, today referred as foster families. These families were supervised by the brothers of Holy Spirit Order, called 'holy ghosts'. These children at the age of 10-12 came back to hospital school to 'obtain due to hospital effort their own place in the society after a few years' [3].

'Socialization of the foster children was done inside the hospital by inculcating moral and religious code creating the sense of community. It was also of great economic and social significance that the children worked in the hospital [3].

Those children who did not get to foster families or who were not under adoption, stayed to grow up in hospital. After becoming adults, the children took jobs as the staff and the girls were getting married [3,4].

It is an interesting fact that at those times in Rome there had been meetings organized a few times a year in which girls from the Hospital of the Holy Spirit took part. The girls who wanted to get married wore blue dresses and those who wanted to become nuns were dressed in white. From the surroundings of London young men were coming who could find their chosen heart love. If this choice was taken together with their parents, they had to go to special matrimonial department in the hospital. After checking the reliability, the young men was sent to the girl with a bouquet of roses. She also had the possibility to choose, she could accept him or not. Once a year, around the time of the Pentecost there were wedding ceremonies held. Rich citizens of Rome donated some dowry to the girls. The Holy See assigned special privileges for the abandoned children in Holy Spirit Hospital. It was gaining automatically the citizenship rights.

The scale of this phenomenon is confirmed by the number of 100 thousand 'foundlings' who were registered in the Hospital of Holy Spirit in 17th- 18th centuries [3].

Fig. 1. The first window of life in Rome [Source: http://pl.wikipedia.org/ wiki/Okno_%C5%BCycia]

The windows of life are also applied in Germany, Czech Republic, Lithuania, Slovakia, Russia, Switzerland and Belgium [5].

In Poland there were also the Hospitals of Holy Spirit founded. The first one was established in Cracow, then in Sandomierz, Kalisz, Stawiszyn, Sławków, Wisznica near Kłodawa [4].

Windows of life in Poland

In Poland windows of life has been established since recent time. The first window was created on 19th March 2006 in Cracow in Nazareth nuns in Przybyszewskiego street 39. It was honoured with John Paul II coat of arms and Caritas logo [1]. At present in different Polish cities there are 51 windows of life (fig. 2).

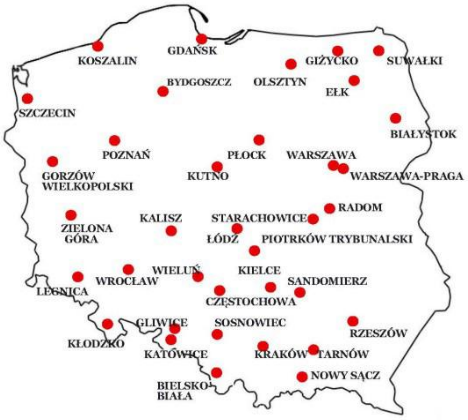


Fig. 2. Windows of life in Poland [6]. [Source: http://www.caritas.pl/caritas-w-diecezjach/4-okna-zycia]

Window of life in Kalisz

The window of life in Kalisz was opened on the celebration of Saint Joseph’s Day on 19th March 2009. It is located in Nazareth Nunnery, and more precisely in the kindergarten building that is run by the Nazareth nuns in Harcerska Street number 1. There were Kalisz government and the representatives of many institutions present at the celebration such as: Caritas of Kalisz diocese, a representative of Children’s Hospital Department and the adoption centre. In Kalisz window of life there have been two babies saved so far.

What happens to a baby left in the window of life?

When the baby is left in the window, the alarm starts ringing. The nuns take care of the baby and they inform the hospital about this fact. The baby is transported to hospital. There he/she is being examined or treated if necessary. Then the hospital informs the court, which gives the decision for this baby to be given under care of a foster family or care centre. Meanwhile there are also run the procedures connected with issuing the birth certificate and giving identity to this baby. Afterwards the adoption procedure starts. The adoption centre applies to the court for pre-adoption. It usually happens that the court decision is made very quickly and the baby is placed in the family, waiting for the adoption decision [7].

Conclusion

Windows of life do not encourage abandoning children but they are a message that if for any reasons mother is not able to take care and bring up her baby, there is an alternative for them. If there were not for such places, then those 50 saved children in Poland would not have had the chance for development. The window of life is above all the chance to save baby’s life so that he/she could be alive, to let him/her grow up. Even if he/she discovers the truth about his/her life he/she will try to justify his/her mother’ act as being caused by love and caring for her child’s future which she was not able to provide for her baby. The windows of life should be used in necessary situations, not serving as an escape from responsibility.

References

1. Drozd I. Idea duchacka w ratowaniu życia dzieci [The idea of the Order of the Holy Spirit in saving children's lives] http://www.kanoniczki.pl/index.php/home/historia-zgromadzenia/40-historia-zgromadzenia/w-historycznym-zarysie/21-idea-duchacka-w- ratowaniu-zycia-dzieci [cited 09 April 2014].
2. Surdacki M. Il brefotrofio dell'ospedale di Santo Spirito in Roma nel XVIII secolo. Varsavia : Accademia polacca delle scienze, Biblioteca e centro di studi a Roma, 2002. http://www.worldcat.org/title/brefotrofio-dellospedale-di-santo-spirito-in-roma-nel-xviii-secolo/oclc/606080119 [cited 09 April 2014].
3. Surdacki M. Dzieci porzucone w Szpitalu Świętego Ducha w Rzymie w XVIII wieku [Children abandoned at the Hospital of the Holy Spirit in Rome in the eighteenth century]. Towarzystwo Naukowe KUL, 1998.
4. Popielewicz M. Gwidonowe Wspólnoty [The Community of the Society of the Holy Ghost]. Nasz Dziennik 12/2010; www.gwidon.pl/gwidonowewspolnoty?start=1 [cited 09 April 2014].
5. Okna życia [The windows of life]. Caritas http://www.caritas.pl/aktualnosci/wiadomosci-z-diecezji/5/4-oknazycia [cited 09 April 2014].
6. Magdalena Środa twierdzi, że uratowanie 100 dzieci w „oknach życia” nie ma znaczenia. „Czyli co, pani profesor? Jednak beczka?” [Magdalena Środa claims that the rescue of 100 children in the "windows of life" does not matter. "What's that, Professor? But the barrel?"] http://wpolityce.pl/dzienniki/dziennik -marzeny-nykiel/41773-magdalena-sroda-twierdzi-ze-uratowanie-100-dzieci-w-oknach-zycia-nie-ma-znaczenia-czyli-co-pani-profesor-jednak-beczka [cited 09 April 2014].

7. Okno życia w Kaliszu [The window of life in Kalisz] http://www.kalisz.caritas.pl/_STARE/artykul,10 [cited 09 April 2014].

Bajek Anna[1], Marcinkowski Jerzy T.[2], Trzmiel Jolanta[3], Nowak Anna[3], Kaczmarek Agata [3]

The window of life in Kalisz – Nazareth nun's story about serving for unwanted babies

1. Ludwik Perzyna Regional Hospital in Kalisz
2. Department of Hygiene, Chair of Social Sciences, Poznan University of Medical Sciences
3. Vocational Schools in Kalisz

Nowadays there is much publicity given to organizing animal's life condition applying to animal dignity, there are regulations made in this matter. The institutions responsible for applying these regulations are monitoring the way they are introduced. There is a paradox however, that unfortunately not always human poverty, difficulties and problems of the families are not noticed until a tragedy takes place, then the problem is given much media coverage, though it is usually too late.

The mass media inform from time to time about human's life as not being fully protected or that there has been a tragedy. There are various reasons for such behavior. It should be remembered that to every difficult situation there is a possible solution, a way out. The children whose parents are not able to provide care for, must be given a chance to live. The windows of life are such a chance to survive.

The authors of the article has interviewed sister Gabriela from Nazareth Nunnery in Kalisz who takes care of the window of life. She presented the way that the window works and the chance it gives which should not be taken away.

God bless you, sister!

God bless you. I'm pleased to meet you, too.

At your nunnery and assembly there was the window of life created. Today we want to talk about it with you.

All right.

Could you tell us why you entered the nunnery and how your calling had started?

The God called me and how it happened remains the God's mystery. I was thinking about entering the nunnery before, though my life used to be the same as every ordinary girl.

How many years have you been in the nunnery?

I have been there for 28 years.

What name have you chosen?

My nun's name is sister Gabriela.

Why did you choose this particular nunnery?

I was delighted that here in this assembly everything is done for the family, that you move all that is beautiful in people's family, the God's family into nunnery grounds and our family, that we form one, common nuns' family.

Who decided on that and when the decision was accepted that at your nunnery was created and opened the window of life.

Our window of life was not one of the first windows. In Poland it was just another window of life. It was not my decision. I provided the place in the kindergarten to create the window of life. The idea and the decision belongs to sister Iwona and priest Ryszard Krakovski from Caritas House. It is worth mentioning here that the windows of life are mainly created under the patronage of Caritas.

What 'the window of life' means, what this place is and what function it serves?

The window of life is the specially prepared place enabling those mothers who due to various life situations cannot take care of their new born babies. This is an anonymous place. The baby can be left there being aware that he/she will be safe and that it will be given to adoption.

What did the preparation of the window look like?

To start the window of life it was necessary to find a proper place first of all, so that it could be accessed from the street, then it was needed to buy the equipment, install an alarm which informs that the window has been opened, that a baby appeared in it.

I know that along the opening of the window there was the celebration held to consecrate it. Do you remember that day?

This event was held a few years ago, it is hard to remember all the details because different situations had already taken place. However, it was a solemn celebration in Kalisz diocese. The opening of the window was performed in a celebrated way by the priest bishop Stanisław Napierała. There were many guests that took part in this celebration, above all the president of Kalisz – Janusz Pęcherz, Radio Family, Kalisz media and Kalisz citizens. I was taking part in it as a guest not the person who organized this opening.

From the facts that appeared in the mass media I got to know that there were two children left in the window. Do you remember those days?

It does not happen frequently but I often recall those days.

What is your view on parent's decision to bring their baby to the window of life?

I do not make my views on parents. It is difficult to estimate the situation in which we do not take part. It is definitely a difficult situation to leave your baby. I do not blame this decision. Thank God those children were saved.

Were the local media interested in those events?

Obviously, they were. Each time the baby had been left, the media appeared asking about child's personal details. We mustn't give any information about the baby's details.

What message would you like to give to young people, to mothers and fathers?

Be good people. Be the good ones. It seems to me that it is the best message. If we look at the Holy Family and we would see them as a model, then we would make such a family ourselves, too. We would feel safe, a wife, a husband and he children who will appear in the family.

What can we make for the window of life?

It is a difficult question. The window of life is just a place, it exists, there is nothing to be done there. It is necessary to shape your life to make it a good life, to use it in a good way, so as not to be ashamed of what I did in my life.

Can we ask you to explain the way it works in practice?

The window of life works in a way that from the outside it can be opened. The opening itself starts an alarm signal which some people have in their phones. My telephone rings as well and I am obliged to enter the place to see what is going on there, if there is anybody who looked into there just because he/she was curious or if something more important happened. There have been many openings, but mainly it happens due to people's curiosity,

At the end of our conversation I would like to ask you for the common prayer for our families, mothers, fathers, young people…

I will say the prayer that we, Nazareth nuns pray every day for all the families in the world, for our families, for yours: The Holiest Family, bless and guard all the families in the world. Preserve them connected by unbreakable knot of love, faithful to their duties an calling. Make them live according to the God's rules and commandments, so that their life was the reflection of Your life on the Earth and let them enjoy your happiness in heaven. Amen.

Thank you, sister. This meeting convinced us about the gift of human life and that it should be protected since the conception until natural death. The windows of life are located in different parts of Poland, there are 50 of them. Until December 2012 fifty babies have been saved thanks to these windows of life. We approve of the need to create such life

windows not only in Poland but in the world as well. God bless you sister on your further life and service in Kalisz window of life.

Oleszczuk Tadeusz[1]**, Słowińska Joanna**[2]

The most common complications of blood transfusion and its risk factors based on cases of adverse reactions to transfusion reported to the Regional Blood Center in Warsaw in 2011

1. The State Higher School of Computer Science & Business Administration in Łomża
2. Regional Blood Center in Warsaw

Introduction

Blood transfusion and blood components have been associated with certain adverse side effects. Blood is one of the most powerful remedies available to twenty-first century medicine. Determining of identified complication risk groups which can arise during or after this procedure is extremenly important. Different side effects can arise depending on the type blood component being administered. The sooner they will be observed the faster appropriate treatment can be started.

Any transfusion procedure has appropriate rules for the preparation and administration of blood or its components [1].

People of all ages require treatment with blood or its components. Especially heavy bleeding occurs after accident associated trauma. These kinds of the blood loss and coagulation disorders are most dangerous. Depending on test results whole blood , plasma, fibrinogen, or blood clotting factors are used [2,3,4].

Blood donation in Poland is voluntary and noncompensatory.

Despite the highest standards blood transfusion carries a risk of adverse reactions ranging from mild and febrile, to heavy, and life threatening (such as acute hemolytic reaction) [5,6].

Nowadays proper verification of risk factors for adverse reactions allows to reduce the risk of complications [7].

Before starting the transfusion it is necessary to determine the benefits and risks associated with administering of blood or its components. They can activate a dangerous and irreversible mechanism of immunization in the body of the recipient.

If during or after the transfusion symptoms appear, which may indicate the occurrence of adverse reaction associated with it, applicable procedures should be followed. Information about the occurrence of adverse reaction should be put into the patient records and adverse reaction reporting form which should be sent to the Regional Blood Center in Warsaw.

Complications are a group of adverse reactions to transfusion of blood and blood components. They generally occur during transfusion or shortly thereafter. Some of them are chronic and can occur after months or years following the procedure [8,9].

