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editorial

Dear Readers,

The journal "Zdravotníctvo a sociálna práca" (Health and Social Work) was renamed in 2021 to International Journal of Health, New Technologies and Social Work.

Our long-term effort is to gradually acquire for the journal European significance and be included in international databases. Starting with issue No. 4 in 2016, the journal accepted the Harvard style of referencing, and changed guidelines for the authors. The aim of the changes was to move closer to the standard in international journals published in English in the area of health and helping professions. The editors are aspiring for registration in other relevant international databases. Since last 2020 the journal has published all articles in English only.

The journal "Zdravotníctvo a sociálna práca" *(Health and Social Work)* was established in 2006 at Faculty of Health and Social Work blessed to P. P. Gojdič in Prešov and St. Elizabeth University College of Health and Social Work in Bratislava. In 2023, the journal celebrated its 18th year of publication.

Previously professional journal, within 5 years developed into an international, peer-reviewed scholarly journal, published quarterly (4 issues per year). The journal were published by the St. Elizabeth University of Health and Social Work in Bratislava. The journal became international in 2009. The journal was published and distributed in the Slovak Republic and also in the Czech Republic.

Since 2011, the journal is published both in print and as electronic issues, available from: www.zdravotnictvoasocialnapraca.sk. Starting by issue No. 3 in 2014, the scope of the journal has broaden and the journal is covering health sciences, such as Public Health, Nursing, Laboratory Medicine, but also helping professions such as Social Work or Pedagogy.

The journal is indexed in the following databases: Central and Eastern European Online Library — CEEOL (since 2018), Bibliographia Medica Slovaca (BMS), and Slovak reference database CiBaMed.

The part of journal is Supplementum, to publish abstracts from international conferences organized by the St. Elizabeth University of Health and Social Work in Bratislava. In 2024, the conference will take place in October, in Zakopane, Poland.

prof. Miron Šrámka, MD, DSc.
redactor-in-chief

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Anniversaries of Vicar General Jozef Zorvan
Výročia generálného vikára Jozefa Zorvana

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ABSTRACT

Backround: In March of 2024, the 142nd anniversary of his birth, and in February of 2024, 62 years since his death Jozefa Zorvana, vicar general for Slovak Greek Catholics, from 1940 to 1950 Bishop Mons. Pavol Peter Gojdič.

Core of Work: In 1918, he was transferred with his whole family to the rectory in the former Klembark, now Klenov. There, in addition to priestly duties, he undertook educational work with the people. He established a fruit orchard and grafted fruit trees, especially different types of cherries. His two-harves cherry orchard was famous, and people from all over came to pick cherries for a small fee. He also taught people to graft, and the poor village in the basin thrived with a variety of fruits. He founded a beekeeping association and, as an avid mushroom picker, introduced people to edible, lesser-known, tasty mushrooms that enriched the modest variety of their diet. He treated cataracts with the sacred oil of myrrh so successfully, that even people from abroad, who had cataracts visited him. He wrote many articles for the publisher Matica Slovenská, which are stored in the archives in Martin.

In Prešov, he was part of the comittee who approved the changes to the eastern rites of the seminarians. At that time, national struggles were taking place between Ruthenian and Slovak seminarians. The Ruthenians (Rusins) were in the minority and were not recognized. He founded a volunteer theater in Klenov. He directed talents such as Janko Borodáč, Jozef Matys and others. He published mainly in the magazine Apostolát of Sts. Cyril and Methodius, some of which he published under the pseudonym Karpaty. Together with his wife, he was a founding member of the Slovak Museum Society. From 1922 he went on the Velehrad Cyril and Methodius pilgrimage, where he served the main liturgy in the Old Slavonic language. He established cooperation with Moravian enthusiasts and with Olomouc archbishop ThDr Anton Stojan. After the establishment of the Jednoty (Union) of Sts. Cyril and Methodius in Michalovce, he became its first chairman.

Conclusion: Jozef Zorvan dedicated his whole life to the welfare of the church and to the uplifting of his people. Thank God for that educated, tenacious and fruitful priers. May his memory be honored!

Key words: Jozef Zorvan, vicar general for Slovak Greek Catholics, Slovak Museum Society, Union of Sts. Cyril and Methodius in Slovakia.

ABSTRAKT

Úvod: V marci 2024 uplynulo 142 rokov od narodenia a vo februári 2024 62 rokov od úmrtia Jozefa Zorvana, generálneho vikára slovenských grékokatolíkov, ktorý pôsobil v rokoch 1940 až 1950 u Mons. Pavola Gojdiča.

Jádro práce: V roku 1918 bol Jozef Zorvan preložený s celou rodinou na faru do niekdajšieho Klembarku (súčasného Klenova). Tam sa okrem kňažských povinností ujal osvetových prác s ľudom. Založil ovocinárstvo a štepil ovocné stromy, najmä rôzne druhy čerešní. Jeho dvojholdový (stará plošná jednotka siahovej sústavy (0,575 ha), jutro) čerešňový sad bol známy a zo širokého okolia sa tam zbiehali ľudia zbierať čerešne za lacný peniaz. Naučil ľudí štepiť stromy a chudobná dedinka v kotline zanedlho hýrila pestrosťou ovocných plodov. Založil včelársky spolok a ako náruživý hubár učil ľudí rozoznávať jedlé a menej známe chutné huby, ktoré obohacovali skromnú pestrosť ich jedálnička. Liečil šedý zákal posvätným olejom mirom tak úspešne, že ho s týmto neduhom zraku navštevovali až zo zahraničia. Písal veľa článkov do Matice Slovenskej v Martine. Tieto články sú uložené v jej archíve. V Prešove zasadal pri prijímaní bohoslovcov, ktorí menili obrad na východný. V tom čase sa odohrávali národnostné boje medzi rusínskymi a slovenskými bohoslovcami, ktorí boli v menšine a boli zaznávaní. V Klenove založil ochotnícke divadlo. Z jeho režisérskych rúk vyšli talenty ako Janko Borodáč, Jozef Matýs a ďalší. Publikoval najmä v časopise Apoštolát sv. Cyrila a Metoda. Niektoré články uverejňoval pod pseudonymom Karpáty. S manželkou Margitou bol zakladajúcim členom Slovenskej muzeálnej spoločnosti.

Od roku 1922 chodieval na velehradské Cyrilometodejské púte, kde slúžieval hlavnú sv. liturgiu v cirkevnoslovanskom jazyku. Nadviazal spoluprácu s moravskými nadšencami a s olomouckým arcibiskupom ThDr. Antonom Stojanom. Po založení Jednoty sv. Cyrila a Metoda v Michalovciach sa stal jej prvým predsedom.

Záver: Jozef Zorvan celý svoj život venoval blahu cirkvi a povzneseniu svojho ľudu! Vďaka Bohu za toho vzdelaného, húževnatého a plodného kňaza. Česť jeho pamiatke!

Kľúčové slová: Jozef Zorvan, generálny vikár slovenských grékokatolíkov, Slovenská muzeálna spoločnosť, Jednota sv. Cyrila a Metoda na Slovensku.

In March of 2024, the 142nd anniversary of his birth, and in February of 2024, 62 years since his death.

Jozef Zorvan's parents, his father Juraj and his mother Mária, born Mlynáriková, came from Kolpach, now Banský Studenec, the District of Banska Štiavnica. They had a small farm and they had three sons, Juraj, Jozef, Ján and a daughter Anna.

Jozef was extremely gifted, loved to learn and read a lot. He borrowed books and magazines from a local priest, who persuaded his parents to let him study further. They didn't have the financial means for it, but finally they agreed.

In 1899, he transferred from the gymnasium in Banská Štiavnica to the local seminary in Ostrihom, where he successfully graduated in 1902. He continued his studies at the theological seminary in Ostrihom.

During his studies, he met Andrej Kmeť, Roman Catholic parish priest in Prenčov, where he spent his free time during the holidays. He helped him with botanical excavations and the preparation of the Bešeň mammoth, which became an exhibit in the Slovak Museum in Martin.

Several Greek Catholic clerics also studied in Ostrihom, from whom he learned that services were conducted in the Old Slavonic language, which was brought to us by Sts. Cyril and Methodius. The young theologian chose them as his patrons and remained faithful to the Cyril Methodist idea throughout his life.

When the management of the seminary learned that the young Jozef Zorvan was gathering Slovak natives around him and was publishing a Slovak magazine and sending it to Jozef Čarský, they expelled both of them from the seminary. On the recommendation of Andrej Kmeť and the intervention of Košice Roman Catholic Bishop ThDr. Augustín Fischer-Collbrie's, young Jozef Zorvan was accepted by Bishop ThDr Ján Valyi into the Prešov Greek Catholic Eparchy.

After finishing his studies, he got married in 1907. As a deacon, he was commissioned to perform the relevant ceremonies and teach religion in the village of Jakubovany, near Stara Ľubovna. At the same time, he taught at a local school, with his wife Margita.

In 1908, he was appointed a professor at the Greek Catholic Teacher's Institute in Prešov. After permission to change from the Roman Catholic rite to the Greek Catholic rite, he was ordained a priest and was assigned to a parish in Hradisk, the District of Presov. There he became not only a popular priest, but also a notary public, a spreader of culture and enlightenment, and even a healthcare provider.