Materials and methods

The groundwork consists of data obtained from the forms of blood transfusion complications which were collected in 2011 by the Regional Blood Center in Warsaw. The data involved adverse reactions after the transfusion of blood or its components in hospitals which treated patients with indications for treatment with blood or its components.

Data were collected in the period from 01.01.2011 to 31.12.2011.There were 174,021 transfusions of blood components in year 2011 in Masovian Voivodeship. Overall in 2011, - 320 adverse reactions after treatment with blood or its preparations were reported. During the initial analysis of the data three cases were discarded on the basis of incomplete description. Ultimately 317 procedure related complications were qualified for testing.

In the collection and processing of data following documentation was used:

- Form (Application for complications after transfusion) filled in by the physician supervising transfusion in health care units, which held patients with indications for treatment with blood and its components,
- Form filled in by the staff of Regional Blood Center in Warsaw, which based on the results of immunological evaluation analyzes the relationship between the an adverse reaction and the transfusion of blood or blood component

Taking into account the age of people who during or immediately after blood transfusion or its components had a various severity of transfusion-related complications, suggests that patients of age 47 and older account for the most cases in the study (Table 1).

Table 1. Reported adverse reactions taking into account the age of the recipients

Specification	Frequency	Percent	Percentage important	Cumulative percent
1920-1942	112	35,3	35,3	35,3
1943-1965	107	33,8	33,8	69,1
1966-1988	58	18,3	18,3	87,4
1989-2011	40	12,6	12,6	100,0
Total	317	100,0	100,0	

A similar proportion of patients were born in the periods between 1920 - 1942 (35.3%) and 1943-1965 (33.8%). The smallest, and the youngest group (40 recipients) are people born between 1989 to 2011, (12.6%). The collected data suggests that the need for blood transfusion is clearly dependent on the age of the patient.

Turning to the assessment of the changes observed in the measurement of the body temperature of patients during transfusion or immediately after its completion, it should be noted that in six cases out of 317 analyzed there was an absence of information on the subject in the patients form of transfusion related complications. As the results suggest more than 61% of patients did not show any change of the body temperature. In 37.0% of patients the temperature increased. Only 6 patients reported a decrease of temperature.

In comparison to the results presented above reactions associated with an increase or decrease in blood pressure in the recipients were formed differently (Table 2). A similar proportion of recipients (37.9%) showed an increase in blood pressure. Its decrease was observed in 43 cases (13.8%). No changes were reported in almost half of patients (48.2%).

Table 2. The patient's blood pressure after the transfusion of blood components with respect to the baseline before the transfusion

Specification	**Frequency**	**Percent**	**Percentage important**	**Cumulative percent**
No change	150	47,3	48,2	48,2
Fall	43	13,6	13,8	62,1
Height	118	37,2	37,9	100,0
Total	311	98,1	100,0	
No data	6	1,9		
Total	317	100,0		

Another of the analyzed parameters was the change of heart rate. The structure of the study group in this respect is formed similarly as in the previous two cases. After the transfusion of blood or blood component increase in the heart rate was recorded in 37.3% of cases, (116 people), and its decline in 26 patients (8.4%). More than 54% of the study population showed no changes in the values of the analyzed factor in relation to the data prior to transfusion.

As indicated by the data collected on transfusion recipients, adverse events reported after transfusion of blood or its components are dominated by shivers 46.9% of cases, and feelings of anxiety - 44.7% . Subsequently, 81 patients (26,9%) complained on shortness of breath and in 76 recipients (24.4%) body rashes were observed (Table 3). One in five patients (20.6%) pointed out the redness around the injection site, and the similar rate (19.3%) reported the occurrence of itching.

Table 3. symptoms reported by patients during the blood component transfusion or after

Those indicated	Yes	No	Total		
	Frequency	% important	Frequency	% important	
Chills	146	46,9	165	53,1	100,0
Anxiety	139	44,7	172	55,3	100,0
Dyspnea	81	26,0	230	74,0	100,0
Rash	76	24,4	235	75,6	100,0
Redness	64	20,6	247	79,4	100,0
Itching	60	19,3	251	80,7	100,0
Nausea and vomiting	27	8,7	284	91,3	100,0
Chest pain	19	6,1	292	93,9	100,0
Shock	11	3,5	300	96,5	100,0
Abdominal pain	10	3,2	301	96,8	100,0
Loss of consciousness	9	2,9	302	97,1	100,0
Feeling hot	7	2,3	304	97,7	100,0
Urticaria	5	1,6	306	98,4	100,0
Swelling of the lips and nose	5	1,6	306	98,4	100,0
Pain in the lumbar area	5	1,6	306	98,4	100,0
Headache	4	1,3	307	98,7	100,0
Pain vein shunting	4	1,3	307	98,7	100,0
Acute respiratory failure	3	1,0	308	99,0	100,0
Feeling cold	3	1,0	308	99,0	100,0
Scotoma	3	1,0	308	99,0	100,0
Shaking hands	2	0,6	309	99,4	100,0
Respiratory arrest	2	0,6	309	99,4	100,0
Cough	2	0,6	309	99,4	100,0
Jaundice	2	0,6	309	99,4	100,0
Seizure	1	0,3	310	99,7	100,0
Red spots on the body	1	0,3	310	99,7	100,0
The increase in bilirubin	1	0,3	310	99,7	100,0
Skin marbled	1	0,3	310	99,7	100,0
Pain in the thighs	1	0,3	310	99,7	100,0
Peripheral cyanosis	1	0,3	310	99,7	100,0
Sore throat	1	0,3	310	99,7	100,0
Renat failure	1	0,3	310	99,7	100,0
Orthostatic	1	0,3	310	99,7	100,0
Weakness	1	0,3	310	99,7	100,0
Visual disturbances	1	0,3	310	99,7	100,0
Tinnitus	1	0,3	310	99,7	100,0
Itching right eye soced	1	0,3	310	99,7	100,0
Convulsions	1	0,3	310	99,7	100,0
Tingling tonque	1	0,3	310	99,7	100,0

Taking into account the changes in the vital signs of patients in relation the type of blood component transfused it should be noted that the highest percentage of recipients who have not showed changes in the body temperature (78.4%) was observed in patients who received platelet concentrate (PLTC) and fresh frozen plasma (FFP) (Table 4).

Table 4. The body temperature of the patient in relation to the type of blood component transfused

Description	RBCC	PLTC	FFP			
	Frequensy	**Percent**	**Frequency**	**Percent**	**Frequency**	**percent**
No change	127	53,8	40	78,4	23	76,7
Decrease	6	2,5	0	0,0	0	0,0
Height	99	41,9	10	19,6	6	20,0
No data	4	1,7	1	2,0	1	3,3
Total	236	100,0	51	100,0	30	100,0

Thus, as the data suggests, the highest percentage of recipients who have seen an increase or decrease in temperature (44.4%) was recorded among patients to whom red blood cells concentrate (RBCC) was administered. The temperature increase was observed in 41.9% of people. Only in 2.5% of patients receiving RBCC transfusion had a significant decrease in body temperature compared to pre-transfusion state.

Analyzing data on observed changes in blood pressure in patients receiving transfusions of various blood components it should be noted that the highest proportion of patients in whom there was no change observed in this respect were patients receiving fresh frozen plasma (FFP) - 73.3% (Table 5).

Table 5. Blood pressure of the patient in relation to the type of blood component transfused

Description	RBCC	PLTC	FFP			
	Frequency	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
No change	94	39,8	34	66,7	22	73,3
Fall	36	15,3	3	5,9	4	13,3
Height	102	43,2	13	25,5	3	10,0
No data	4	1,7	1	2,0	1	3,3
Total	236	100,0	51	100,0	30	100,0

Next were the recipients, of the transfusion of PLTC (66.7%) and RBCC (39.8%). Thus, as in the case of temperatures, the highest percentage of patients (43.2%) who had an increase in blood pressure was observed in the population which received red blood cell concentrate (RBCC). The same condition was reported in every fourth person administered with PLTC and in every tenth patient receiving FFP. Hypotension occurred in 15.3% of patients after RBCC transfusion, in 13.3% of patients after administration of fresh frozen plasma (FFP) and in 5.9% of recipients having platelet concentrate (PLTC) transfusion.

In regard to the third vital sign observed in patients who underwent blood or its components transfusion it should be noted that the changes were reported in half of recipients being transfused with RBCC and 40.0% after administration of FFP (Table 6).

Table 6. The pulse of the patient in relation to the type of blood component transfused

Description	**RBCC**	**PLTC**	**FFP**		
	Frequency	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
No change	115	48,7	37	72,5	17	56,7
Decrease	20	8,5	3	5,9	3	10,0
Height	97	41,1	10	19,6	9	30,0
No data	4	1,7	1	2,0	1	3,3
Total	236	100,0	51	100,0	30	100,0

People who have not showed changes in baseline heart rate took up 72.5% in the group transfused PLTC. The increase in heart rate was observed 41.1% of patients who received RBCC and in 30.0% after administration of FFP, and in every fifth patient after PLTC transfusion. The highest percentage of cases, with a reduction in heart rate was observed after administration of FFP (10.0%) and RBCC (8.5%). The group, which had PLTC transfused, thise direction of change was found in 5.9% of people.

After the analysis of data it should be noted that in the majority of cases (62.6%) the recipients showed the occurrence of adverse reactions during transfusion. Complementary to this fact transfusion recipients showed no adverse side effects in 37.4% of cases.

Results and discussion

The development of transfusion creates more and more treatment options with blood. Transfusion complications still remain an unresolved problem and there are a variety of adverse reactions to transfusion of blood and blood components, which generally occur during transfusion or shortly afterwards. Some adverse reactions which have a chronic character may occur after a few months after the procedure or even after many years. It should be assumed that all undesirable symptoms occurring during transfusion or after , if there is no other evidence of their origin , should arise a suspicion of a transfusion reaction . The intensity of reaction depends on the type and volume of blood component being transfused, the immunogenicity of the antigen, the type of non-compliance, the general condition of the patient and the time elapsed since the start of transfusion [8,9,10].

For the proper conduct of transfusion of blood components it is important to decide on the need of transfusion basing not only on appropriate justifiable medical indications, but also on adverse reactions which should not be a surprise for the personnel involved in the process. Specialized preparation, knowledge and understanding of the causes and mechanisms of reactions allows for the effective exercise of professional patient care [9,10].

In the group of 317 analyzed reactions, only 36 patients had an immediate reaction after transfusion that directly threatened the life of the recipient. The remaining 88.3% of patients did not show any adverse effects which would endanger their life.

The analysis of data contained in the Protocols of complications after transfusions shows that an overwhelming number of reported adverse reactions occurred during the transfusion of blood components - 61.8% and have been described as early transfusion complications.

Similar studies conducted in 2007, by Dorota Król clearly indicated that 99.6% reported complications were early transfusion reactions [11].

In the available literature discrepancies were observed, as for the level of values of hemoglobin and hematocrit at which transfusion of blood components should begin. Literature does not provide the criterion concentrations of these indicators, which should be achieved by transfusion [12,13,14].

Another important issue that arise in connection with complications after transfusion is the relationship between the frequency of adverse reactions and the type of blood component that has been given.

The majority of reported adverse reactions, as many as 74.4% occurred after RBCC transfusion at a frequency of 1 case per 443 units transfused. Transfusion of PLTC - 16.1% resulted in 51 related complications, which is one complication to 244 platelets transfusion. Noteworthy is the fact that, that in contrast to the PLTC smaller number of adverse reactions caused greater number of transfused units of FFP therapy.

Observations indicate that PLTC transfusion is associated with twice the risk of related complications than RBCC transfusion (0.4% vs 0.2%).

The analysis of the FFP transfusion complications shows that a greater number of units transfused resulted in fewer complications.

It is good to remember that the heavy clinical condition of many patients in the treatment process requires transfusion of different formulation/drugs at the same time. The doctor supervising transfusions of blood components in the protocol of complications after transfusion component gives the number of donations during the transfusion, the observed side effects, which may not be clear from the fact that it happened this formulation is the reason for their occurrence.

The analysis of the obtained research material shows that in 2011 there were 174021 patients which resided in health care units in the Masovian Voivodeship which were indicated for the treatment with blood and its components. Out of those 174021, 317 recipients have shown various symptoms of adverse reactions. To sum up the studies, I can say that all the complications of transfusion of blood components account for 0.18% of cases.

Data on this issue, which can be found in the literature are diametrically contradictory. Most authors agree that complications after transfusion of blood components are rare from and account for 0.5% to 3% of all transfusions [15,16,17,18,19].

Conclusions

After analyzing the research material obtained from the submission of protocol related complications we put forward the following proposals:

1. The most common of the adverse reactions reported to RCKiK in Warsaw in 2011, were those observed in the course of RBCC and PLTC transfusions.
2. The need for RBCC transfusion is clearly dependent on the value of hemoglobin in patient.
3. The need for transfusion of blood components is related to the age of patients and increases for patients after 47 years of age.
4. Shivers and anxiety are the most common symptoms reported by patients as response reactions occurring during or after the transfusion of blood components.
5. The previous immunization of the recipient increases the likelihood of complications during or after transfusion.

Risks associated with blood transfusion and / or its preparations depends on:

- type, volume and speed blood component transfusion
- gender and health status of the donor and recipient,
- organization of work and the time of day carried transfusion,
- blood component manufacturing methods,

Precise examination of all adverse reactions and events at every stage of the transfusion allows in many cases, to find a probable cause that existed to explain the response and the immediate implementation of appropriate corrective and preventive procedures that have direct impact on the improvement of the whole process of treatment with blood. The final determination of the causes is performed in the Regional Blood Center in Warsaw. after receiving a full report of the healthcare facility and the results of serological tests.

In summary, the picture that emerges from the research seems to show the quality of the practice of blood transfusion for example Regional Blood Center in Warsaw is generally good. The aim is to further close grouping recipients among patients, and the indications for transfusion by audit and a thorough analysis procedures in modern transfusion

References

1. Łętowska M.: Basis of clinical transfusiology [in:] Bood transfusiology, red. Dmoszyńska A., Robak T. (ed.). Wyd. Czelej, Lublin, 2003, 437-452.
2. National Advisory Committee on Blood and Blood Products. http://www.nacblood.ca [cited 2014 April 10]
3. Rajasekhar A., Gowing R., Zarychanski R., Arnold D.M,.Lim W., Crowther M.A., Lottenberg R.: Survival of trauma patients after massive red blood cell transfusion using a high or low red blood cell to plasma transfusion ratio. Crit Care Med. 2011;39:1507–1513.
4. Meyer M.A., Ostrowski S.R., Windelov N.A., Johansson P.I.: Fibrinogen concentrates for bleeding trauma patients: what is the evidence? Vox Sang. 2011;101:185–190.
5. Viele M.K., Weiskopf R.B.: What can we learn about the need for transfusion from patients who refuse blood? The experience with Jehovah's Witnessess. Transfusion, 1994, 43, 396-401.
6. Rosiek A.: Red blood cell substitutes [in:] Clinical Transfusion , red. Korsak J., Łętowska M. Pub. Alfa Medica Press, Bielsko-Biała 2009, 278-290.
7. Pagliaro P., Rebulla P.: Transfusion recipient identification. Vox Sang. 2006, 9, 97–101.
8. Łętowska M., Żupańska B.: Complications after treatment of blood and its components [in:] Clinikal Transfusion, red. Korsak J., Łętowska M. Pub. Alfa Medica Press, Bielsko-Biała, 2009, 204-222.
9. Król D., Drybańska B., Dyląg S. et al.: Type the most common complications after transfusion of blood components on the basis of a six-year analysis. Acta Haematologica Polonica, 2007, 38, 141.
10. Łętowska M., Żupańska B.: Current views on some of the complications after transfusion. Acta Haematologica Polonica, 2009, 40, 407-423.

11. Król D.: Analysis of related complications reported in the Regional Centre Blood Donation in Katowice in the years 2000-2005. The Main Library Medical University of Silesia in Katowice. Doctor Dissertation, 2007.
12. Mintz P. D.: Treatment with blood. Rules of conduct clinical. AABB Press Section Transfusion Polish Society of hematologists and Transfuzjologów, Warsaw, 2001, 423-444.
13. Shander A., Gross I., Hill S., Javidroozi M., Sledge S.: A new perspective on best transfusion practices, Blood Transfus. 2013, 11, 193–202.
14. Tinmouth A.: Reducing the amount of blood transfused by changing clinicians' transfusion practices. Transfusion. 2007, 47, 132S-136S; discussion 155S-156S.
15. Pandey S., Vyas G.N..: Adverse Effects of Plasma Transfusion, Transfusion. 2012, 52, 65S–79S.
16. Sakr Y., Lobo S., Knuepfer S., Esser E, Bauer M, Settmacher U, Barz D, Reinhart K.: Anemia and blood transfusion in a surgical intensive care unit. Crit Care. 2010, 14, 92.
17. Dzik WH, Blajchman MA, Fergusson D, Hameed M, Henry B, Kirkpatrick AW, Korogyi T, Logsetty S, Skeate RC, Stanworth S, MacAdams C, Muirhead B.: Clinical review: Canadian National Advisory Committee on Blood and Blood Products - Massive Transfusion Consensus Conference 2011: report of the panel. Crit Care. 2011, 15, 242.
18. Alvarado-Ramy F, Kuehnert MJ, Alonso-Echanove J, Sledge L, Haley NR, Epstein J, Vostal J, Pearson M..: A multistate cluster of red blood cell transfusion reactions associated with use of a leucocyte reduction filter. Transfusion Medicine, 2006, 16, 41-48.
19. Murphy MF., Kay JDS.: Patient identification: problems and potential solutions. Vox Sanguinis, 2004, 87, 2, 197-202.

Tałaj Anna[1], Kubik Ewa[2]

Overcoming barriers in transplantation in Poland

1. Department of Health Science, Humane-Economic Academy in Elbląg, Poland
2. District Hospital in Elblag, PolandWojewódzki Szpital Zespolony in Elbląg, Poland

Introduction

Transplantation of organs and tissues is one of the newest and most effective methods of treating end- stage organs' insufficiency. The development of this method of treatment has been possible as a result of passing in Poland an Act About Taking and Transplantation of Cells, Tissues and Organs. However the act itself had not enough power to level the barriers of extracting the organs for transplantation. Persuading the public opinion to such a method of treatment has proved to be a relevant aim. Most of the society has accepted the implantation of organs when it came to their ill parts of the body. A lack of understanding and suspicion have been noticed when it was necessary to agree self-consciously for taking their or their relatives' organs after death. It is not easy to understand that what is necessary is the alive organ of a dead person. The society concern this method of treatment with mistrust and full of suspicion which especially refers to:

- recognizing death on the grounds of the criteria for brain death
- the problem of agreement (or disagreement) for taking the organs of dead person
- the rule of choosing a recipient of each organ
- concern for commercialization (suspicion of the organs' trade)

It has proved to be a social interest to make an immediate full perspicuity of all transplantation procedures. For that reason the rules of recognizing death of a person, a method of selection of a proper organ for a proper recipient has been included in "A new transplantation act" in 2006, complying with the EU Directive referring to the transplantation of tissues and cells (2004) [1].

Amplification

The important task is to solve the suspicions increasing in the society and questions concerning issues of the organs transplantation and the belief that this is the only method of treating the ill with end- stage organs' insufficiency. Here, necessary is the help of the media, however the problem has to be introduced reliably, not as a cheap sensation, because such a statement contributes to more damages than benefits in the development of polish transplantology.

Polish Medical Transplantation Union, in order to make the problem of transplantology more common in the society, takes lectures for youth in schools, organizes transplantation picnics, cooperates with the associations of patients after the organs transplantation, has recorded a series of radio broadcast; "*The secrets of organs transplantation*" and exports it in other radio broadcast and transplantation centers [2].

Polish society is a catholic one, therefore it is necessary to introduce the stance of the Catholic Church in case of transplantology. The Pope John Paul II claimed that the Church accepts the idea of the brain death, assuming that a human being is dead when his brain is dead, as a whole part. A very valuable aspect is the witness of the hospital chaplains and the parish priests referring to the Church stance in case of the organ donation of the congregation [3].

In Poland, the law allows taking the organs from dead persons, provided that as alive they did not express their opposition- there are allowed three forms of this opposition:

- *"an entry in the central registry of opposition for taking the cells, tissues and organs from the human cadaver;*
- *written statement provided with the autographic signature;*
- *the oral statement handed in the presence of at least 2 witnesses and signed by them*"[4]

Despite the fact that in Poland, there does not exist a regulation in that case, a talk with the family of a potential organ donor is a common aspect. Doctors ask for the agreement for taking the organs in order to transplant them. If the members of the nearest family express their opposition for making their dead relative an organ donor, the begun procedures stop and doctors derogate from taking the organs [5]. It should be taken into account, that such an opposition always means death sentence for a few persons. The highest amount of organs is taken from the dead donors.

An independent medical board consisting of three specialists in the field of medicine; Anaesthesiology and Intensive Therapy, Neurology, Neurosurgery and Forensic Medicine recognizes the death of a person in accordance with strictly determined procedures [6]. None of the specialists affirming the death takes part in the act of taking or transplanting the organs. After the death has been affirmed, the "POLTRANSPLANT" is announced which coordinates the further process of taking the organs and choosing a proper recipient. The choose of the recipient is set in accordance with strictly determined medical criteria and it is not possible that an organ would be received by a person who is not on the list of the expecting ones. Acts referring to transplantation and their amendments are likely to eliminate any mistake and make a profession of a proper process of actions.

A big influence on the quality of taken organs have the consequences of the brain death. In the period of the brain indentation, sinus bradycardia can be noticed, as well as additional supraventricular boosts, cardiac arrest and the hemodynamic symptom of these occurrence is hypotension.

The next symptom of so called "vegetative storm", here occurs the release of catecholamines from adrenergic glands. As a result of the "vegetative storm", we will observe an increase in the peripheral vascular resistance and mean arterial pressure. Such a phenomenon may This phenomenon may lead to an increase in heart rate and oxygen consumption, cardiac output is reduced, a large volume of blood vessels is moved capacitive vessels and bearings pulmonary. Cardiac hypoxia can be noticed, acute mitral valve regurgitation, increased pressure in the left atrium, which has the consequences of pulmonary edema. After some time, the lesions recedes but subendocardial necrotic lesions similar to heart attack lesion can stay.

On the cell level lesions can also occur and they can lead to the disintegration of cell structure. Disintegration of cell structure may occur in such organs as heart, lungs, kidneys, liver. These disintegrations considerably decrease the value of the taken organs or even disqualify them at all.

The death of the brain has an influence also on the functioning of the hypothalamic-pituitary axis. The most common symptom is the diabetes insipidus caused by a lack of antidiuretic hormone. Diabetes insipidus is recognized on the basis of polyuria, which leads to the hyperosmolality of the plasma, hyponatraemia, hypocalcaemia, hypomagnesaemia, hypercalcaemia. The occurring hypovolemia and the concomitant increase of the osmolality and the changes in concentration of electrolytes lead to circulatory disorders in organs taken for transplant and adversely affect their quality.

The center of the body temperature control is the hypothalamus and the effect of its damage is the hypothermia. The persistent hypothermia can cause:

- cardiovascular instability;
- clotting disorder;
- acidosis;

- arrhythmia (ventricular fibrillation resistant to therapy can occur);
- abnormal urination;
- shift left hemoglobin dissociation curve [7].

Staff of the Intensive Medical Care is struggling with these problems, which can affect the proper functioning of the donor's organs and limit their suitability for transplantation.

A big role plays staff knowledge about transplantation, including the conducting of donors since the declaration of brain death to organ donation.

Conclusion

Taking up the issue concerning transplantation and care of potential organ donor, it should be emphasized that the goals of care nursing with the change in patient status from a living donor organs for dead - do not change.

Despite the short time of planning and implementing the nursing process of potential donors, it takes a very important place in the treatment of recipients of various organs.

Statistical data from Poltransplantu indicate that the largest amount of collected organs come from donors who have had vascular death of brain disorders. With the change of status of the patient on the deceased donor living organs - the nursing process has not changed. Nursing interventions are maintained until the removal of organs, but definitely with changing of their purpose. The care of the living patient and dead donor is identical. In both cases, the reliability and conscientiousness in carrying out nursing is important for the health of the alive patient as well as for the potential organs recipient.

It should be emphasized that the care of the sick, who is presumed dead, drains mentally the nursing staff. At least the fact of the failure of the therapy and the patient's death is aggravating the contact with the family of the deceased (talks, the observation of their sorrow and despair) as well as acting in the same way as in case of the alive patient. Nurses caring for organ donors must have a broader look at the issue of transplantation. On the one hand they see the human body, to which they treat with respect, they perform all nursing tasks and ask themselves "what if he is not dead" - they see only suffering and pain. At this point, they need to see the other side of the coin - the people are suffering, fearing for his life, waiting for a healthy organ. They will never see the results of their hard work in the care and preparation of donor organs, but this effort will certainly result. Poltransplant always informs the staff working in the ICU and Operations Block about the further history of the taken organs. It thanks in a written statement the staff who participates in the care and preparation of the donor for the organ donation, which raises the morale of the staff.

References

1. Rowiński W: Bariery przeszczepiania narządów w Polsce i sposoby ich pokonywania. Med. Prakt., 2009, 1.
2. Rowiński W.: Transplantologia kliniczna. PZWL. Warszawa, 2010.
3. Kruszyński Z.: Przygotowanie Dawcy Narządów, Wykłady z Anestezjologii i Intensywnej Terapii. PZWL. Warszawa, 2009.
4. Rutkowski B.: Wytyczne dotyczące zasad zgłaszania, kwalifikacji i przygotowania zmarłych dawców do pobrania narządów. Praktyczny przewodnik. Via medica. Gdańsk, 2009.
5. Przenny A., Czerwiński J.: Krajowy Rejestr Przeszczepień. Poltransplant, 2012, 1, 20.
6. Iwańczuk W.: Śmierć mózgu. ISBN. Wrocław, 2010.
7. Wołowicka L., Dyk D.: Anestezjologia i Intensywna Opieka, Klinika i Pielęgniarstwo. PZWL. Warszawa, 2007.

.

Tałaj Anna[1], Rychcik Katarzyna[2]

Patient after a sudden out-hospital cardiac arrest, in defibrillation rhythm

1. Department of Health Science, Humane-Economic Academy in Elbląg, Poland
2. District Hospital in Elblag, PolandWojewódzki Szpital Zespolony in Elbląg, Poland

Introduction

A sudden out-hospital cardiac arrest (SCA) is still a very difficult to treat clinical problem, saddled with high mortality. Percentage of obtaining the return of spontaneous circulation in the scene is still small. SCA is defined as the sudden cessation of the state of cardiac arrest which will lead to blood and secondary respiratory arrest. It Applies to about 700 000 people per year and is the leading cause of death in Europe. In some cases, it is possible to prevent death by urgently implementing resuscitation and lifesaving specialist treatment [1].

The basic criterion for patient survival from cardiac arrest in defibrillation rhythm is the time of performing the defibrillation. Every minute of delay in defibrillation performed results in 10% -12% reduction in the chance of survival. Therefore, in addition to good quality of chest compressions and ventilation defibrillation is the primary intervention in cardiac arrest in defibrillation rhythm [2].

Amplification

One of the major challenges of modern emergency medicine is still a necessity to improve the unsatisfactory results of cardiopulmonary resuscitation (CPR). Prognosis depends on the initial cardiac rhythm in cardiac arrest, the presence of the occurrence witnesses, their actions (BLS), emergency system and the time to reach qualified help (ZRM). The literature relays that during the first 2 minutes of cardiac arrest, two thirds of patients are found in the heart rhythm recording the defibrillation rhythm. Therefore, early defibrillation is an independent prognostic factor of survival after SCA [3].