In 1918, he was transferred with his whole family to the rectory in the former Klembark, now Klenov. There, in addition to priestly duties, he undertook educational work with the people. He established a fruit orchard and grafted fruit trees, especially different types of cherries. His two-harvest cherry orchard was famous, and people from all over came to pick cherries for a small fee.

He also taught people to graft, and the poor village in the basin thrived with a variety of fruits. He founded a beekeeping association and, as an avid mushroom picker, introduced people to edible, lesser-known, tasty mushrooms that enriched the modest variety of their diet. He treated cataracts with the sacred oil of myrrh so successfully, that even people from abroad, who had cataracts visited him. He wrote many articles for the publisher Matica Slovenská, which are stored in the archives in Martin.

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He founded a volunteer theater in Klenov. He directed talents such as Janko Borodáč, Jozef Matys and others. He published mainly in the magazine Apostolát of Sts. Cyril and Methodius, some of which he published under the pseudonym Karpaty. Together with his wife, he was a founding member of the Slovak Museum Society.

From 1922 he went on the Velehrad Cyril and Methodius pilgrimage, where he served the main liturgy in the Old Slavonic language. He established cooperation with Moravian enthusiasts and with Olomouc archbishop ThDr. Anton Stojan.

In this village, during the years of 1918 — 1950, lived and worked Vicar General Rev. Jozef Zorvan (1882 — 1962), pioneer of the Cyrilo - Methodius movement of Greek Catholics. Association of Sts. Cyril and Methodius — 1998

After the establishment of the Jednoty (Union) of Sts. Cyril and Methodius in Michalovce, he became its first chairman.

In 1940, Bishop Mons. Pavol Gojdič appointed him vicar general for Slovak Greek Catholics.

In 1950, due to a serious illness, he retired, but remained in Klenov, where he secretly provided comfort to believers in the banned Greek Catholic Church.

In 1953 he and his family were deported, as undesirable citizens, to Lomnička in the District of Stara Lubovna.

When Andrej Kmeť learned that a mammoth had been found in Beš, (Kmeť, A.,2018) he wrote to pastor Zeleňák asking if he could get the mammoth. Zeleňák tried to have it acquired by a museum in Budapest. Andrej Kmeť started preparing the excavation in Beš. A Jew who owned the land on which there was a mammoth persuaded the subjutant so that it would not fall into the hands of a pan-Slav. Andrej Kmeť bought

the mammoth for 100 gold coins, which was donated to the poor. The wrapped bones of the mammoth were loaded onto wagons and taken to the Prenčovská parish. They invited professor J. Knies from Prague, (Knies, J.,2018) who dissected the bones. He initiated Andrej Kmeť and Jozef Zorvan into the secrets of taxidermy. (Knies, J., 2018). They cooked glue in the cauldron, which they used to coat the bones while hot. The whole rectory was filled with the bones of a mammoth calf six meters high and ten meters long. Even though state institutions tried to transfer the mammoth to Budapest, Andrej Kmeť did not succumb to threats and pressure, and the Bešian mammoth became the property of the Slovak Museum in Martin.

Jozef Zorvan: In 1940, Bishop Mons. Pavol Gojdič appointed him vicar general for Slovak Greek Catholics

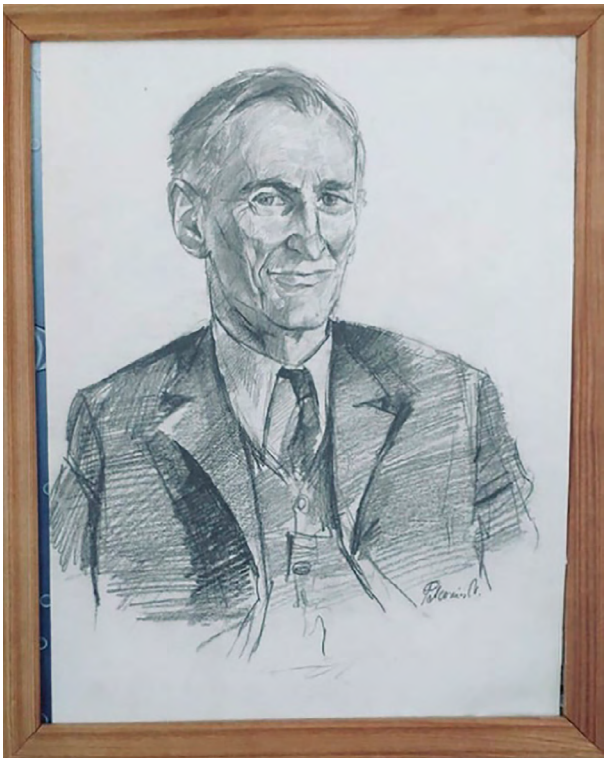
Of his eight living children, Canon, Emil Zorvan, became a young widower and raised three children. His son, Emil Zorvan, became a Greek Catholic parish priest in Michalovce. He had another son, Jozef Zorvan, whose son Michal is a priest in Lutina and whose twin sister Mária is a nun. The second son of Jozef studied at the theological faculty in Prešov. The son of his daughter Viera who studied at the theological faculty in Prešov, died in 1988.

The second daughter, Margita-Emília Šramková, was married to Rev. Ján Šramka.

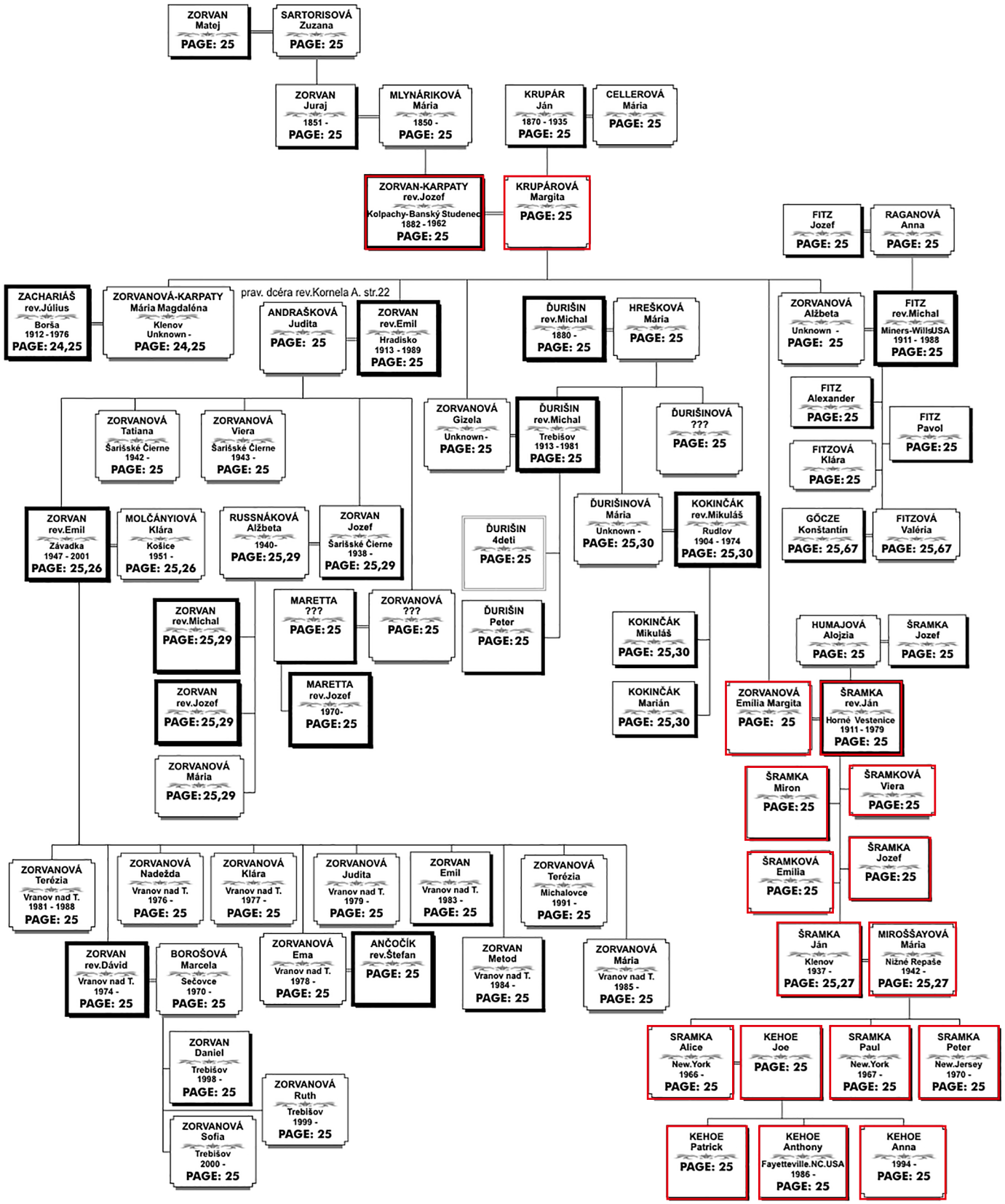
Father Jozef Zorvan had four daughters married to priests. Magdalena was married to Rev. Július Zachariáš, who had a son, Rudolf, a priest, and his daughter Eva was married to Michal Hospodár, a priest from Poprad.

The third daughter, Alžbeta was married to Rev. Michal Fitz. The fourth daughter, Gizela was married to Rev. Michal Ďurišin. (Babjak, J,: 1998; Babjak, J.: 2009).

His son-in-law Rev. Jan Sramka, professor of religion, music and vocals, composed the first Slovak liturgy, after the introduction of liturgical rites from Old Slovanic into the colloquial language.



The painting of Rev. Jan Sramka, Sr. was painted by the academic artist Vojtech Petrovics in 1970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Jozef Zorvan dedicated his whole life to the welfare of the church and to the uplifting of his people. Thank God for that educated, tenacious and fruitful priest. May his memory be honored!

Remembering Bishop Pavol Peter Gojdič, OSBM of the Greek-Catholic (Byzantine) Church of Presov, Slovakia.

Bishop Pavol Peter Gojdič, OSBM (July 17, 1988 — July 17, 1960) was beatified on November 4, 2001.

In July 1944 he visited Father's parish in Nizne Repase, a small village, about 8 miles from the town of Levoca, Eastern Slovakia.

Rev. Vasil Hopko (1904 — 1976), Rev. Metod Dominik Trcka, CSsR (1886 — 1959) and Rev. Miron Podhajecky (1911 — 1995) accompanied him.

Photo 1
From the left:
Rev. Vasil Hopko, Rev. Metod D. Trcka, CSsR, Bishop P. P. Gojdič, OSBM, Rev. Michal Maslej (1903 — 1986) from the parish of Olsavice, Angela Mirossayova (1918 — 1997), mother, Maria Mirossayova (2 y. old), Viktoria (local teacher)

Sitting, from the left:
Rev. Miron Podhajecky, Rev. Alexej Mirossay, Jr. (1916 — 2000)

As a little girl, I was sitting on Bishop Gojdic's lap, noticed the cap on his head, and told him: „You have such a beautiful red cap!"

My niece, Hela, sent it to me, shortly after the altar with the relics was arranged, and pictures were put on the wall.

Photo 2

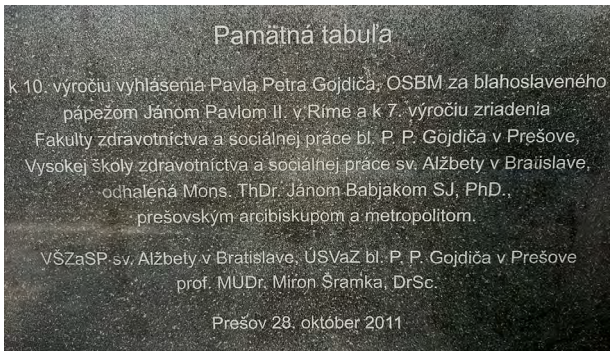
Also, not pictured, Bishop Teodor Romza (1911 — 1947) from Mukacevo, Ukraine was beati ed June 27, 2001.
Rev. Metod Dominik Trcka, CSsR was beati ed on November 4, 2001.
Bishop Vasil Hopko was beati ed on September 14, 2003.

All of the above listed beatified persons died a martyr's death during the persecution of the Greek-Catholic (Byzantine) Church, that started in 1950. In Ukraine it began even sooner. We hope that one day the church will canonized them as saints.

Photo 1 and photo 2 were taken at the Bishop' s Chapel in Presov in December 2013.

A Bust and Memorial Plaque, commemorating the 10th Anniversary of the beatification of Pavol Peter Gojdic, OSBM by Pope John Paul II in Rome, and the 7th Anniversary of the founding of the Faculty of Health Care and Social Work of Blessed P. P. Gojdic in Presov of the St. Elisabeth

University of Health Care and Social Work In Bratislava, was unveiled by Mons. ThDr. Jan Babjak, SJ, PhD, Archbishop and Metropolitan of Presov.



MEMORIAL PLAQUE
commemorating the 10th Anniversary of the beatification of Pavol Peter Gojdic, OSBM by Pope John Paul II in Rome, and the 7th Anniversary of the founding of the Faculty of Health Care and Social Work of Blessed P. P. Gojdic in Presov of the University of Health Care and Social Work of St. Elizabeth in Bratislava, was unveiled by Mons.ThDr. Jan Babjak, SJ PhD., Archbishop and Metropolitan of Presov.

University of Health Care and Social Work of St. Elizabeth in Bratislava, Faculty of Health Care and Social Work of Blessed P. P. Gojdic in Presov

P. P. Gojdic in Presov
Prof. MUDr. Miron Sramka, DrSc
Presov, Oktober 28, 2011

The Bust and Memorial Plaque will be gifted and placed in Lutina, by the family and the descendants of Rev. Jan Sramka, Sr. and Vicar General Jozef Zorvan, while on a Pilgrimage (Odpust) there, on August 18, 2024.

They previously attended a family gathering in Bratislava on June 20, 2024.

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Implementation of professional ethics in the practice of a social worker

Implementácia profesijnej etiky v praxi sociálneho pracovníka

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ABSTRACT

Introduction: In the article, we describe the code of ethics of a social worker with an emphasis on the importance of professional ethics in the relationship of a social worker versus recipients of social services.

Reserach objectives: The main aim of our work was to point out the connection between ethics and social work, the application of the code of ethics in the practice of a social worker in selected social service facilities.

Material and methods: In the conducted research, which was of a quantitative character, we used a questionnaire method to determine the application of the code of ethics in the practice of a social worker in three selected social services facilities in the city of Košice. The goal of the research was to confirm that the code of ethics affects social workers in the performance of their profession, as well as recipients of social services and their life in the facility.

Results: The implementation of the code of ethics in the practice of a social worker is beneficial and at the same time improves life for recipients of social services in facilities.

Conclusions: The code of ethics is the basis for quality social services, so within our results we can state that it improves life for recipients of social services in the facility. The professional ethics of a social worker is an important component for his practice.

Keywords: Ethics, Social Work, Social Worker, Code of Ethics

ABSTRAKT

Úvod: V príspevku popisujeme etický kódex sociálneho pracovníka s dôrazom na dôležitosť profesijnej etiky vo vzťahu sociálny pracovník verzus prijímatelia sociálnej služby.

Cieľ práce: Hlavným cieľom našej práce bolo poukázať na prepojenie etiky a sociálnej práce, aplikácia etického kódexu v praxi sociálneho pracovníka vo vybraných zariadeniach sociálnych služieb.

Materiál a metodika: V realizovanom výskume, ktorý mal kvantitatívny charakter, sme dotazníkovou metódou zisťovali uplatňovanie etického kódexu v praxi sociálneho pracovníka v troch vybraných zariadeniach sociálnych služieb na území mesta Košice. Cieľom výskumu bolo potvrdiť, že etický kódex ovplyvňuje sociálnych pracovníkov vo výkone profesie a rovnako aj prijímateľov sociálnych služieb a ich život v zariadení.

Výsledky: Implementácia etického kódexu v praxi sociálneho pracovníka je prínosom a zároveň skvalitňuje život prijímateľom sociálnych služieb v zariadeniach.

Záver: Etický kódex je základom pre kvalitné sociálne služby, preto v rámci našich výsledkov môžeme konštatovať, že zlepšuje život prijímateľov sociálnych služieb v zariadení. Profesijná etika sociálneho pracovníka je dôležitou zložkou pre jeho prax.

Kľúčové slová: etika, sociálna práca, sociálny pracovník, etický kódex

Introduction

Nečasová (2001) claims that the topic of social work ethics rarely appears in professional literature. Nevertheless, ethics in the countries of Western Europe has been a very topical topic for the last twenty years and has become the subject of many professional discussions. The authors of the Anglo-Saxon world have reached a consensus that ethics could be a phenomenon that can be a link between individual specific areas that social work involves. Increased interest in ethics in the context of social work is mainly stimulated by discussions related to incidents in the practice of social workers who have failed in the moral field. The limitation of resources that flow into the social sphere and the use of new and unexplored technologies that bring with them ethical dilemmas also have a great impact. Expert discussion devoted to ethical issues helps social workers to be able to act correctly when they have to make a decision that falls within the moral sphere.

The code of ethics is a set of standards that govern the professional behavior of social workers. It is relevant to all social workers and social work students, regardless of their specific function or setting. (Mátel 2018)

Professional ethics is a type of applied ethics. Professional ethics can be viewed as a set of rules of conduct that are expected of a person of a given profession when performing work and at the same time allow him to self-reflect on this activity. These naturally develop together with the field and ensure both confidence in professional conduct and the related credibility of the given profession. (Rapčan 2021)

After creating the code of ethics, it is time to implement it. We understand implementation as the introduction of a code of ethics into the practice of a social worker. The code of ethics of a social worker should not be a forced implantation of a moral law at individual levels of management, compliance with which would be forced by external incentives. (Slovak Chamber of SW and ASW 2021)

The risk of the code of ethics lies in the fact that it can only represent a form of an obligation that must be fulfilled, the values and principles should be close and personal to the workers and should also be reflected in their personal life, not only in the profession. Problems can also often arise during the actual creation of codes, when in some areas they can be disputed and difficult to define or describe. Clarity in the wording is therefore necessary when creating a code of ethics in order to avoid misinterpretation. Many authors are critical of codes, pointing to the importance of the internal disposition of a person before external rules and a certain limitation inherent in universality and unattainability, which can lead to employee frustration. (Reamer 2023)

The code of ethics is a support for social workers. The explicit inclusion of self-care in the code of ethics confirms its value and importance for professionals as an integral part of ethical practice, thus encouraging its promotion and practice. (Grise-Owens, Miller 2021)

One of the goals of the code of ethics can be to help solve ethical problems and dilemmas. Another goal is the standard for professional behavior among experts of a specific profession, and the formation of professional responsibility and the creation of a system and mechanism for the management and control of this responsibility is mentioned as the last goal. (Barnsley 2020)

The Code also mentions the duty of workers to take care of themselves professionally and personally, in the ethical principle of trustworthiness, where it points to the role of self-care in realizing how personal difficulties affect workers and their professional practice. (Powers, Engstrom 2021)

The Code encourages workers, organizations and educators to engage in self-care. (NASW 2021)

Research objectives

The main goal of the research was to point out the connection of ethics with social work, the application of the code of ethics in the practice of a social worker in selected social service facilities and the impact of the provision of social services in the facility in connection with the code of ethics.