The sudden and unexpected death is still a serious and difficult to solve social problem. This is due to the fact that, inter alia, its unexpected nature as well as the lack of effective methods to identify a group of patients of the most risk. It was assumed that a quarter of all deaths occur suddenly. Often they are the first symptom of the disease. Generally accepted definition defines *"death as sudden if the death occurred unexpectedly within one hour of the onset of symptoms"* [4]. The most common causes of SCA include ventricular arrhythmias, especially ventricular fibrillation resulting from the coronary artery disease. Patients with such a history are at risk 10-fold more than those without incidents of heart disease. The literature says that about 80% of the events of the cardiac arrest occurs at home, and in 40% of cases there are no witnesses to the incident [4].

Survival of the out hospital cardiac arrest victims is still small. Numerous studies conducted in this group of patients indicate that people who experienced cardiac arrest at home were usually the elderly, and the ECG showed lack of defibrillation rhythm. Among the people who came into cardiac arrest in a public place, the starting rhythm was ventricular fibrillation cardiac arrest. In this group, the bystanders more often gave first aid in the form of a BLS (basic life support operations), which significantly improved the performance of CPR. These patients compared with the other groups showed more than twice the chance of admission to hospital and about four times higher in the extract into the house. Patients whose initial rhythm included defibrillation had four times higher chance of successful resuscitation. Numerous reports indicate a significant difference in the effectiveness of interventions dependent on the time of the first defibrillation. In the group of patients whose time of diagnosis of cardiac arrest and performance of the first defibrillation was less than 7 minutes, a higher percentage of successful resuscitation. Numerous reports suggest that in addition to the arrival time of emergency medical team, resuscitation undertaken by witnesses on the spot, early defibrillation is an independent prognostic factor that has an impact on survival after SCA outside hospitals.

The after- resuscitation team is a condition that we can observe in survivors of SCA. *"It includes the changes resulting from ischemic brain injury, myocardial dysfunction generated from the cardiac arrest, systemic response to the generalized ischemia and reperfusion and the potential persistence of the process that caused the SCA"* [1]. *Differentiation of the clinical picture is influenced by: time without perfusion, causes of SCA and comorbid conditions.*

In 75% of the out-hospital cardiac arrest was observed damage to the CNS. There are several reasons that have an impact on such a high percentage of complications from the CNS. These include a small-cell tolerance to ischemia of the brain and specific response to reperfusion.

In comparison with other tissues of the body the brain has 5 - fold higher energy requirements. SCA, and thus decrease organ perfusion triggers compensatory mechanisms (centralized circulation, release of brain glycogen and glucose). Literature reports that SCA lasting more than eight minutes causes permanent and severe brain damage. Excessive blood viscosity and the effect of stagnation in microcirculatory cause minor heart attacks. One of the most common result of SCA is a type of, Korsakoff amnesia syndrome, characterized by backward and afterward amnesia, confabulations and / or pseudo- reminiscence.

"The medical success in the form of rescue of life after cardiac arrest does not always mean success in the process of healing and therapy, providing rescued independent existence and functioning in society" [1].

Due to the fact that witness of the event, which is the SCA, rarely undertakes rescue activities, the promotion of first aid it becomes purposeful in the community, in each age group. Already dispatchers provide advice and tips on how to carry out rescue activities until the arrival of the medical rescue team [5].

The ideal situation would be to train the entire population in CPR (cardiopulmonary resuscitation - respiratory). There is no scientific evidence both for and against the teaching of first aid to the people at high risk of SCA. However, such training can reduce the concerns of the patient and his family, give sufficient emotional acceptance, which in situations of high stress, will mobilize forces and take resuscitation steps [6].

CPR trainings are necessary for the people without medical education, as well as the. The problem of training should be tailored to the needs of the trainees, and the method of teaching should provide acquire and store knowledge and practical skills.

Conclusion

There are several reasons why the SCA witnesses shall not take any action. These include panic, fear of infection, fear of the consequences of properly performed CPR, fear of harm to the person being rescued.

It was found that the systematic training of people not related with the medicine, definitely increases their willingness to take CPR. All groups should be trained standard CPR (compressions and ventilation ratio of 30:2). In the situation of an emergency such as mass, telephone, instructing the witness, public awareness campaigns, teaching should focus on the exclusive external chest compression. *"Teaching citizens CPR should be widely promote. However, the lack of training should not be an obstacle in performing CPR with chest compression-only, which is best done with a telephone instruction dispatcher"* [7].

Another method significantly increasing the chance of survival from SCA are programs of public access to PAD defibrillation. The premise of the program is to place in the in public places such as shopping malls, sports centers, casinos, cinemas, where in the past two years there has been a place of SCA, AED - automated external defibrillators. Information about their availability and CPR training is important in situations of cardiac arrest . The average time examined to reach the victim is 8 minutes, often longer, because without the help of witnesses and the use of AED chances of survival are slim. Therefore, it is so important to know by ZRM as well as witnesses, the presence of the AED " which in a completely automated and reliable, recognizes arrhythmias and defibrillation decide ." Very important is the fact that they are device safe for rescue and victim, and that they should be used in every case of suspected cardiac arrest [8].

The Act on State Emergency Medical Services points at the nurse of the system next to the emergency worker and system doctor, to implement a training program for children and youth of education in first aid. *"Implementation of the training is important in preparing people to take emergency action to reduce mortality in the so-called golden hour* " [9].

References

1. Polanowska K.E.: Konsekwencje poznawczo-behawioralne nagłego zatrzymania krążenia. Studium przypadku. Terapia, 2012, 1, 46-51.
2. Deakin Ch.D., Nolan J.P., Sunde K., Koster R. W.: Elektroterapia: automatyczne defibrylatory zewnętrzne, defibrylacja, kardiowersja i stymulacja [w:] Wytyczne resuscytacji 2010, Andres J. (red.). Wyd. Fall, Kraków, 2011.
3. Rudner R.: Wyniki postępowania resuscytacyjnego w pozaszpitalnym zatrzymaniu krążenia o etiologii kardiologicznej. Anest. Intens. Ter., 2004, 4, 264-275.
4. Berent D (red.): Defibrylatory publicznego dostępu–nowe możliwości w leczeniu pozaszpitalnego zatrzymania krążenia. Forum kardiologów 2006. tom 11. Nr 1.
5. Rudner R.: Ocena wybranych czynników wpływających na wyniki postępowania resuscytacyjnego w pozaszpitalnych zatrzymaniach krążenia. Anest. Intens. Ter., 2005, 37, 174-180.
6. Soar J.: Zasady nauki resuscytacji. Wytyczne resuscytacji 2010. Wyd. Fall, Kraków, 2011.
7. Frączek B.: Bezpieczeństwo a przepływ. Defibrylacja według Wytycznych Resuscytacji Krążeniowo-Oddechowej 2010. Na ratunek, 2011, 1, 22-26.
8. Kózka M., Ścisło L.: Kompetencje zawodowe pielęgniarki w ratownictwie medycznym [w:] Pielęgniarstwo Ratunkowe. Kózka M., Rumian B., Maślanka M. (red.). PZWL, Warszawa, 2013.

Tyrakowska Zuzanna[1], Zalewska Anna[2], Zalewski Karol[3], Kuszczak Anita[1], Turko Barbara[1], Sochoń Karolina[2], Sarnacka Emilia[4], Krajewska-Kułak Elzbieta[4]

Obesity as a civilization disease of the 21th century. Work supported by research examples

1. Medical Volunteeres Students Association Department of Integrated Medical Care, Medical University of Białystok
2. Department of Pediatric Rehabilitation, Medical University of Białystok
3. The Poznan University of Medical Sciences, Faculty of Physiotherapy
4. Department of Integrated Medical Care, Medical University of Białystok

Introduction

Definition of obesity

The definition of the World Health Organization (WHO) defines the discussed problem of obesity very accurately. It is stated that obesity is the pathological accumulation of adipose tissue in an organism, exceeding its physiological needs and adaptability, which may lead to adverse health effects. In men it is over 25% of body mass, and in women – over 30%. According to the WHO, there is about 1.6 million people with overweight, and over 522 million people with obesity in the world. Obesity is not only a medical problem, which directly contributes to 10-13% of premature deaths in the European region, but it is also an economic problem – obesity-related costs account for about 5% of expenditures on health care in Great Britain, and in Europe they range between 2 and 7% [1].

Epidemiology of obesity

Polish society has started to perceive obesity as a global health problem of the 21st century. Its incidence in Poland and in the world has been continuously increasing for many years. The optimum body mass depends on many elements, such as: genetic and psychological factors, age, sex, body build, lifestyle, physical activity, as well as consumed - often high-calorie - products. Excessive weight gain is a problem in developed and developing countries. In regions undergoing economic and cultural revolutions overweight and obesity coexist with malnutrition. The problem concerns all age groups, irrespective of their race and sex [2].

According to the research conducted in 2002, overweight (BMI > 25 kg/m2) afflicted 1.4 billion people in the world, whereas obesity (BMI > 30 kg/m2) – 365 million people. In 2007 a significant increase of those indexes was observed by 1.5 billion and 523 million, respectively. Due to this upward trend specialists estimate that in 2015 there will be 2.3

billion people with overweight and 704 million people with obesity. Epidemiological data from the last twenty years in the USA indicate that the incidence of obesity has doubled, and in case of children and adolescents, the number has increased three times and amounts to 17% [3].

Over 50% of the European population is overweight, and 30% have been diagnosed with obesity [4,5]. The highest rates are in Greece, where 51% of men and 37% of women are overweight, and 28% of men and 38% of women are obese. Countries with the lowest incidence of overweight and obesity are France, Sweden, Denmark and Norway. Overweight afflicts 35-41% of men and 20-24% of women, whereas obesity is observed in 7-9% of men and 6-8% of women. High rates of overweight and obesity can also be observed in European children. In girls and boys at the age of 4-6 it is 9-27% and 8-24%, respectively. The highest rates are observed in girls at the age of 10-14 in the Spanish population and in boys at the age of 7-9 in the Italian population (36%) [5].

Overweight and obesity have become a serious problem also in Poland. The research conducted in 2000 by the Institute of Food and Nutrition showed that overweight occurred in 41% of men and 28.7 of women, whereas obesity occurred in 15.7% of men and 19.9% of women [6,7]. In the research of WOBASZ (Wieloośrodkowe Ogólnopolskie Badania Stanu Zdrowia Ludności – *the Multicentre Polish Studies of Population Health Status*), conducted in 2003-2005 among adults at the age of 20-74, the occurrence of overweight in men was estimated to be 40.4% and 27.9% in women. Obesity afflicted 21.2% of men and 22.4% of women [8]. Whereas, in the research of NATPOL overweight was diagnosed in 34% of adults (39% of men and 29% of women), and obesity in 19% (19% of men and 19% of women) [9].

It shall be noted that in Poland, as well as in other countries, an upward tendency of the discussed phenomena can be observed. On the basis of the studies of the Institute of Food and Nutrition it was estimated that in 1991-2000 the occurrence of obesity in adults under the age of 60 increased by about 5% [10].

Apparent increase in the incidence of overweight and obesity among children and adolescents has also become a serious problem. On the basis of the research of the Institute of Food and Nutrition it has been estimated that overweight afflicts 15.9% of boys and 11.1% of girls, and obesity – 4% of boys and 3.4% of girls [7].

Division of obesity

In practice we distinguish two divisions of obesity:

- Due to its causes:

  - Simple obesity (also called primary or alimentary obesity) is caused by positive energy balance. Mostly, it is caused by environmental factors related to excessive consumption of processed food with a high content of animal fats and simple carbohydrates, but also by almost non-existent physical activity. This type of obesity is most commonly diagnosed in developing populations. It is found in over 98% of children that are diagnosed [11,12,13].
  - Secondary obesity is a symptom of endocrinological diseases, e.g. hypothyroidism, Cushing's syndrome and Cushing's disease, growth hormone deficiency, hypogonadism; genetically conditioned syndromes, e.g. Prader-Willi, Lawrence-Moon-Biedl, Turner, Klinefelter; damages to hypothalamus by inflammations, malformations, injuries of the central nervous system and chronic use of some medicines, such as: corticosteroids, derivatives of phenothiazine, antidepressants and anti-epileptics, insulin etc. [13].
- Due to anthropometric measurements:
  - Android obesity (also called central abdominal, "apple"), the accumulation of adipose tissue in the abdominal cavity and abdomen. It is related to greater risk of cardiovascular complications, as well as metabolic syndrome and some tumors. This type of obesity occurs mostly in men.
  - Gynoid obesity (also called peripheral, waist-hip, "pear") the accumulation of adipose tissue in the area of bottom, hips and thighs. This type of obesity is characteristic for women.

Particular attention shall be paid to the early identification of people with a predisposition or developing obesity, due to a possibility of future occurrence of dangerous complications [11,13].

Causes of obesity

The phenomenon of obesity is caused by many different factors, such as: genetic, hormonal, mental, environmental, biological, pharmacological, cultural, economic and ethnic factors. However, the most common cause still consists in eating too much greasy and high-calorie food, lack of physical activity, sitting lifestyle, devices facilitating professional work and house works, cars used even for small distances and change of the way of spending free time. Consumed alcohol provides us with empty calories and is toxic for many organs. People who have quit smoking are much more prone to gaining body mass due to an increased appetite occurring after quitting smoking. Continuously, obesity becomes the way of life, a possibility of explaining all failures for many people. Food becomes a form of consolation, a possibility of relieving anxiety, failures, anger or boredom [14]. Hereditary conditions are also significant. In a study of identical twins, being brought up in different families, it was shown that they reached similar body mass as adults, irrespective of eating habits or other environmental factors [15].