Material and Methods

We carried out quantitative research focused on mapping the application of the code of ethics in the practice of social workers in selected social service facilities and on the quality of life of recipients of social services as a result of the application of the code of ethics. The goal of the research was to confirm that the code of ethics affects social workers in the performance of their profession, as well as recipients of social services and their life in the facility. Data collection was carried out in March 2024 and 127 respondents participated in our research. We then processed the data from the questionnaire using descriptive statistics. We included social workers and recipients of social services from three specific social service facilities in the district of Košice in the sample set. The research sample consisted of an occasional, non-random selection. This sample consisted of 127 respondents, while we divided the respondents based on gender, age, whether they are social workers or recipients of social services, and according to the selected social service facilities.

Hypotheses

H1: The implementation of the code of ethics in the practice of a social worker is beneficial.
H2: The application of the code of ethics affects life for recipients of social service facilities.

Results

H1 The implementation of the code of ethics in the practice of a social worker is beneficial. We formulated the hypothesis based on theoretical knowledge according to Mátel (2018), who says that ethics is not only a special part of social work as a profession, but is an inseparable part of it. It is important that the theoretical knowledge of ethics is incorporated into the moral thinking and actions of social workers within the framework of providing social services. The code of ethics does not guarantee ethical behavior, but it has a positive effect on the entire field of work and relationships within the provision of these services. Through research, we found out whether the implementation of the code of ethics in the practice of a social worker is beneficial.

Respondents had a choice from a scale of options 1 — 5. Whereby 1 represents completely disagree and 5 completely agree. The average score of the respondents was 3.93, which represents the answer I agree. So, based on our findings, we can say that the hypothesis has been confirmed.

H2 The application of the code of ethics improves the quality of life for recipients of social services facility. We formulated the hypothesis based on theoretical knowledge according to Tvrdoň et al. (2014), who claims that knowledge of ethics is an essential part of the professional activity of social workers. His ability and commitment to act in accordance with the code of ethics is a basic prerequisite for the quality of the provision of social services.

Table 1: H1 The implementation of the code of ethics in the practice of a social worker is beneficial

H1	Scale 1 completely disagree to 5 completely agree									
	1	2	3	4	5					
	f	%	f	%	f	%	f	%	f	%
Question no. 5	2	4,87	3	7,31	5	12,19	9	21,95	22	53,65
Question no.6	2	4,87	2	4,87	5	12,19	18	43,9	14	34,14
Question no. 7	4	9,75	7	17,07	12	29,26	11	26,82	7	17,07
Question no.8	1	2,43	6	14,63	5	12,19	19	46,34	10	24,39
Question no. 9	1	2,43	6	14,63	13	31,7	13	31,7	8	19,51
Question no. 10	1	2,43	2	4,87	2	4,87	20	48,78	16	39,02
Question no. 11	1	2,43	3	7,31	1	2,43	13	31,7	23	56,09
Question no. 12	2	4,87	3	7,31	4	9,75	14	34,14	18	43,9
Together	14	29,22	32	78	47	114,58	117	285,33	118	287,77

Source: Author

Table 2: H2 Application of the code of ethics in social service facilities

H2	Scale 1 completely disagree to 5 completely agree									
	1		2		3		4		5	
	f	%	f	%	f	%	f	%	f	%
Question no. 4	1	1,16	1	1,16	11	12,79	50	58,13	23	26,74
Question no. 5	2	2,32	1	1,16	13	15,11	41	47,67	29	33,72
Question no. 6	1	1,16	2	2,32	11	12,79	32	37,2	40	46,51
Question no. 7	1	1,16	3	3,48	11	12,79	43	53,48	28	32,55
Question no. 9	0	0	0	0	10	11,62	43	50,01	33	38,37
Question no. 10	0	0	5	5,81	8	9,3	38	44,18	35	40,69
Question no. 11	0	0	3	3,48	11	12,79	29	33,72	43	50,01
Question no. 12	0	0	5	5,81	13	15,11	44	51,16	24	27,9
Together	5	5,8	20	23,22	88	102,3	320	375,55	255	296,49

Source: Author

Through research, we found out whether the application of the code of ethics improves life of the recipients of social services in the facility. The questions are included in the author's questionnaire aimed at recipients of social services. Respondents had a choice from a scale of options 1-5. Whereby 1 represents completely disagree and 5 completely agree. Most respondents marked level 4 on the scale, which represents the answer I agree. The average score of the respondents was 4.19, which represents the answer I agree. So, based on our findings, we can say that the hypothesis was confirmed.

Discussion

In the first hypothesis, we mapped whether the application of the code of ethics is beneficial for the performance of the social worker profession. Based on our results, which we processed statistically, we found that the hypothesis was confirmed for us and the application of the code of ethics is therefore a benefit. The second hypothesis examined whether the application of the code of ethics improves the quality of life in the institution for recipients of social services. From the research results, we can say that within our research sample, this hypothesis was confirmed. Mátel (2022), conducted research in November 2010, the aim of which was to submit a draft revision of the ethical code of social workers in the Slovak Republic. He appealed to the need to update the ethical code of social workers in Slovakia. Through this research, Mátel prompted two revisions of the code of ethics. The first revision of the code of ethics was implemented in 2019 and the second in 2021. Both revisions were reactions to global stimuli.

In connection with our research, we can state that the revision of the code of ethics was a benefit, because within the revision the ethical responsibility of the social worker towards himself was supplemented. So we can say that the implementation of the code of ethics in the practice of the social worker is definitely beneficial as well as in our research. Based on the application of the code of ethics in the practice of the social worker, the quality of the social services provided by the social worker in the social services facility also improves, which was also confirmed in our research.

Conclusion

Professional ethics in the practice of a social worker is an important element for the performance of his profession. The results of the research point to the fact that social workers are properly familiar with the code of ethics when they start work and are aware of its importance, they know the individual points and apply ethical responsibility not only to recipients of social services but also to themselves. They are continuously educated in various forms and participate in supervisions. The implementation of the code of ethics in the practice of a social worker is clearly beneficial, however, according to our research sample, there are no sanctions for non-compliance. The code of ethics is the basis for quality social services, so within our results we can state that it affects the life for recipients of social services in the facility. According to our results, not all respondents agreed that the code of ethics affects their life in the facility in some way, their answer was neutral, which can be considered that they do not have sufficient knowledge about it. However, we cannot apply the researched results to the entire population. The professional ethics of a social worker is an important component for his practice. It is necessary for the performance of the profession not only towards recipients of social services, society, colleagues, workplace, profession, but also towards himself.

Conflict of interest

The authors declare that there is no conflict of interest regarding the publication of this article.

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The quality of life of the patients with rheumatoid arthritis before and after balneotherapy

Kvalita života pacientov s reumatoidnou artritídou pred a po balneoterapii

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ABSTRACT

Objective: Rheumatic diseases are the most common reasons of partial disability and the fourth leading reason of the full disability. The rheumatoid arthritis (RA) is a chronic autoimmune disease characterized by synovium inflammation with subsequent joints harming. The complex RA treatment has several objectives — symptomatic relief, suppression of active inflammation, prevention of tissue damage, improvement of physical function, self-reliance, and improvement of the quality of life. The integral part of the therapeutic approach to patients with chronic musculoskeletal disease is a spa treatment. Spa treatment has positive impact on the quality of life improvement. Properly performed spa treatment does not only reduce the pain, but it also improves the function of musculoskeletal system and furthermore it positively affects the quality of life. Physiotherapy is an integral part of RA complex treatment, and it participates in preventive measures with patients in the initial stage of disease without major disability.

The aim of the present work: Men since Ancient times used natural healing sources for diseases treatment as well as for health strengthening. „Spa treatment is one of the oldest therapy methods. It is based on the healing effects experience of some water sources, mud or climate locations. An essential part of modern spa treatment is utilization of objectified therapeutic effects of natural medicinal resources, physical medicine, rehabilitation, nutrition, psychotherapy and pharmacotherapy. The main objective of this work is the assessment of spa therapy effects on patients´ quality of life with rheumatoid arthritis. 1. Based on the SF-36 questionnaire find out the changes of quality of life evaluation with RA patients who passed spa treatment.

2. Compare the results in quality of life assessment with men and women before and after the spa treatment.

Material and Methods: The investigation was created with 40 participants. The female and male ratio was balanced in the group 20 : 20. The average age was in our complete investigated group 61.95. In male group was the average 62.4 and with female group it represented 61.5. The male age variance was from 39 to 78 years of age and with female group the youngest patient was 45 and the oldest 76. Patients diagnosed with rheumatoid arthritis completed Jáchymov Spa treatment with 21-day length. For the quality life assessment we used SF-36 questionnaire, which assesses 8 domains.

Results and discussion: The quality of life index in the whole group of patients after completing the spa treatment reached higher values as before the spa treatment. Men gained in the quality of life evaluation better results both before and after the spa treatment completion in comparison with women. The result index of the quality of life with men before spa treatment was 51.6, and the spa treatment was 63.1. With women was the result index of quality of life before spa treatment 48.7 and after the spa treatment it reached 60.4.

Conclusion: 1. Spa treatment is aimed at completing the healing process following the inpatient or outpatient care with a wide range of different diseases of musculoskeletal, or other types of apparatus. 2. It is complexly aimed at the whole patient personality and uses rich variety of methods such as baths, wraps, kinesiotherapy, physical therapy, etc… 3 Any disease, especially of chronic progressive character, brings deterioration in the quality of life, which is reflected in physical, psychical and social sphere. Spa treatment positively affects the quality of life of patients with rheumatoid arthritis.

Keywords: Rheumatoid arthritis, Quality of life, Balneotherapy

ABSTRAKT

Cieľ: Reumatické ochorenia sú najčastejšou príčinou čiastočného postihnutia a štvrtou najčastejšou príčinou vedúcou k úplnému postihnutiu. Reumatoidná artritída (RA) je chronické autoimunitné ochorenie charakteristické zápalom synovie s následným poškodením kĺbov. Komplexná liečba RA má niekoľko cieľov — úľavu od symptómov, potlačenie aktívneho zápalu, prevenciu poškodenia tkaniva, zlepšenie fyzických funkcií, sebestačnosti a zlepšenie kvality života. Neoddeliteľnou súčasťou terapeutického prístupu k pacientovi s chronickým muskuloskeletálnym ochorením je kúpeľná liečba. Kúpeľná liečba má pozitívny účinok na zlepšenie kvality života. Dôkladne prevedená kúpeľná liečba nielen znižuje mieru bolesti u pacienta, ale tiež zlepšuje funkcie podpornopohybovej sústavy a pozitívne vplýva na kvalitu života pacienta. Fyzioterapia je neoddeliteľnou súčasťou komplexnej liečby RA, ktorá je súčasťou preventívnych opatrení u pacientov v počiatočnej fáze ochorenia bez veľkého postihnutia.

Cieľ práce: Ľudia od staroveku používali prírodné liečebné nástroje/zdroje pre liečbu ochorení rovnako ako pre posilnenie zdravia. Kúpeľná liečba je jednou z najstarších terapeutických metód. Je založená na skúsenostiach s liečebnými účinkami niektorých vodných zdrojov bahna alebo klimatických lokalít. Podstatnou časťou modernej kúpeľnej liečby je využitie objektivizovaných liečebných účinkov prírodných liečivých zdrojov, fyzikálnej medicíny, rehabilitácie, výživy, psychoterapie a farmakoterapie. Hlavným cieľom tejto práce je posúdenie vplyvu kúpeľnej liečby na kvalitu života pacientov s reumatoidnou artritídou.

Na základe výsledkov dotazníka SF-36 sme zhodnotili zmeny v hodnotení kvality života u pacientov s RA, ktorí absolvovali kúpeľnú liečbu.

Porovnanie výsledkov kvality života mužmi a ženami pred a po absolvovaní kúpeľnej liečby.

Materiál a metodika: Výskumu sa zúčastnilo 40 respondentov. Pomer žien a mužov bol v skupine vyrovnaný na 20:20. Priemerný vek skúmanej skupiny bol 61,95. V mužskej skupine bol priemerný vek 62,4 a v ženskej predstavoval 61,5 roka. Vekové rozpätie mužov sa pohybovalo od 39 do 78 rokov, v skupine žien mala najmladšia pacientka 45 a najstaršia 76 rokov. Pacienti s diagnostikovanou reumatoidnou artritídou ukončili 21-dňovú kúpeľnú liečbu v Jáchymove. Na zhodnotenie kvality života sme použili dotazník SF-36, ktorý posudzuje 8 domén.

Výsledky a diskusia: Index kvality života v celej skupine pacientov po ukončení liečebnej terapie dosahoval vyššie hodnoty ako pred jej absolvovaním. Muži dosahovali v hodnotení kvality života lepšie výsledky pred aj po ukončení liečby v porovnaní so ženami. Index kvality života mužov bol 51,6 pred kúpeľnou liečbou a 63,1 po jej absolvovaní. U žien sa index kvality života zvýšil z 48,7 na 60,4.

Záver: 1. Kúpeľná liečba je cielená na ucelenie liečebného procesu nadväzujúceho na ústavnú alebo ambulantnú starostlivosť so širokým spektrom rozličných porúch podpornopohybovej sústavy, či iných typov aparátu. 2. Je komplexne zameraná na celkovú osobnosť pacienta využívajúc bohaté možnosti metód ako sú kúpele, zábaly, kinezioterapia, fyzická terapia, atď. 3. Akékoľvek ochorenie, najmä chronického progresívneho charakteru, so sebou prináša zhoršenie kvality života, čo sa prejavuje vo fyzickej, psychickej a sociálnej oblasti. Kúpeľná liečba pozitívne vplýva na kvalitu života pacientov s reumatoidnou artritídou.

Kľúčové slová: reumatoidná artritída, kvalita života, balneoterapia

Introduction

Rheumatic diseases are the most frequent reasons of partial disability and the fourth frequent reason of the full disability. Rheumatoid arthritis (RA) is a chronic autoimmune disease characterized by inflammation of the synovium with follow-up damage to the joints. Complex treatment of RA has several goals — symptomatic relief, suppression of an active inflammation, prevention of tissue damage, improvement of the physical function, self-sufficiency, as well as the improvement of the quality of life. A spa therapy is an inseparable part of the therapeutic approach to the patients with chronic musculoskeletal diseases. Several authors from different workplaces concluded that the spa therapy positively influences and improves patient's quality of life (Kalová et al. 2004; Pavelka, Vencovský 2012; Slováček 2004). Their results led us to verification of the facts and the affects of the spa treatment on the patients' quality of life, treated with a specific diagnosis — RA.

Contemporary situation

Balneology, balneotherapy, rheumatoid arthritis, quality of life

In many countries the spa treatment is an integral part of the complex treatment procedures for patients with various kinds of diseases. Bender (2005) states that spa therapy has beneficial effects on the stress removal, relieves pain and reduces consumption of analgesics, which positively affects the quality of life. Appropriate way of provided spa treatment does not only reduce the pain but it also improves musculoskeletal functions and thereby positively affects the quality of life. In 2006, a group of authors (Kalová et al. 2004) proved beneficial effects of the spa treatment and the quality of their conditional health on the group of 260 patients with chronic musculoskeletal disabilities. They evaluated their quality of life through the HRQoL concept (Health Related Quality of Life), with utilization of the SF-36 questionnaire. Within all 8 assessed domains was the quality of life 3 months after the balneotherapy much higher than before the spa treatment. Similar results were achieved by Moravcová (2010). From 2009 to 2011 Franke recorded significant pain relief in the blind randomized study in the set of 681 patients dealt with the radon used in therapy of rheumatic diseases.

History of spa treatment

The earliest descriptions of hydrotherapy forms come from the Chinese literature around 3 700 BC. The Indian Vedas clearly set the number and length of bathing together with precise description for procedures implementation. Except for India, development of predominantly cleansing baths and therapeutic spas were recorded in Japan around 1 800 BC (Jandová 2009).

The Greek physician Hippocrates watched the effects of hot water on human organism. He, as the first one, described basic rules of hygiene and categorized mineral waters based on the salt content. At that time the spas were built in Thermopylae, Oete, Hypote and other places. Some of them recently belong to the most well-known spas such as Aque Mutiaecences (now Wiesbaden), Aque Aureliae (Baden-Baden), Aque Domitiancae (Aix-les-Bains), Herkulaneum spa in Romania and so on (Zvonár 2005).

In the Middle Ages spas did not record any boom, but, on the contrary it was a period of spas failure. Modernity brought a renewal to almost all spa locations bound with an intensive use of mineral waters. The 20th century events, two world wars combined with great political power shifts of the forces were for the spas generally unfavourable (Jandová 2009; Mašán 2019; Mašán, Haring 2017).

Spas in the Czech Republic and Slovakia have rich tradition what is related to abundant occurrence of natural medicinal resources in the both territories.

Spa treatment from medicinal viewpoints

„A spa treatment is one of the oldest therapeutic methods, which is coming out of the experienced therapeutic effects of some water sources, mud or climate locations. The essential part of modern spa treatments is utilization of objectified therapeutic effects of natural medicinal resources, physical medicine, rehabilitation, nutrition, psychotherapy and pharmacotherapy in needful measures, implemented as a complex spa treatment" (Zvonár 2005).