Obesity complications

Obesity has become a huge problem, which contributes to falling for particular diseases that, in consequence, may cause death. The World Health Organization qualified obesity as a chronic non-infectious disease. Obesity accompanies such diseases as: cardiovascular system diseases, diabetes, tumors and some gastrointestinal tract diseases. In the majority of developed countries, as well as developing ones, these diseases are the major cause of death, they afflict life expectancy and quality, and are related to high costs of treatment [16]. Epidemiological studies showed that with increasing BMI, the risk of death increases. Mortality connected with obesity results from such cardiovascular diseases as: arterial hypertension, cardiac failure, coronary artery disease, pulmonary heart disease, pulmonary embolism, stroke and varicose veins. Diabetes and tumors are other dangerous complications associated with obesity [17,18]. Abdominal obesity is most often accompanied by metabolic complications [19,20].

Overweight and obesity are responsible for the occurrence of diabetes type 2, coronary artery disease, and hypertension. Osteoarthritis, gastrointestinal tract diseases, gallstones, fatty liver, cirrhosis, obstructive sleep apnea, reproductive system dysfunction, skin changes, and urologic and renal complications are the other health consequences, resulting directly from obesity [21,22].

Diagnostic methods used for diagnosing obesity

The occurrence of obesity cannot be simply stated on the basis of body mass. An important element is the presence of adipose tissue in the amount exceeding the allowable standard. Obesity and overweight can be diagnosed using the body mass index - BMI, which is essential for that purpose. Measurement of the index is made by dividing body mass by squared height. If the result is 18.5-25kg/m^2, it is proper. But if it is 25-30kg/m^2, we can speak of overweight. The result above 30kg/m^2 indicates obesity, and the result above 40kg/m^2 – morbid obesity. The index reflects a relation between body mass and height. A separate group consists of pregnant women, elders, fast growing children - in case of which it is difficult to make measurements, people with osteoporosis - due to reduced bone mass, and sportsmen, whose body mass consists mostly of muscles.

In diagnosing obesity, measurement of content and decomposition of adipose tissue in particular organs and in the retroperitoneal space is much more important. Here, specific application is found for Magnetic Resonance Imaging (MRI), Computer Tomography (CT), and Bioelectrical Impedance Analysis (BIA) which is used for measurement of hydrated, fatless tissue. Due to its non-invasiveness and ease of use, it is widely applied.

DEXA, dual-energy X-ray absorptiometry was described as “gold standard” of assessing the amount of adipose tissue. It makes accurate measurement of adipose tissue, and indicates the exact location of fat.

There are also anthropometric examinations conducted. They consist in measurements of body mass, girth of waist and hips. On that basis one can calculate anthropometric index adapted to the age and sex of the examined person. However, anthropometric examination is connected with some difficulties, which forced the need to create different reference systems in a form of growth charts and scales.

Because of ethnic differences there are still no graphic values defined, which would help to describe the problem of overweight and obesity of population. The most often determined parameters are: skin-fold calipers, Least Mean Square (LMS) – Cole’s index used for measurements in younger children, previously mentioned Body Mass Index (BMI), Waist Circumference (WC), Waist to Hip Ratio (WHR), Waist to Height Ration (WtHR). Body Adiposity Index (BAI) is one of the latest indexes; it was introduced in 2011 and it is calculated on the basis of formula: hips circumference/ height^{1,5} – 18, and it has become an alternative for BMI that has been used for hundreds of years. Family history also plays an important role in diagnostics; we shall also pay attention to the need for additional laboratory tests [23-28].

Consequences of obesity

An increased incidence of the discussed problem is connected with an increased incidence of ailments that are directly associated with it. Younger and younger people are afflicted with their first problems related to obesity, which lead to serious problems in the future [29].

The problem is followed by numerous consequences, starting with the risk of premature death to the occurrence of many non-infectious diseases. The most serious health problems are: hypertension, diabetes type 2, hyperlipemia, stroke, cardiac failure, coronary artery disease, cholecystolithiasis, osteoarthritis, respiratory tract diseases, mental problems, tumors (endometrial cancer, cervical cancer, ovarian cancer, gallbladder cancer, prostate cancer, colorectal cancer), varicose veins, as well as infertility in men and women, and pregnancy complications (such as pregnancy diabetes, the need for caesarian section). The degree of risk depends on the amount of adipose tissue, its location and physical activity [30].

Obesity is also associated with lack of self-acceptance connected with low self-esteem, reduced quality of life, and in many cases, tendency for depressive and anxiety states [13].

Prophylaxis and treatment of obesity

In order to prevent and treat obesity effectively, one should find its causes. All steps should be directed at prophylaxis and prevention of the problem. Despite development of medicine and methods of treating obesity, they often turn out to be ineffective. Methods of treatment are properly and reasonably adapted to the severity of obesity, as well as the coexistence of accompanying diseases. Here, we can distinguish: increasing physical activity, behavioral therapy, changing lifestyle and bad eating habits, pharmacological and surgical treatment. Slow weight loss and keeping it at a constant level are necessary to maintain the long-term treatment effects. Loss of 5-10% of weight within six months is the most beneficial. Then, the patient should keep body weight at a constant level and adhere to new behavioral habits. One should effectively follow low-calorie diet and pay attention to consumption of vitamins and larger amount of vegetables and fruit. It is important to match the right amount of meals per day to the needs of one's body [31].

Summary

The discussed question is one of the most significant problems of society. It is indicated by high rates of its incidence, upward tendencies and most of all, complications that are directly connected with obesity. These factors affect the health status of population, which deteriorates with remarkable rapidity. Another important factor is consumption of large amounts of high-calorie food and non-existent or minimal physical activity. To reduce the adverse effects of obesity, we should promote a healthy lifestyle at any age. People afflicted with overweight or obesity require constant specialist care, diet, pharmacological treatment or, if necessary, a surgery. By reduction of body mass and simultaneous improvement of metabolic index one improves one's health and frame of mind. Despite all the efforts, there has not been invented a golden mean allowing to eliminate overweight and obesity, yet. Therefore, it is right to say that obesity has already become a disease of the 21st century.

References

1. World Health Organization: The challenge of obesity in the WHO European Region. Fact sheet EURO, 2005, 13, 1-4.

2. James WPT.: The epidemiology of obesity: the size of the problem. J. Intern. Med., 2008, 263,336-352.
3. Wang Y,, Beydoun M,A.: The obesity epidemic in the United States – gender, age, socioeconomic, racial/ethnic, and geographic characteristics: a systematic review and metaregression analysis. Epidemiol. Rev., 2007, 29, 6-28.
4. Andreyeva T., Michaud P.C., van Soest A.: Obesity and health in Europeans aged 50 years and older. Public. Health, 2007, 121, 497-509.
5. Health and lifestyle indicators in the European Union. European Nutrition and Health Report 2009. Forum Nutr. Basel, Krager, 2009, 62, 157-201.
6. Otyłość, żywienie, aktywność fizyczna, zdrowie Polaków. Diagnoza stanu odżywiania, aktywności fizycznej i żywieniowych czynników ryzyka otyłości oraz przewlekłych chorób niezakaźnych w Polsce (1960-2005) red. M. Jarosz, wyd. Instytut Żywności i Żywienia, Warszawa, 2006.
7. Szponar L, Sekuła W, Rychlik E. i wsp.: Badania indywidualnego spożycia żywności i stanu odżywienia w gospodarstwach domowych. Wy. Instytut Żywności i Żywienia, Warszawa, 2003.
8. Wieloośrodkowe Ogólnopolskie Badanie Stanu Zdrowia Ludności. Program WOBASZ. Wyd. Instytut Kardiologii, Warszawa, 2005, 90, 1-128.
9. Zdrojewski T., Babińska Z., Bandosz P.: Związek nadwagi i otyłości z podwyższonymi wartościami ciśnienia tętniczego w badaniach reprezentacyjnych grup dorosłych Polaków w 1997 i 2002 roku (NATPOL II, NATPOL III). Med. Metab., 2002, 6, 32 (suppl.).
10. Rywik S., Pająk A., Broda G. i wsp. Częstość występowania nadwagi i otyłości w wybranych populacjach Polski – Pol-Monica BIS Projekt. Med. Metabol., 2003, 2, 8-15.
11. Sweeting H.: Measurement and Definitions of Obesity In Childhood and Adolescence a field guide for the uninitiated. Nutritional J., 2007, 9, 345-356.
12. Nawarycz T., Ostrowska-Nawarycz L: Rozkłady centylowe obwodu pasa u dzieci i młodzieży. Pediatr. Pol., 2007, 87, 5-6.
13. Pisuła A.: Otyłość – jak ją pokonać? Medicover, 2008, 11-12.
14. Nierubiec A.: Rodzinna Encyklopedia Zdrowia. medycyna konwencjonalna, alternatywne metody leczenia, samoleczenie. Reader's Digest Przegląd 1999, 252-254.

15. Diet, nutrition and the prevention of chromic diseases. Report of the joint WHO/FAO expert consultation. WHO Technical Report Series, No.916 (TRS 916).
16. Poirier P., Giles T.D, Bray G.A., et. al.: Obesity and cardiovasculardisease: pathophysiology, evaluation, and effect of weight loss. an update of the 1997 American Heart Association Scientific Statement on Obesity and Heart Disease from the Obesity Committee of the Council on Nutrition, Physical Activity, and Metabolism. Circulation, 2006, 113, 898-918.
17. Renehan A.G., Tyson M., Egger M., et. al.: Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. Lancet 2008, 371, 569-578.
18. Despres J.P. Abdominal obesity: the most prevalent cause of the metabolic syndrome and related cardiometabolic risk. Eur. Heart. J., 2006, 8 suppl. B: B4-B12.
19. Zhang C., Rexrode K.M, van Dam R.M., et.al.: Abdominal obesity and the risk of all-cause, cardiovascular, and cancermortality. Sixteenn years of follow-up in US women. Circulation, 2008, 117, 1658-67.
20. Kopelman P.: Health risk associated with owerweight and obesity. Obes. Rev., 2007, 8, suppl. 1, 13-17.
21. Jung R.T.: Obesity as a disease. Br. Med. Bull., 1997, 53, 307-321.
22. Bolanowski M., Zadrożna-Śliwka B., Zatońska K.: Badanie składu ciała – metody i możliwości zastosowania w zaburzeniach hormonalnych. Endokrynol. Otyłość, 2005, 1, 920-925.
23. Majcher A., Pyrzak B., Czerwonogrodzka A., Kucharska A.: Body fat percentage and anthropometric parameters in children with obesity. Med. Wieku Rozwoj., 2008, 12, 493-498.
24. Jakubowska-Pietkiewicz E., Prochowska A., Fendler W., Szadkowska A.: Comparison of body fat measurement methods in children. Pediatr. Endocrinol. Diabetes Metab., 2009, 15, 246-250.
25. Pyrżak B., Majcher A., Rumińska M., Janczarska D., Czerwonogrodzka A.: Analiza częstości występowania zespołu metabolicznego z zastosowaniem kryteriow Cook'a, de Ferranti i IDF u dzieci z otyłością. Pediatr. Endocrinol., 2008, 7, 21-32.
26. Kułaga Z., Rożdżyńska A., Palczewska I., Grajda A., Gurzkowska B., Napieralska E., Litwin M. oraz Grupa Badaczy OLAF: Siatki centylowe wysokości, masy ciała i wskaźnika masy ciała dzieci i młodzieży w Polsce – wyniki badania OLAF. Standardy Medyczne, 2010, 4.

27. Bergman R.N., Stefanovski D., Buchanan T.A., Et al.: A Better Index of Body Adiposity. Obesity (Silver Spring). 2011, 19, 1083-1089.
28. Fichna P., Skowrońska B.: Powikłania otyłości u dzieci i młodzieży [Obesity related complications in children and adolescents]. Endokrynol. Diabetol., 2006, 12, 223-228.
29. Buczek S.: Leczyć czy zapobiegać otyłości u dzieci?. Med. Rodz., 2003, 1, 35-37.
30. Spruijt-Metz D.: Etiology, Treatment and Prevention of Obesity in Childhood and Adolescence: A Decade in Review. J. Res. Adolesc., 2011, 21, 129-152.

Trypuć Marta[1], Samusik Maciej Jerzy[3], Kułak Piotr[4], Ryniec Malwina[5], Bączek Grzegorz [3], Downar-Maksimiuk Jakub[3], Tołoczko Helena[3]

The X-ray digital imaging of Kahler's disease

1. Department of Radiology, Medical University of Białystok, Poland
2. Faculty of Health SciencesMedical University of Białystok, Poland
3. Student of Faculty of Health Sciences Medical University of Białystok, Poland
4. Department of Pediatric Radiology, Medical University of Białystok, Poland
5. Department of Radiology, Provincial Hospital of Włocławek, Poland

Introduction

Multiple myeloma Kahler's disease or Myelocytoma or multiple myeloma [1]. Multiple myeloma or plasma cell myeloma is a malignant, nonmatrix-forming „ round cell" bone marrow tumor usually affecting the entire skeleton. Kahler's disease is a cancer of plasma cells, a type of white blood cell normally responsible for producing antibodies [1].

Myeloma multiplex develops in 1–4 per 100,000 people per year [1]. The contemporary diagnosis is based on imaging with the use of Digital X-rays. Multpilex myeloma may appear as an isolated entity, but usually there are multiple foci of involvement in many bone of the body with predominant affection of the skull, spine, pelvis, femora, humeri, sternum, ribs. It is unusual to see myelomatous foci beyond the elbow or knee. Noteworthy that these are also the sites of hematopoiesis in the adult [1].

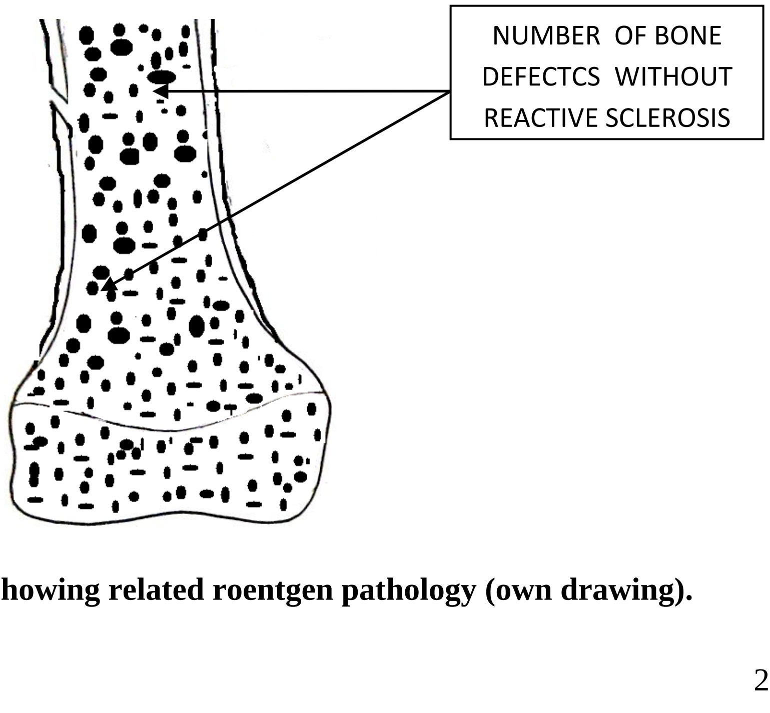
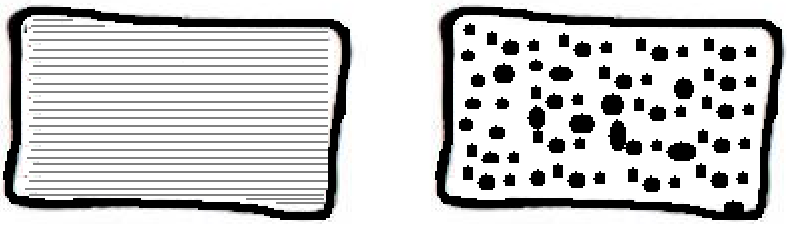


Figure 1A. Drawing showing related roentgen pathology (own drawing).



Normal Kahler's disease

Figure 1B. Vertebral in bony textures (own drawing).

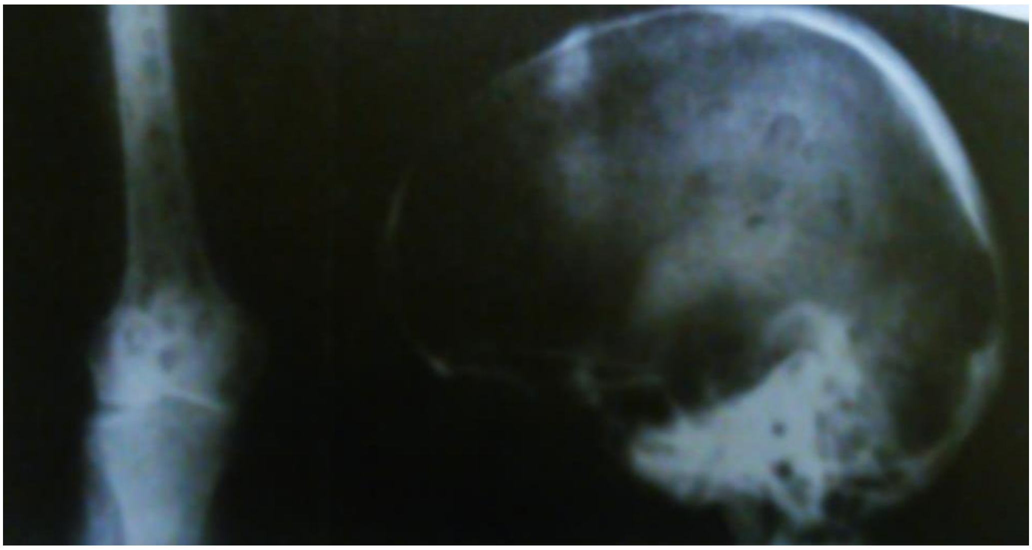


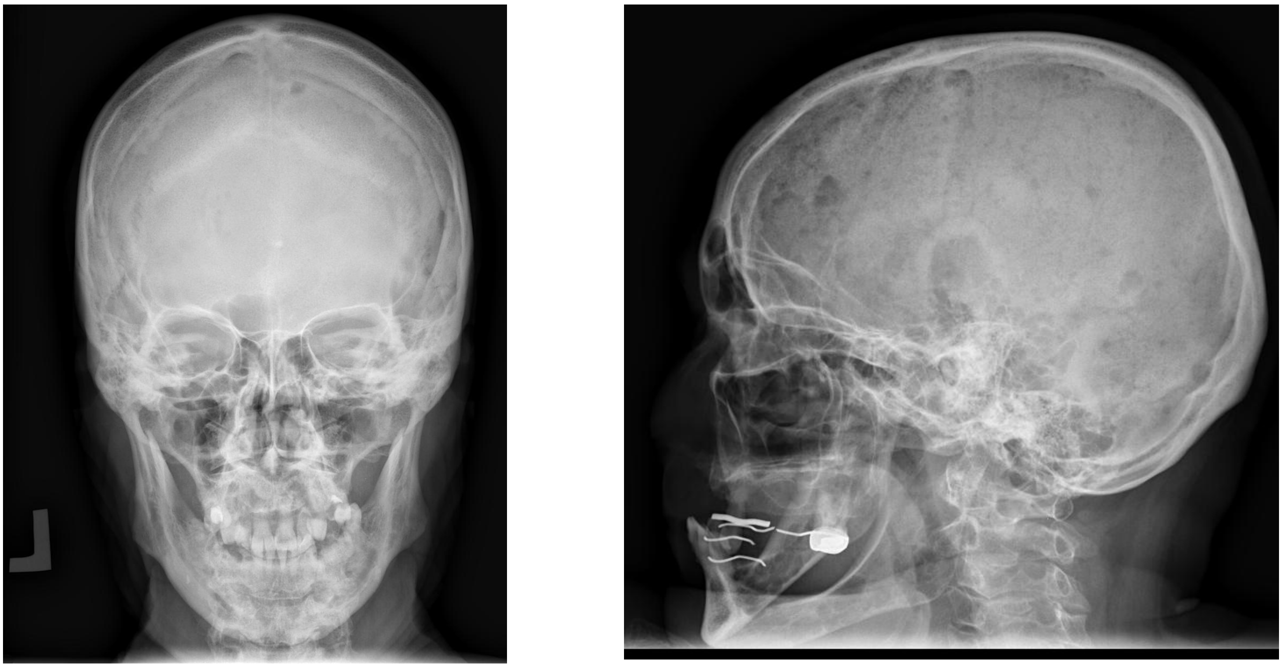
Figure 3. Multiple Myeloma- discrete punched out areas-no reactive sclerosis.

Myeloma is diagnosed the contemporary diagnosis is based on imaging with the use of X-rays of commonly involved bones. Myeloma is generally thought to be incurable but highly treatable. Remissions may be induced with steroids, chemotherapy, proteasome inhibitors, immunomodulatory drugs such as thalidomide or lenalidomide, and stem cell transplants. Radiation therapy is sometimes used to reduce pain from bone lesions [2].

Material and methods

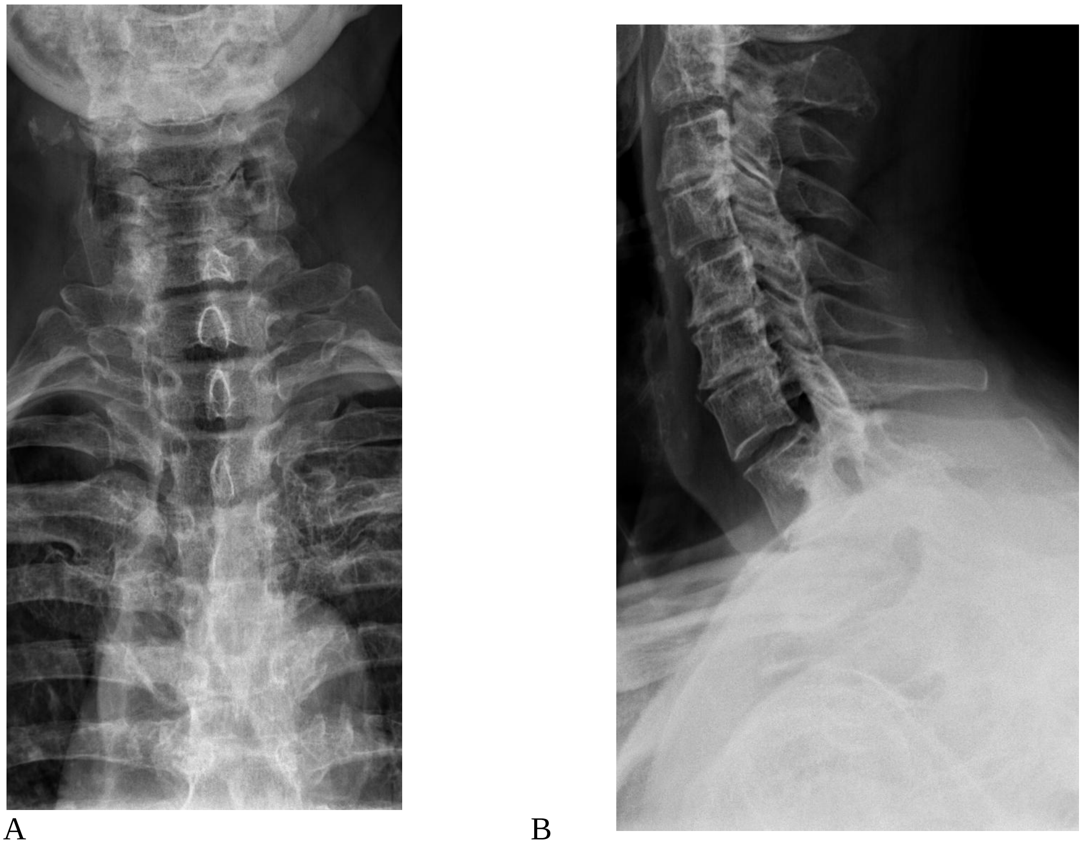
20 patients with Multiple Myeloma (10 women and 10 men between 50 and 80 years of age) who underwent x-ray bone were included in this study. Each patient had a bone digital X-rays: chest, skull, long bones, spine (cervical, thoracic, lumbar).

Digital X-rays of the spine were performed in two projections: anterior-posterior and lateral.



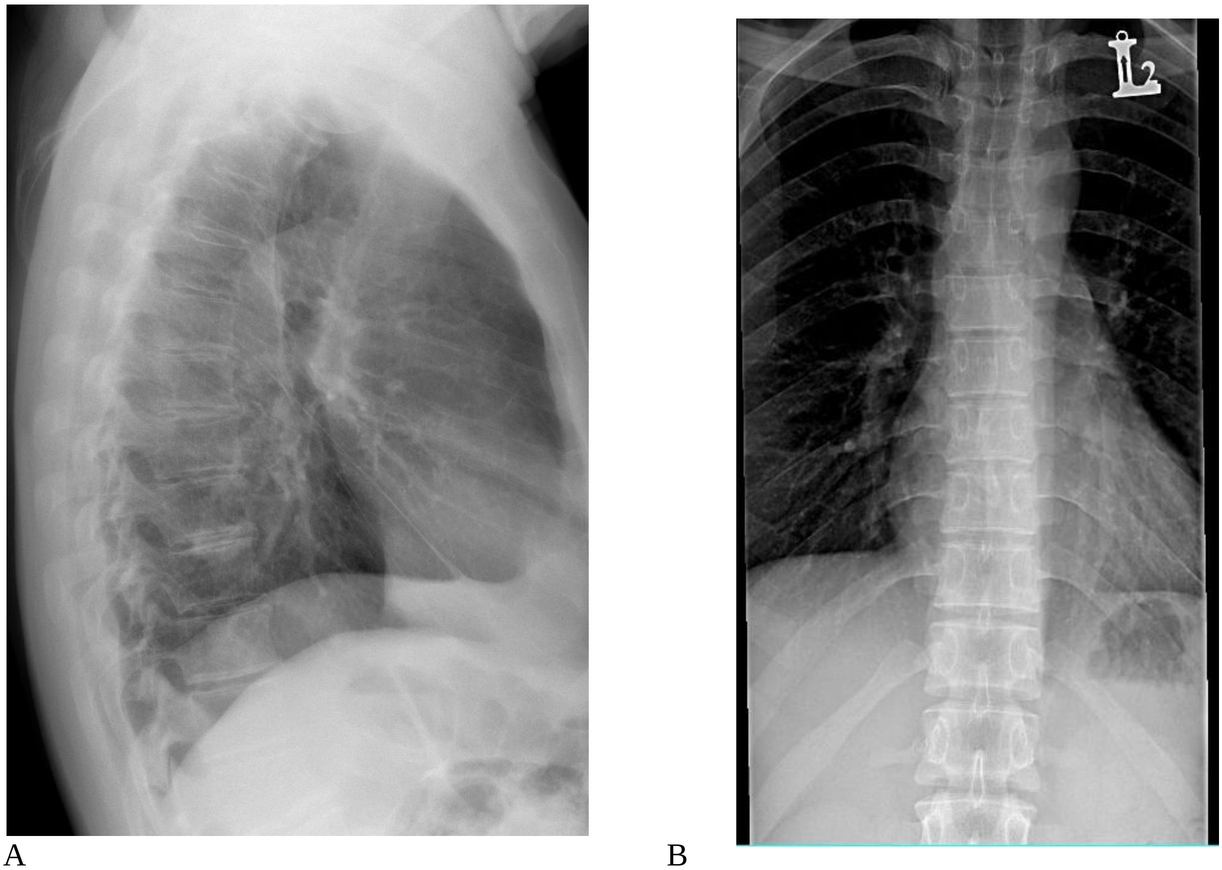
A B

Figure 4. Digital X-ray skull of the patient with multiple punched out areas-no reactive sclerosis , A. P-A B. Lateral.