Progress of the spa treatment can be divided into several phases:

a) *Spa entry phase* — this is the first period of diagnostic stage aimed at setting the adequate balneo-rehabilitation programme.
b) *Acclimatization phase* — the patient adapts to the new environment, the impact of different stimuli of the undergone procedures within the balneo-rehabilitation programme.
c) *Effective spa phase* — represents interaction of the patient's organism and prescribed balneo-rehabilitation program, the resulting response of the individual functions for the spa treatments.
d) *Spa reaction* — characterizes own effects of the spa treatment.
e) *Re-acclimatization phase* — represents the post-spa treatment period, after which the patient returns to domestic environment and comes the phase of de-adaptation (Zvonár 2005).

The final form of spa reactions are in addition to the objective factors (the impact of individual balneo-rehabilitation treatments) influenced by the subjective factors characterized by patient's own processing of experience during the spa treatment. This interaction can be considered as a starting point and prognosis of the spa treatment effects.

Response to the spa treatment can persist within varying periods of time, but usually disappears after 1 — 7 days. The rheumatic diseases with massive activity have more substantial spa reaction compared with the other diseases (Zvonár 2005, Table 1). The spa treatment represents an inseparable part of the spa and preventive care.

Table 1: General spa treatment effects

Normalization of the disturbed functions of the individual systems, as a result of homeostasis
Improvement of regulation activity of the individual organs
Normalization of individual functional systems
Increased coordination of rhythmic functions — chronic-biologic homeostasis
Renewal of chronic-biologic balance
Well-being fitting — subjective feeling of health
Change of resistance and immunity — protection against intercurrent infections

Processed according to Zvonár (2005).

Rheumatoid arthritis

The rheumatoid arthritis have been defined by several authors (Draská 2005; Jandová 2009; Kalová et al. 2005; Loscalzo et al. 2022; Pavelka, Vencovský 2012; Trnavský 1993).

Pavelka (2010) defines it as follows:
„Rheumatoid arthritis (RA), is a chronic inflammatory disease where the main symptoms are with synovial lining of the joints, tendons and gravimetric follicles. The basic manifestation is infiltration of the joint environment by the inflammatory cells, synovial tissue hyperplasia and progressive destruction of cartilage and adjacent bone. Clinically, the most common manifestation is via symptoms of chronic symmetric poly arthritis with consequent joint destructions and deformities formation."

Definition of RA by Olejárová (2008) souds as follows:
„Rheumatoid arthritis (RA), is a relatively common chronic inflammatory joint disease, leading to the development of joint destructions and deformities. Joint involvement is most often polyarticular. RA is a systemic autoimmune disease, and therefore it can be further manifested by non-joint disabilities."

Rheumatoid arthritis has almost worldwide occurrence. The disease incidence per 100 000 population is between 10 and 50, the higher rates are valid for Northern Europe and America, and lover rates are for example in the southern Europe. The prevalence is on average at the level about 0.8 % with a range from 0.3 to 2.1 %. The RA prevalence can rarely be found among some Indian tribes in the United States (Cippewa or Pima Indians), with recorded 7.1 % and 5.3 %. On the other hand, in some rural areas of South Africa were not reported any RA cases. In general we can state that RA is not tied to the cold climate, the disease occurs within all the continents and climates and it affects all the races. More frequently, the disease affects women where is the ratio 3:1 compared to men. The disease usually starts during the fourth and fifth life decade, but up to 80 % of RA patients start between 35 and 50 years of age. For women over 60 year of age is the disease presence 6 times higher compared with the age from 18 and 29 (Pavelka, Vencovský 2012).

The disease has more frequent family history with relatives in the first level, predominantly with women, often among mother and daughter or the female siblings. Up to 10 % of patients with seropositive RA has a disabled relative (Pavelka, Vencovský 2012).

Despite significant advances in RA research, the cause of RA is still unknown. Chronic joint inflammation develops after the initial activation of the immune system of the genetically predisposed individual by recently still unidentified antigen. The cytokine TNF-α (the tumour necrotizing factor), pays the key role in development of local and systemic inflammatory changes (Olejárová 2008). Rheumatoid arthritis is a chronic progressive poly arthritis where the spectrum of clinical manifestation can vary (Pavelka, Vencovský 2012).

Quality of life

Definition of the concept — quality of life

It is difficult to grip the concept of quality of life. The quality of life is more difficult than definition of the length of life — that means the quantity. The cause can be sought in the fact that the quality of life is highly subjective matter and for each individual it can represent something different (Hajdučíková 2012; Taylor 2012). Quality of life may include characteristics of the natural and social environment of a person, his physical and mental state, questions on sense and usefulness of life, the subjective assessment of life in the terms of personal comfort and satisfaction. It also denotes the parts of individual and social life, which cannot be captured by quantitative characteristics, and not to measure them as it is possible with living standards (Olejárová 2008). Based on WHO definition of the quality of life „it is the individual perception of the position in life in the context of culture and value systems in which they live related to their goals, expectations, standards and concerns." Except for the person's physical health, the quality of life comprises also the state of psyche, level of independence, social relations, personal beliefs and relation to salient features of the environment. It is only a subjective evaluation inserted in the cultural, social and environmental context. The health state, life style, life satisfaction, mental health or subjective well-being represent are only the individual features of the multi-dimensional assessment (Payne 2005).

WHO conception of quality of life comprises 6 domains, each with different amount of indicators:

1. Physical health (energy and fatigue, pain and discomfort, ability to sleep and rest);

2. Psychological domain (negative and positive emotions, self-esteem, thinking, learning, memory and concentration);
3. Level of independence (mobility, everyday activities, addiction on medical substances and medical aids, work capacity);
4. Social relations (personal relations, social support, sexual activity);
5. Environment (financial resources, freedom, physical safety and security, social care, domestic environment, possibilities for gaining new information and skills, physical environment, transport);
6. Spirituality and personal beliefs (religious, spiritual, personal) (Dragomerická, Bartoňová 2006; Payne 2005).

In medicine, the emphasis lies on HRQoL — Health Related Quality of Life, which evaluates the effect on quality of life with the current health of the individual and involves physical aspects (elimination of symptoms, especially the pain), psychological (mental wellbeing of the patient), importance and life satisfaction (existential and spiritual aspects). (Doyle, Jeffrey 2000; Slováček 2004)

THE AIM OF THE PRESENT STUDY

The aim of the present study is to consider the impact of the spa therapy to patient's quality of life with the rheumatoid arthritis.

1. Via Questionnaire SF-36 find out the changes in assessment the quality of life with RA patients who underwent the spa therapy.
2. Comparison of results for the quality of life evaluation with men and women before and after completing the spa therapy.

Material, methods and results

The research sample was created by 40 participants. The sample was very balanced, amount of male and female representatives was in the ratio 20:20.

The average age of the research participants was 61,95. Average age for the men sample was 62,4 years and with women 61,5 years of age (Table 2). The research sample was created only with RA diagnosed patients in different stages and development and functional abilities. The age scale of the male sample was from 39 to 78 years of age and in the female sample was the youngest woman 45 and the oldest one 76 years old. The research includes only patients diagnosed with the rheumatoid arthritis in the different stage of illness and with varying functional fitness. The RA patients passed 21-day spa therapy at spa Léčebné lázně Jáchymov a. s.

Table 2: Age characteristics of respondents

Sample unit characteristic	Average age
Complete unit (n =40)	61,95
Male unit (n =20)	62,4
Female unit (n =20)	61,5

The spa treatment was realized from September 2013 till January 2014. Each of the addressed patients signed the informed consent. During the entrance procedure, each patient received a SF-36 questionnaire for filling in. The full wording of SF-36 Questionnaire was published by Petr (Petr 2002; Petr et al. 2003; Petr, Kalová 2002; Petr, Kalová 2004). Three months after completing the spa therapy the patients filled in the questionnaire again. For the statistical evaluation we used all the collected data from the patients before and after the spa therapy.

SF-36 Questionnaire

SF-36 questionnaire is a 36-question generic questionnaire created for assessment of the health state condition and the quality of life bound with it. It comprises physical, social and mental parts not only of positive but also the negative health aspects. The multicomponent scale evaluates 8 health domains. It consists of:

- PF — Physical Functioning
- RP — Role-Physical
- BP — Bodily Pain
- GH — General Health
- VT — Vitality
- SF — Social-Functioning
- RE — Role-Emotional
- MH — Mental Health

All the questions were evaluated in the scale from 0 to 100, where the highest the score the better functioning results were. The numerical values of the individual responses are given in the questionnaire. The resulting score of the questions which are related together form one of the 8 dimensions, and then the arithmetic average was calculated for each of dimensions, which represent the final score.

Question number 2 does not belong to any of the dimensions nor to any resulting score. It represents the individual part which identifies how the patient himself perceives own health change for the past year (HT — Reported Health Transition).

On the basis of possible difficult interpretation of eight dimensions were developed two summary scores — scores of the overall physical health (PCS) and overall mental health (MCS). To work with the overall quality of life can be expected the index of overall quality of life (SF-36), which gathers all the mental and physical circuits, again calculated as an arithmetic average. In this case, the arithmetic average has the eight dimensions. For full wording of the SF-36 questionnaire see the Annex.

Summary score of SF-36 Questionnaire
Total physical health (PCS = Physical Component Summary)
It brings together the topics affecting the physical health:

- Physical activity (PF),
- Limitation of physical activity (RP),
- Pain (BP),
- General Health Assessment (GH).

It is calculated as simple arithmetic average of the given dimensions. The value of total physical health varies in the interval from 0 up to 100, where the higher the value the better physical health.

Total psychic health (MCS = Mental Component Summary)
Aggregates circuits influencing psychical health:

- Vitality (VT),
- Social activity (SF),
- Limitation of emotional problems (RE),
- Mental health (MH)

It is calculated as the simple arithmetic average of the dimensions. The value of total psychic health dimension varies in the interval from 0 to 100, where the higher value means better physical health.

Index of total quality of life (sf-36)
It groups all mental and physical circuits. Through the simple arithmetic average of individual dimensions it calculates the total health, where the result is the index of the total quality of life. The value of resulting index of the quality of life SF-36 can vary from 0 to 100, where the higher value means higher total health, better quality of life. After assessment of all collected questionnaires before and after the spa therapy, with three month interval, was the whole set of data collected and processed statistically and reported in the following Table 3.

Rheumatoid arthritis is a chronic, extremely serious disease that ultimately results in patient's disability. Our group of respondents are equivalent in the age structure, as well as in the volume of participants. All the gained data both before and after the balneotherapy, the respondents' data were significantly lower compared with the Oxford data and the data collected from the sample of healthy population, represented by the police workers in the Central Region of the Czech Republic. In some cases were the domain values highly significantly lower p <0001 (for RP, BP, GH, VT with men and women).

The spa therapy influenced beneficially and the significantly lower values were positively modified. Better results were gained with men in all the searched parameters compared to women, except for BP and VT.

Discussion and conclusion

Based on the collected data we found out that the spa therapy positively influences the assessment of quality of life with RA patients. The results show that the index of quality of life in the whole searched set of patients after completed spa therapy achieved higher values than before the spa therapy. The positive effect of the spa therapy on the quality of life of patients with chronic musculoskeletal disabilities were showed in the work of Kalová et al. (2004) (Kalová et al. 2005; Kalová 2005) The similar results were also gained by the work of Moravcová (2010), who investigated the impact of the spa therapy on the quality of life on a sample of 31 respondents.

The aim of our study was to assess the effect of the spa therapy on the quality of life of the patients with rheumatoid arthritis. The quality of life was investigated via standardized SF-36 questionnaire and the expressed total quality of life represented the value 50.1 for the whole set before the spa therapy. After completing the spa therapy with 3 months apart, were measured the values of the index of quality of life was 61.8 for the entire set. From the results we concluded that the spa therapy in our survey set had a positive effect on the

Table 3: Comparison of respondent results — men and women before and after the spa therapy with data gained in Oxford and the Czech Republic

	Domains and their values										
Sets	PF	RP	BP	GH	VT	SF	RE	MH	PCS	MCS	SF36
Oxford	88,40	85,62	82,93	88,01	81,49	73,77	61,13	73,52	86,24	72,48	79,36
Czech Republic	94,86	67,52	76,74	69,08	89,25	70,98	77,70	70,18	77,05	77,03	77,04
Men before	66	35	39,5	37	50,3	61,3	63,3	60,2	44,4	58,8	51,6
Men after	74,3	51,3	54,9	44,3	60,8	70,6	80,7	70	56,3	69,9	63,1
Women before	62,3	35	40	42,8	50,3	53,1	50	56	44,6	52,4	48,7
Women After	68,3	52,5	53,5	49,3	60	63,1	71,7	64,8	55,9	64,9	60,4

quality of life of patients with rheumatoid arthritis, whereas we found higher values of the resulting index of the quality of life after completing the spa therapy. Men compared with women gained better results in the assessment of the quality of life both before as well as after the spa therapy. The resulting index of quality of life with men before the spa therapy was 51.6 and after the spa therapy it represented 63.1. Women accounted the resulting index of quality of life in the value of 48.7 before the spa therapy, and after the spa therapy it reached the value 60.4.

The BP (pain) domain of the SF-36 questionnaire, which is from therapeutic point of view very important were the average values before the spa treatment with men 39.5 and after the spa treatment 54.9, what means that the patients reported reduction in pain. The same occurred the female sample survey where before the spa treatment were measured average values for dimension BP (pain) 40 and after its completion 53.5. For the total BP dimension before spa treatment was the average value of 39.8 and after its completion 54.5. From the showed results came out, that the spa treatment had an effect on reduction of pain the surveyed set and our results for the pain within the SF — 36 questionnaire are the same as those described by Franke's (2000) study conducted in the years 2009-2 011 on a sample of 681 patients. Our assumption, that the influence of spa therapy improves the quality of life of patients with rheumatoid arthritis was correct and our hypothesis was confirmed. After completing the spa therapy were measured higher values of total index of quality of life.

It was found, that the evaluation of quality of life with men and women is different, both before as well as after the spa treatment. In both cases women evaluated the quality of life as poorer one. However, the positive effect of the spa therapy on quality of life with men and women was the same. Spa treatments are aimed at completing the process of recovery following the inpatient or outpatient care with variety of different diseases of the locomotive, or the other apparatuses. It is not only related to physical recovery but also to the complete health. It focuses on the complete personality of the patient, and utilizes the whole scale of methods such as baths, wraps, kinesiotherapy, physical therapy, etc. The complex care has a demonstrable effect on the quality of life of patients undergoing the spa therapy.

Every disease, especially with chronic progressive character, brings deterioration of quality of life, which is reflected in the physical, psychological and social area. Patients' quality of life was in our survey sample higher after completing the spa treatment than before the spa treatment. In the sample of 40 patients, we tried to prove positives of the spa treatment in the set of patients with rheumatoid arthritis, what was achieved. The positive effects were similar in the female and male sample. Our survey showed that the value of the resulting index of quality of life after completing the spa therapy was higher and therefore it is possible to conclude that the spa treatment positively affects the quality of life of patients with rheumatoid arthritis.

Conflict of interest
We declared that we have no conflict of interest.

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Disaster medicine as a separate subject at all medical faculties

Medicína katastrof ako samostatný predmet na všetkých zdravotníckych fakultách

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ABSTRACT

Introduction: Every major change in conditions is a disaster in its own way. But with joint efforts, people survived situations that at first glance appeared to be deadly, associated with a permanent change in conditions. All the events that negatively affect the life of the society reveal how important the security literacy of the population is. Without a fundamental change in the education of healthcare workers at undergraduate and postgraduate level, it will not be possible to ensure adequate care while protecting the life and health of the population. The presented publication points to the complexity of the issue.

Core of work: It provides a legislative overview of statutory standards on crisis management in healthcare in the event of an emergency. It points to the necessity to ensure the teaching of the subject of disaster medicine in all health professions in undergraduate and postgraduate education. Education in the field of crisis management of healthcare during emergencies is an inherent part of the course. For the correct response of the healthcare system, it is essential that healthcare workers are theoretically prepared and have the necessary information in the field of disaster medicine and crisis management.

Conclusions: In the presented short overview of the complex issue related to the protection of life, health and property of the population, we tried to point out the need for fundamental changes in the training of health workers at the undergraduate and postgraduate level so that the management of emergency situations by health workers and their integration into an integrated rescue system were for the benefit of affected pat

Keywords: Mass accident, Crisis, Disaster, Crisis management,

ABSTRAKT

Cieľ: Každá veľká zmena podmienok je svojím spôsobom katastrofou. Spoločným úsilím ale ľudia prežili situácie, ktoré sa na prvý pohľad javili ako smrtiace, spojené s trvalou zmenou podmienok. Všetky udalosti, ktoré akokoľvek negatívne zasahujú do života spoločnosti odhaľujú, aký veľký význam má bezpečnostná gramotnosť obyvateľstva. Bez zásadnej zmeny vzdelávania zdravotníckych pracovníkov na pregraduálnej, ale aj postgraduálnej úrovni sa nepodarí zabezpečiť adekvátnu starostlivosť pri ochrane života a zdravia obyvateľstva. Predkladaná publikácia poukazuje na komplexnosť problematiky.

Jadro práce: Poskytuje legislatívny prehľad zákonných noriem o krízovom riadení v zdravotníctve v prípade mimoriadnej udalosti. Poukazuje na nevyhnutnosť zabezpečiť výuku predmetu medicíny katastrof vo všetkých zdravotníckych odboroch v pregraduálnom a postgraduálnom vzdelávaní. Do výuky neodmysliteľne patrí aj vzdelávanie v oblasti krízového riadenia zdravotníctva počas mimoriadnych udalostí. Pre správnu odpoveď zdravotníckeho systému je nevyhnutné aby boli zdravotnícki pracovníci teoreticky pripravení a disponovali potrebnými informáciami z oblasti medicíny katastrof a krízového riadenia.

Záver: V predkladanom krátkom prehľade o komplexnej problematike týkajúcej sa ochrany života, zdravie a majetku obyvateľstva sme sa snažili poukázať na potrebu zásadných zmien v príprave zdravotníckych pracovníkov na pregraduálnej a postgraduálnej úrovni tak, aby zvládanie mimoriadnych situácií zo strany zdravotníckych pracovníkov a ich integrácia do integrovaného záchranného systému boli na prospech postihnutých pacientov.

Kľúčové slová: hromadné nešťastie, kríza, katastrofa, krízový manažment

Introduction

The safety of the citizen and the safety of the community is guaranteed by the Department of Health through the provided health care, the scope and quality of which, during emergencies, is conditioned by a comprehensive set of knowledge, skills and abilities of medical personnel of all levels.