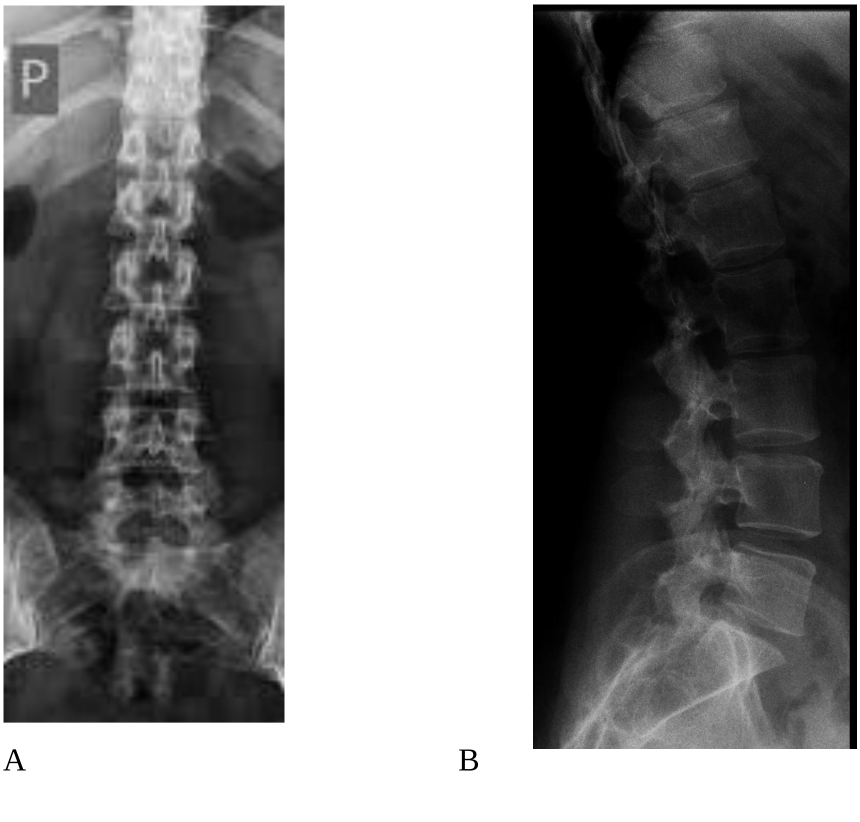
A B

Figure 5. X-ray spine C .A. Anterior-Posterior B. Lateral.



A B

Figure 6. X-ray spine Th .A. Anterior-Posterior B. Lateral.



A B

Figure 7. X-ray spine L .A. Anterior-Posterior B. Lateral.

Figure 8. X-ray pelvis A-P

Figure 9. X-ray femora A-P

Results

Multiplex plasmocytoma demonstrated in 60 per cent of the cases. Most frequently 80% of patients had bone lesions.Three patients had a neurological complications in relation to the pathologic fractures in the lumbar spine with bone pain frequent.Pathologic fractures at the site of involvement are frequent. Vertebrae which are involuted have a particular propensity toward collapse and even when collapsed retain the bubble-like apperance characteristic of this disease.

Figure 10. Pathologic fracture vertebra.

Discussion

Radiographically, one sees numerous sharply circumscribed defects throughout the bones with no reactive sclerosis. In many cases also be a diffuse osteoporosis with no particular punched-out area. Usually there is no periosteal reaction. Bone pain affects almost 70%of patients and is the most common symptom. Myeloma bone pain usually involves the spine, mainly in the lumbar spine.

Persistent localized pain may indicate a pathological bone fracture. Pathologic compression fractures of the vertebrae are common, particularly in reaction to osteolytic metastases and the osteolitic marrow type tumors such as myeloma, neuroblastoma, lymphoma. Although the exact primary nature of the tumor is usually not recognizable, the vertebral architectural obliteration or other trabecular alteration usually provides a clue as to the nature of the primary cause of the wedged appearance of vertebrae so affected.

Figure 11. X-ray pelvis A-P.

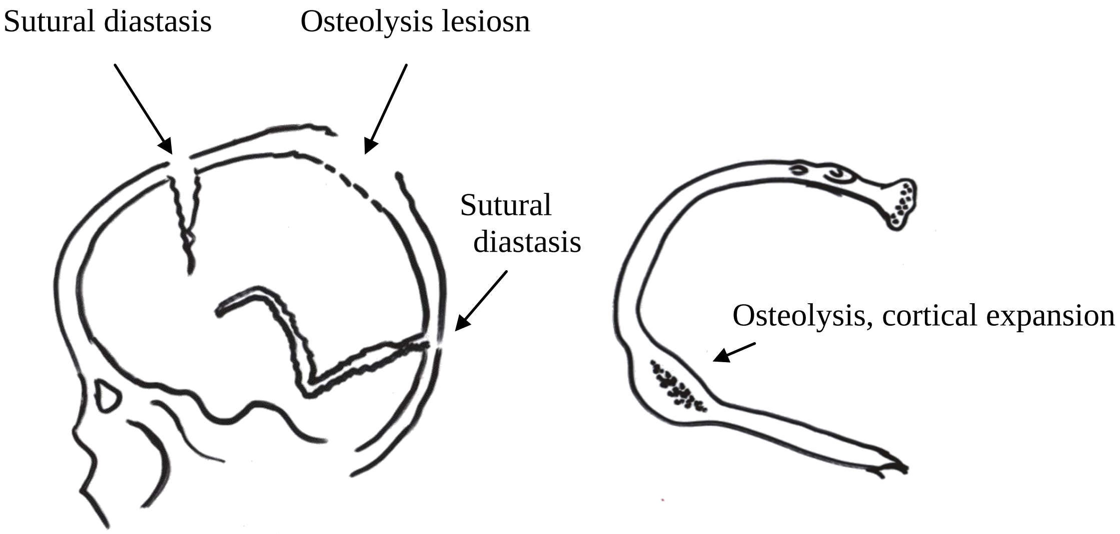


Figure 12. Salient roentgen pathologic fractures of neuroblastoma (own drawing).

Multiplex myeloma differentiated, for example, neuroblastoma, where changes are osteolysis - slight cortical expansion layer-like subperiosteal.

Kahler's disease numerous sharply circumscribed defects throughout entire bone, no relative sclerosis.

Conclusions

Diagnostic X-rays of the pelvis limit artifacts of the digestive gas in the intestines. However, the patients receive a dose compared to CT is much lower. Therefore, necessary to repeat diagnostic radiology (X-rays) in the course of the disease.

REFERENCES

1. Meschan I.: Roentgen Signs in clinical practice. Meschan. 1966, 1, 278-303.
2. Raab M.S., Podar K., Breitkreutz I., Richardson P.G., Anderson K.C.: Multiple myeloma. Lancet 2009, 374, 324–339.

Szostek Karolina, Zalewska Krystyna

The quality of a process of a communication between a nurse and a patient

Students Scientific Society, Propedeutics Department of Nursing and Social Sciences, Department of Health and Human Sciences, State Higher Vocational School in Ciechanów

Introduction

Interpersonal communication is a very complex process which is used by people to communicate with each other. In general it is defined as gaining and exchanging information, rather than a common phenomenon that accompanies people in daily life (animal as well), a kind of condition of individual and social life. Usually it is processed by oral and written language and also non-verbal communications that can appear with those verbal communications at the same time [1].

Communicating is a basic factor of nursing care and one of condition of patients and their family satisfaction. Having the ability of making correct communication is necessary to create proper human relationships and is important to reach satisfactory life comfort, self-realization, self-development, self-motivation of acting. Communicating is not a method of treatment but a psychological reaction used as a useful aid [2,3].

Communicating is one of the basic needs, especially of the ill and suffering people. The responsibility for the quality for communicating with a patient lies on the whole therapeutic team in which a nurse is also included. Communicating consists of every positive contact with patient that has impact on patient's physical condition and general frame of mind as well as support of nursing care, treatment and rehabilitation of patient that is carried out by skilful and carefully planned holding of the conversation [2].

A medical team have the very first contact with the patient during the inquiry. Patients that are satisfied with their communication conducted with the medical team assess better the received treatment. They are more satisfied with nursing care and moreover are gaining better effects in their therapy. And these are the reasons why communication between the whole team - in which the nurse is included – and the patient has a significant importance in a caring and healing process [3]. It is impossible to successfully conduct the treatment and nursing care without making proper contact with the patient who leads to satisfactory cooperation between a patient and a therapeutic team [4].

The aim of nurses' communication with the recipients of their services should be both-sides understanding, creating proper relationships and giving effective counsel. The main factor that determines the proper process of communicating between a nurse and her patient is that the value of both sides should not be against each other, e.g. patient's health is a nurse's value, however for the patient who is not willing to live, and this is not valuable at all [5].

Communicating in nursing care very often puts therapeutic meaning on the conversation.Correct therapeutic relation should be known for its acceptance, empathy, assertiveness, diplomacy which in one word is a called professionalism. Thanks to that it is possible to get familiarize with patient's problem and being able to give the needed help, which is expected from the whole medical team. Touch could be another form of communication. Therapeutic touch strengthens positive relations, calms down, makes patients feeling safer and helps in healing their souls [6].

To establish a high level the quality of communicating process all communicating boundaries that harden creating the wanted relationship nurse-patient should be removed. They are not consciously controlled, so that means the nurses usually are not aware of making it. The most common communicating mistakes that occur in communicating process with a patient are unconsciously made by nurses: prescribing/ordering, rebuking, moralizing, assessing/judging as well as blaming, ignoring and interrupting. Disadvantageous influence on quality of communicating process for sure has blockades - non-verbal communication that is strongly connected with body language. It should be remembered that 65% of information (especially at the very first meeting) are shown in a non-verbal way (gestures, mimicry, voice ton and outfits) [5]. The most happening communicating blockades that are unconsciously made by nursing staff are behaviour like: avoiding eye-contact by excessive studying medical documentation, pen play etc. This previously mentioned specific patterns of behaviour increase the distance between a patient and medical staff which, on the other hand, makes a proportionally inverse situation from the expected one [4].

The aim of this survey was to get to know the quality of communicating process between a nurse and a patient and to define which one of nurses' attitudes and behaviour is a major factor in such communicating process. During researches defining what kind of problems nurses find in communicating with patient was also taken into account.

Materials and methods

150 nurses working in Provincial Specialist Hospital (Specjalistyczny Szpital Wojewódzki) in Ciechanów in a period between December and March 2013/2014 participated in the researches. Among the surveyed nurses were 150 women (100%). The group consists of females aged between 25 and 60 (the average age is 43 years old); (SD=7.47). The average of the questioned nurses' working years is 21 years (SD=8.37). Most of the questioned nurses

have higher education- 91 women (60.7 %), however 59 women (39.3 %) have only secondary education.

65 nurses of the group (43.3%) mostly worked with children and 64 nurses (42.7%) worked with adults. For the rest 14% of surveyed the typical patients were the elderly.

Most of surveyed nurses declared participation in interpersonal communication training. A hundred of the questioned nurses in the last 5 years attended the interpersonal communication training, while 50 nurses (33,3%) claimed that they had not taken part in any interpersonal communication trainings.

In researches were used methods of diagnostic survey, survey technique. As a research tool was used a Self-esteem and Quality of Pro-social Communication application. The application consisted of 17 closed questions referring to the nurses' attitudes and behaviour during the process of communicating with the patient. The questions from the application were closed, so the respondent could only choose one of the given answers. The questions were capturing the knowledge of openness and readiness to accept the patient, initiating the conversation with the patient, ensuring patient's dignity, the quality of listening to the patient and forwarding the information, the positive attitudes to the way of solving the problems, explaining the rules and procedures of healing in a pro-social way as well as the checking and controlling the process of communicating with the patient.

Psychometric properties of the researching tool were good. The reliable indicator measured by alfa Cronbach method was 0,810.

The obtained results were given into statistic analysis and statistic verification of the hypothetic statements. To the average comparison was used t-Student test, U Manna-Whitney test was used to the independent sample group and Spearman correlation. The importance level of statistic resulting was told to be at $p<0.05$. 150 completed and correctly filled applications were received during the surveying process.

Results

The average result in a communicating scale was 69.25 ($x=69.25$) ($SD=7.85$). The results schedule is not a usual schedule (Z Kołmogorov Smirnov =1.557, $p= 0.016$). Among the results those higher are dominating.

The communicating process plays the basic role in creating the relation nurse-patient, which has impact on the quality of listening to the patient, quality of transferring and ensuring the dignity for the patient. The results for ensuring by the nurse the patients' dignity were placed in the scale at the point 4.45 the average of the quality of the transferring process was 4.36 whereas the score in the quality of listening to the patient on a self-esteem scale was pointed at 4.34.

The most numerous group of the questioned nurses – 83 women (55.3 %) always treat their patients with honour, sensitively asking about their private affairs, accepting their emotions both positive and negative. They do not avoid questioning what patient says or tries to say and find it obvious and also they do not diminish it. Another 54 women (36%) said that they often ensure their patients' dignity. However 11 asked nurses (7.3%) ensure their patients dignity sometimes. The smallest group of questioned consisting of 2 people (1.3%) said that they never ensure their patients' dignity (Tab.1.).

Table 1. Self-esteem of ensuring the patient's dignity.

Ensuring patients' dignity	The amount of surveyed	Interest rate (%)
Never	-	
Rarely	2	1.3
Sometimes	11	7.3
Often	54	36.0
Always	83	55.3

74 women (49.3%) of the questioned group always transfer the information to patients in the most friendly, clear and suitable to patients' personality, culture, age, abilities and limitations way. 58 nurses showed that transfer of information is made in an understandable way. 17 nurses stated that sometimes their quality of transfer of information is understandable for the patient although 1 questioned nurse (0.7%) explained that rarely their transfer quality is adapted to patient's abilities (Tab.2.).