In order to achieve an optimal state of health care preparedness for emergencies, in addition to securing financial resources and legislation, it is also a necessary condition to ensure the education of health workers in the field of disaster medicine and the basics of crisis management. Education must be implemented in all health departments. The introduction of a separate subject „Disaster Medicine" into the study syllabi can be important for improving the operability of the health sector in managing emergency and crisis situations (Bulíková et al. 2011, Masár et al. 2016).

Core of work

Basic tasks of disaster medicine

Every major change in conditions is a disaster in its own way. But with joint efforts, people survived situations that at first glance appeared to be deadly, associated with a permanent change in conditions. All events that negatively affect the life of society reveal how important the safety literacy of the population is (Masár et al. 2016).

History and characteristics

The development of medical sciences and medical experience gained from extensive health activities in the world, in difficult conditions, when it was necessary to deal with the serious consequences of natural elements, but also the consequences of human activity, are still being implemented into a comprehensive scientific system. The goal of this scientific system is to systematically deal with the issue of effective and efficient management of the consequences of devastating events through an effective tool. For the field of managing health consequences, this tool has become disaster medicine, which coordinates the specific focus of individual medical departments focusing on the permanent study of individual medical disciplines and targeted information into the health care provision system while respecting the law of the so-called catastrophic cycle (Smetana 2007, Stone 2008). The scope of interests defined in this way determines the basic goal of the medical understanding of disaster medicine, i.e. to cover the needs of prevention, immediate assistance and subsequent solutions to possible health consequences arising in direct relation to the disaster and, in cooperation with other non-medical activities, to participate in the creation of a common system, a disaster management system (Brzybohatý et al. 2001).

Disaster medicine is an interdisciplinary and multisectoral field. It includes a variety of activities — from purely medical to technical, which have one goal — to help victims of all kinds of disasters (Eichler 2009, Eichler 2010).

The construction of such a system is always a reflection of the time in which it was created, the level of knowledge and the level of science in the society that will create it, as well as use it.

In history, we observe efforts to cope with adverse effects on society using various systems:

- the experience of war medicine, which developed into today's military medicine,

- the performance of Florence Nightingale in the war and the gradual professionalization and education of nurses,
- agreements of the International Red Cross, the Geneva Convention and other related agreements,
- United Nations Disaster Relief Organization (UNDRO) — The UN report for relief and reconstruction, which at the end of II. World War started work on a disaster management project on a global scale,
- a research facility of the United Nations and the World Health Organization (WHO), which is constantly working on issues of disaster management.

It was these expert groups that created the definition of a new field in medicine in 1991 — disaster medicine (Cigánik 2006, Středa 2002).

Disaster medicine is an effective management and performance tool of the health system, using a comprehensive method of activities covering all phases and aspects of the disaster cycle, including preparation, prevention, immediate deployment, provision of on-site assistance, recovery of subsequent development in the affected area (Cigánik 2002, Klement 2008).

A disaster is understood as a serious event — suddenly or slowly arising — of such magnitude that the affected society must make extraordinary efforts to cope with it. Often with the help of other regions or the international community (S. W. Gunn) (Štetina 2000, Tarasovič et al. 2005).

WHO defines a disaster as: „…a sudden ecological phenomenon of sufficient degree that requires external assistance."

In the conditions of Czechoslovakia, the concepts of disaster medicine were gradually developed when applying information from emergency medicine and war medicine. After the breakup of Czechoslovakia, a comprehensive concept of disaster medicine was developed under the conditions of Slovakia. In both newly formed republics, there was an attempt at a comprehensive medical concept and a new system of providing health care in the conditions of mass disability (Šimko 1997, Škvrnda 1997).

The fundamental step in the realization of the concept of disaster medicine was the transformation of the healthcare system in the years 1990-93 and it took place synchronously with the transformation of emergency services. The essence of these changes became the so-called the rescue chain, which is the carrier of the requirements for ensuring available and effective help in situations of sudden threat to the life and health of an individual and is the skeleton of the medical rescue service system.

For more than 15 years, the teaching of emergency medicine and disaster medicine has been provided by the Clinic of Emergency Medicine and Disaster Medicine of the Faculty of Medicine, Comenius university Bratislava — the first in Slovakia and the Czech Republic, which educates fifth-year students in the issues of disaster medicine. Interest in the issue of disaster medicine is growing only gradually, especially with the changing situation in the world. When the clinic was established, the students considered the problem to be overcome, detached from the reality in Slovakia. Gradually, however, when confronted with the current situation, interest grows. The clinic has developed study material for all those interested in the given issue.

Preparation of the state and healthcare to face emergency events and crisis situations

With the adoption of the Act on the Security of the Slovak Republic, the construction of a legislative environment for the application of the so-called crisis management, both at the highest level of ensuring security (in the sense of uniformly understood external and internal security in the understanding of non-military and military crisis situations) of the Slovak Republic, and mainly within the scope of the individual departments. The provisions of the aforementioned law, which regulate that state authorities are obliged to participate in ensuring the security of the Slovak Republic, became key (Law no. 129/2002 Coll).

This expanded the scope of all state administration bodies, and for the level of central bodies, the requirement of this law is given, according to which all ministries examine social issues within their sphere of competence, analyze the results achieved, take measures to solve current issues and

Table 1. Classification of extraordinary events (Fabiny 2024)

Event	The number of affected	Characteristics of the event
Accident	2 — 5	
Mass accident limited	5 — 10	A situation where up to 10 people are affected, with at least one person in critical condition.
Mass accident	< 50	A situation where more than 10 people are affected and will not exceed 50.
Extensive disaster	> 50	A situation in which more than 50 people are affected, regardless of the number of dead, seriously or lightly injured.

develop concepts for the development of entrusted industries (Šimák 2004).

The health care provision system, which is based on the existence of independent health care providers, is thus faced with the difficult task of ensuring the readiness of its functioning even under conditions that will be induced by such events that force the declaration of a certain state of crisis, and this with the full use of departmental legislation and department management acts (Mičková 2009, Novák et al. 2010, Novák et al. 2005).

Covering the spectrum of requirements for the provision of health care — both in standard and non-standard conditions — requires a systemic and systematic solution, based on the current and real possibilities of health care providers (Šín 2017, Tencer 2015).

Crisis Management
Crisis Management is a set of scientific knowledge, professional procedures and application tools of preventive, decision-making and technological measures enabling responsible workers to solve crisis situations. Phases of crisis management include analysis of a potential source of threat, correction of an existing potential source of threat, prevention, rescue and restoration of life and activities in new conditions after liquidation of the consequences of the crisis (Klement, 2011, Štourač et al. 2024).

Crisis management authorities of the Slovak Republic:
a) Government of the Slovak Republic, Security Council of the Slovak Republic
b) Ministries and other central state administration bodies
c) National Bank of Slovakia
d) Regional Security Council
e) District Office
f) District Security Council
g) Municipal authorities
h) Higher territorial unit

Crisis management in practice. The need for medicines and materials is determined by the type and extent of the mass disaster. However, in principle, certain standards and estimates are followed. It will be necessary to supply departments and emergency vehicles within 4 hours. Analgesics and anesthetics, infusion solutions, sedatives, antidotes, cardiotonics, corticoids, burn kits and consumable medical supplies are dispensed from pharmacies within 6 — 24 hours. Within 24 — 72 hours, medications to manage post-traumatic stress, heart disease, antibiotics, and medications for chronic patients will be required from pharmacies.

From the 4th day, medicines for vaccination, prophylaxis and for chronic diseases will be needed. In the event of a mass disaster, medicines and medical supplies must be available for the needs of the EMS and emergency departments, while they are stored in containers available 24 hours a day so that they can be taken to the field if necessary (Law no. 129/2002 Coll, Jančo 2011).

Forces and resources of the Slovak Republic to deal with mass disasters
In the event of a mass disaster, the Slovak Republic has at its disposal the basic and other rescue components of the integrated rescue system (Law no. 129/2002 Coll).

The basic rescue units consist of the fire and rescue service, the emergency medical service, the control chemical laboratories of civil protection, the mountain rescue service, the mine rescue service, the police force.

In Slovakia, the coordination of rescue services is organized by several operational centers. Every citizen should be able to call these operation centers free of charge. Telephone numbers 155 for the emergency medical service, 150 for the Fire and Rescue Service, 158 for the Police Service and the number 112, which is defined as a general emergency number. This number is common to all 27 EU member states and is used to call emergency services free of charge in an emergency (Masár et al. 2010, Fedorová 2021).

International disaster relief
Disasters usually have a large scale, so depending on the situation, it is necessary to ask another country or several countries for help based on pre-concluded international agreements or as part of humanitarian aid. It should be noted that the Slovak Republic currently does not have adequate agreements with neighboring countries on cooperation in emergency situations, which can significantly slow down the speed and effectiveness of intervention, especially in border areas.

Conclusion

In the presented short overview of the complex issue related to the protection of life, health and property of the population, we tried to point out the need for fundamental changes in the training of health workers at the undergraduate and postgraduate level so that the management of emergency situations by health workers and their integration into an integrated rescue system were for the benefit of affected patients.

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19. medzinárodná vedecko-odborná konferencia

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