Table 2. The quality of transfer of information.

The quality of transfer of information	The amount of surveyed	Interest rate (%)
Never	-	-
Rarely	1	0.7
Sometimes	17	11.3
Often	58	38.7
Always	74	49.3

A very similar number of those questioned: 69 nurses (46.0%) and 68 nurses (45.3%) showed that always or at least very often try verbally and non-verbally to make patient feeling to be listened to. 10 nurses (6.7%) stated that only sometimes listen to their patient carefully whereas the least numerous group of 3 nurses (2%) marked that they rarely listen to their patient (Tab.3).

Table 3. The quality of listening to the patient.

The quality of listening to the patient	The amount of surveyed	Interest rate (%)
Never	-	-
Rarely	3	2.0
Sometimes	10	6.7
Often	69	46.0
Always	68	45.3

The most numerous group of respondents- 66 nurses (44%) admitted that very often they wonder and check if the communication with patient is successful and they adjust if patients do understand the questions and recommendations and they assure themselves if patients are aware of meaning of the medical terms that are used by them. An equal number of surveyed – 39 nurses (26%) answered: sometimes and always verify and control the process of communicating with patient. Although 6 nurses (4%) rarely control the communicating process.

Table 4. Verifying and controlling the process of communicating.

Verifying and controlling the process of communicating	The amount of surveyed	Interest rate (%)
Never	1	0.7
Rarely	5	3.3
Sometimes	39	26.0
Often	66	44.0
Always	39	26.0

63 nurses (42%) of the questioned group explained that before they passed on the diagnose and suggested a method of treatment or just other difficult information, they had checked patient's emotional state, spatial and time conditions so they were suitable for the patient. 48 nurses (32%) declared that they always start a conversation with patient. 29 nurses (19,3%) sometimes check if the conditions to start the conversation with patient are appropriate. However, 5 nurses admitted that they rarely and never check and/or control the communication process.

Openness to revealing nurses' emotions was scored at the lowest level in this research, an acceptance what is seen as negative aspects and putting off those negative thoughts and emotions during the conversation with patient. Scores in a scale of removal of other thoughts and emotions during the communicating process between a nurse and a patient were 3.87, the average in acceptance which is seen as a negative by a patient was 3.64 but the lowest score in this scale of nurses' self-esteem concerned an openness to revealing emotions by nurse and was pointed at 3.42.

Table 5. Openness to revealing emotions.

Openness to revealing nurses' emotions	The amount of surveyed	Interest rate (%)
Never	9	6.0
Rarely	16	10.7
Sometimes	47	31.3
Often	59	39.3
Always	19	12.7

The group of 59 nurses (39,3%) say that they very often show their emotions (worries, doubts and joy) to their patients and their expectation of problems that might occur. 47 nurses (31,3%) said that their emotions are expressed during the conversation with patient. And 19 nurses (12,7%) claimed that they always show their emotions and feelings to their patient. However 9 nurses (6%) of this questioned group never reveal their emotions to their patients.

Table 6. Acceptance of those aspects which are seen negatively.

Acceptance of those aspects which are seen negatively	The amount of surveyed	Interest rate (%)
Never	2	1.3
Rarely	8	5.3
Sometimes	51	34.0
Often	70	46.7
Always	19	12.7

The majority (70 nurses – 46.7%) often accept those negative features that might be seen by patients and the negative features that are already noticed by themselves. 51 nurses agreed that sometimes accept what might be regarded as negative feature. However, it seems to be always accepted by only 19 nurses (12.7%).

Table 7. Removing feelings and thoughts.

Removing feelings and thoughts	The amount of surveyed	Interest rate (%)
Never	-	-
Rarely	11	7.3
Sometimes	33	22.0
Often	70	46.7
Always	36	24.0

It is shown that the most numerous group of the questioned nurses – 70 nurses (46.7%) very often can remove their feelings and worries to be in a 100% ability to pay attention only to the patient, less numerous group of 36 nurses claimed that they always put away their private affairs while they are with patients. 33 respondents (22%) state that only sometimes can remove the emotions and thoughts. Although only 11 nurses (7.3%) are rarely able to clean their minds from private thoughts and feelings during the process of communicating with patient.

Age does not significantly influence nurses' self-esteem (Rho Spearmana=0,157, p=0.056). But it is possible to notice that dependence of the bond between age and individual components. Older nurses make definitely better assessment in self-esteem of the information transfer quality (Rho=0.201*, p=0.014) and in self-esteem of the verifying and controlling the quality of communication process (Rho=0.249*, p=0.002).

Education does not have an impact on the nurses' self-esteem of interpersonal communication (at Mann Whitney's = 2585.0, p=0.701).

The working years influence the level of self-esteem (Rho=0.185, p=0.023). This also positively correlates with: beginning a conversation with patient, self-esteem of the quality of listening to the patient, self-esteem of the information transfer quality as well as with verifying and controlling the quality of the communicating with patient process. This correlation relies on the fact that nurses with longer work experience make better assessment of the components mentioned before.

Table 8. Workload.

How do I feel about it?	The amount of surveyed	Interest rate [%]
Definitely I do not agree with this-I am not overloaded	3	2.0
I rather do not agree with this	6	4.0
Neither I do not agree nor I do agree	20	13.3
I rather do agree with this	56	37.3
Definitely I do agree with this-I am overloaded	65	43.3

The most numerous group of the questioned- 65 nurses (43.3%) definitely agreed with the statement that they feel to be overloaded and burdened with work responsibilities. 56 nurses (37.3%) said that they rather feel to be overloaded with work. Less numerous groups of nurses in number of 20 people (13.3%) do not have precisely defined feeling about this case - they did not find them to be or not to be overloaded with work. Only 6 respondents (4%)

rather do not feel like agreeing with this statement. The smallest numerous group - 3 nurses (2%) definitely claimed not to be overloaded with work.

There is statistically important dependence between work overload and self-esteem of communicating with patient. The questioned nurses are showing higher self-esteem while they are overloaded with work (Rho=0.185, p=0.23). Older respondents estimate themselves better in a field of ensuring patients' dignity, self-esteem of the quality of listening to the patient as well as in verifying and controlling the process of communicating with patient.

Discussion

Communication is a network of interaction between a nurse and a patient. It is an ability that should be learned, improved and successfully used. During the relationship with patient all conditions ensuring patient the feeling of comfort and safety should be provided. Using the rules of proper communication skills and therapeutic techniques by a nurse allows reliable gathering of essential information about the patient as well as giving the patient the possibility for experiencing the feeling to be understood and able to express their feelings, worries, hopes, thoughts, very often connected with relief and better mood [7].

One of the most important people that play educational role in society is the nurse. She is responsible for explaining medical terms referring to health care, personal hygiene, puberty, etc [8].

As a result of still happening changes in health care system there is bigger need of improving the quality of all medical services. The nursing care on the patient should be based on standards that are developed and implemented in a process of nursing [9].

Bio-psychosocial attitude that sometimes appears in modern medicine which is also characteristic for modern nursing clearly indicates the necessity of linking the methods of treatment and nursing with a practically oriented psychology. This linking fully expresses itself in a therapeutic communication with patient[10].

According to the researches done by psychologists, about 75% of all medical diagnosis consist of information gathered from interpersonal communicating process that is done in a form of enquiry with a patient [4].

The results of the surveys state that the nurses' self-esteem is locked on a high level and was referring to ensure the patient's dignity by the nurse. The level of the self-esteem was (4.45) the average of the quality of the information transfer was (4.36). The result in self-esteem scale of the quality of listening to the patient was (4.34). Defining nurse's personal traits, e.g. self-consciousness, sensitiveness and openness is important and helpful in building relationship and the average result was (4.08).

The major problem in interpersonal communication with patient except the already mentioned case of individual interpretation of received signals, is the fact that this process is still in progress of happening and changing as well as dynamic, and a situation that additionally is influenced by lots of factors is difficult to capture in that moment and furthermore is dependent on patient's personality, their expectations, emotions, a type of disease and its level of advance as well as used methods of treatment, their invasiveness and moreover, the moment of conversation beginning. So as it is seen this process requires flexible adjusting to the situation with its circumstances, so it means that the rules of this process have to be flexible as well. Talking about effective communication can be done when in this conversation communicates appear that are suitable to needs caused by specific situation. On the other hand patients are vulnerable to be treated by doctors and nurses like a diseased organ that needs to be healed or removed rather than an ill person. But psychologists focus only on patient’s experiences and expectations. To be able to effectively and professionally communicate with a patient we need to be aware of the fact that this process is completed once it has those two features. Also we cannot let us forget what should be done with patient's body but we cannot forget about all patient's feelings and thoughts concerned with their health, treatment and decisions that they might experience [11].

Helena Motyka during her researches noticed that some people from the therapeutic team are showing no respect to patient's body and present very instrumental attitude towards it. This might arise from her respondents' low self-esteem and unawareness of importance of ensuring patient's dignity [4].

Conversely in proportion to Motyka's researches the surveyed nurses in Hospital in Ciechanów present a different perspective. The most numerous group of surveyed from a nursing team (55,3%) always honours and respects their patients as a human being, sensitively asking about their private affairs and showing acceptance to their emotions both positive and negative. They do not avoid questioning about things said or tried to be said by patient, finding it obvious and are unwilling to diminish it. Another 54 women (36%) said that they often ensure their patients' dignity,11 asked nurses (7,3%) just ensure their patients’ dignity. The smallest group (1,3%) said that they never ensure their patients' dignity.

Another conclusion of this researches that can be drawn is that the good communication between a nurse and a patient requires great and conscious abilities. Usually they are gained during the working years and gaining experience and mostly by the lessons that are based on mistakes that are made. Communicating abilities can be developed by participating and practising in specific trainings as well as our activeness [12].

High self-esteem level of the interpersonal communicating quality also might be connected with the fact that most of the questioned nurses attended trainings regarding interpersonal communication and are aware of importance of this issue. However 1/3 of questioned nurses have never taken part in similar trainings regarding proper communication.

Providing the safety feeling is one of the satisfaction's determinants, whereas satisfaction determines the quality of health care. Taking into account the fact that European Committee WHO admitted that the improvement of health care quality is one of the priority in a field of health care actions, where ISO 9001 norms makes ZOZ (clinics and hospitals) managers obliged to try to increase patients' satisfaction, it is worth noticing what types of medical staff's attitudes influence and shape patients' feeling of safety [13].

The questioned nurses reached a satisfactory for patient level (the average/mean was 4,2) in area of explaining the rules and procedures in a pro-social way. The vast majority of the respondents (70,2%) tries to explain patient the rules of treatment and caring.

Conclusions

1. Most of the questioned nurses do not have any difficulties in communicating with patient. Nurses' self-esteem of the quality of communicating process is quite high.
2. In the questioned nurses' opinion, the gained education and patients' age do not have an impact on the quality of communicating process.
3. According to the researches participation in specific trainings of good communication skills does not influence nurses' self-esteem in a field of communication.
4. The nursing staff is known for serving high standards of quality of listening to the patient, transferring information, being open and showing readiness to accept the patient as well as starting the conversation.
5. There is statistically important dependence between work overload/burdening and the self-esteem of communication with patient. The questioned nurses usually have higher self-esteem when they are overloaded with work.

References

1. Widomska- Czekajska T., Górejek-Jóźwik J.: Encyklopedia dla pielęgniarek i położnych, [w]: komunikowanie interpersonalne, Wyd. Lekarskie PZWL., Warszawa, 2010.
2. Seguła K,: Rozmowa też leczy, Mag. Pielęg. Poł., 2011, 10, 10-11.
3. Lipińska M., Maj K., Romanowska U.: Komunikowanie się z chorym u kresu życia w opinii pielęgniarek, Pielęg. XXI w., 2012, 4, 35-40.
4. Motyka H.,: Komunikacja interpersonalna w opiece medycznej, Med. Rodz., 2010, 13,

24-128.

5. Krajewska- Kułak E., Kwiatkowska A., Panek W.: Komunikowanie interpersonalne w pielęgniarstwie, Wyd. Czelej, Lublin, 2003.
6. Koper D.: Jak postępować z trudnym pacjentem, Mag. Pielęg. Poł.,2009, 6, 20.
7. Gołębiewska K., Górna K., Jaracz K., Jacenko A.: Specyfika komunikowania się pielęgniarki z chorym umierającym., Pielęg. Pol., 2011, 1, 29-33.
8. Szewczuk W.: Psychologia, PWN, Warszawa, 1966.
9. Bączyk G., Ochmańska M., Stępień S.: Subiektywna ocena jakości opieki pielęgniarskiej w zakresie bólu pooperacyjnego u chorych leczonych chirurgicznie. Probl. Pielęg., 2009, 17, 173-177.
10. Motyka M.: Rola aktywnego słuchania w komunikacji terapeutycznej z pacjentem. Probl. Pielęg., 2011, 19, 259-265.
11. Nęcki Z.: Komunikowanie interpersonalne, Wyd. im Ossolińskich, Wrocław, 1992.
12. Mojs E.: Wybrane aspekty komunikacji pielęgniarka - zespół terapeutyczny, Pielęg. Pol., 2006, 2, 135-138.
13. Kamińska M., Brodowski J., Bażydło M., Dąbrowska O.: Postawy personelu medycznego a poczucie bezpieczeństwa pacjenta, Fam. Medica Primary Care Rev. 2009, 11, 881-885.

Contens

MEDICAL PROBLEMS OF PALLIATIVE CARE

QUALITY OF LIFE

THREATS IN THE WORKPLACE

PROBLEMS OF SOCIAL MEDICINE

HEALTH EDUCATION

ISBN- 978-83-89934-99-4