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OBSAH

Šramka, M.
Editoriál 3

Durdík, Š., Galbavý, Š.
Rare complication of the chronic pancretitis 4
(Zriedkavá komplikácia chronickej pankreatitídy)

Renger, F., Czirfusz A.
Aspects of the Theoretical Application of the Identity Triangle
Of Onstitutions to three Types of Medical Care Centres 21
(Aspekte der theoretischen Anwendung des Identitätsdreieckes
der Institutionen die drei Arten von medizinischer Versorgungszentren)

Sumková, M.
Amendment to Act No 96/2004 Coll.,
The Non-Medical Health-Care Profession Act 28
(Novela zákona č. 96/2004 Sb.,
Zákon o nelekárskych zdravotníckych povolaniach).

Cintulová, L., Buzalová, S.
Using Occupational therapy to Improve
the Quality of Life of People with learning Disabilities 35
(Využitie ergoterapie na zvýšenie kvality života ľudí s mentálnym postihnutím)

Novotná, J., Cintulová, L., Beňo, P.
Sexual Deviations in Perception of Social Work 43
(Sexuálne deviácie v percepcii sociálnej práce)

Gwóźdź, M., Beňo, P.
Withdrawal Methods Outside of the Concept of Natural Family Planning 48
(Stosunek przerywany poza porządkiem Naturalnego planowania rodziny)
(Coitus interruptus nepatrí medzi prirodzené metódy plánovania rodičovstva)

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RARE COMPLICATION OF THE CHRONIC PANCREATITIS
ZRIEDKAVÁ KOMPLIKÁCIA CHRONICKEJ PANKREATITÍDY

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Abstract

Background. Pancreaticopleural fistulas are rare, typical internal pancreatic fistulas arising most of all during an acute exacerbation of underlying chronic alcohol--associated pancreatitis. In posterior disruption of pancreatic ducts leaking pancreatic juice may track through the esophageal and aortic hiatus to the mediastinum.

Methods. Clinical data of 6 patients with chronic alcohol--associated pancreatitis were analyzed in whom pancreaticopleural fistula arised always with left--sided pleural cavity.

Results: In all patients we confirmed pancreaticopleural fistula with disruption of panreatic duct by means of endoscopic retrograde cholangiopancreatography (ERCP) and/or computer tomgraphy (CT) and perioperative fistulography. Visualisation of anatomy and location of pancreatic duct obstruction is important. In one patient with proximal pancreatic duct obstruction successful duodenopancreatic drainage was performed by endoscopic stent placement. Five patients were operated on after initial conservative treatment failure. In 2 patients we created latero--lateral fistulopancreaticojejunostomy Roux--en--Y. In one patient we made segmental(central) resection of the proximal part of pancreas body and termino--terminal pancreaticojejunostomy Roux--en--Y. Two patients with communicating pancreatic pseudocyst were solved by pseudocysto--gastrostomy. Postoperative course in all patients was complications free. Postoperative mortality was 0.0 %. During the follow--up after 5, 6, 7 and 9 years there was no exacerbation of pancreatitis.

Conclusion: Initial way of treatment is short--term conservative practice. In the case of its failure invasive approach on the basis of imaged pancreatic duct anatomy should proceed. Strategy of the treatment is based on the patomorphologic classification of the anatomy pancreatic duct. Fistula is caused by an obstructed pancreatic duct followed by its disruption. The aim is to provide the outflow of the pancreatic duct or its part that possessed impaired drainage.

Key words: chronic pancreatitis, pancreatic duct anatomy – classification, pancreatico--pleural fistula

Súhrn

Úvod: Pankreaticopleurálne fistuly sú zriedkavé, typické vnútorné fistuly pankreasu vznikajúce najmä počas akútnej exacerbácie chronickej pankreatitídy súvisiacej s

alkoholom. Pri prerušení zadnej časti pankreatických vývodov uniká pankreatická šťava cez pažerák a hrudník do mediastína.

Metódy: Analyzovali sme klinické údaje 6-tich pacientov s chronickou pankreatitídou súvisiacou s alkoholom, u ktorých vznikla pankreaticopleural fistula vždy na ľavej strane pleurálnej dutiny.

Výsledky: U všetkých pacientov endoskopickou retrográdnou cholangiopancreatografiou (ERCP) alebo počítačovou tomografiou (CT) a perioperačnou fistulografiou potvrdili pankreaticopleuralu fistula s prasknutím pankreatického vývoddu. Vizualizácia anatomických pomerov a lokalizácia obštrukcie pankreatického kanála je dôležitá. U jedného pacienta s proximálnou obštrukciou pankreasové vývodu bola úspešná drenáž umiestnením endoskopického stentu. Po počiatočnej konzervatívnej liečbe bolo päť pacientov riešených operačne. Dvom pacientom sme realizovali latero - laterálnu fistulopancreatikojejunostómiu Roux - en - Y. U jedného pacienta sme vykonali segmentálnu (centrálnu) resekciu proximálnej časti tela pankreasu a termino - terminálnu pancreatikojejunostómiu Roux - en - Y. V prípadoch kde boli komunikujúce pankreatické pseudocysty (dvaja pacienti) situáciu sme vyriešili pseudocystogastrostómiou. Pooperačný priebeh u všetkých pacientov bol bez komplikácií. Pooperačná mortalita bola 0,0%. Počas sledovania po 5, 6, 7 a 9 rokoch nedošlo k exacerbácii pankreatitídy.

Záver: Liečba na začiatku je konzervatívna. V prípade zlyhania by mal pokračovať invazívny prístup na základe zobrazenej anatómie pankreatického vývodu. Stratégia liečby je založená na patomorfologickej klasifikácii pankreatického vývodu. Fistulu spôsobuje prekážka pankreatického vývodu a následne prasknutie. Cieľom je zabezpečiť odtok z pankreatického vývodu alebo jeho časti, ktorá má zhoršenú drenáž.

Kľúčové slová: chronická pankreatitída, anatómia pankreatického vývodu, pankreaticko - pleurálna fistula

INTRODUCTION

Pancreaticopleural fistulas are rare, typical internal pancreatic fistulas arising most of all during an acute exacerbation of underlying chronic alcohol-associated pancreatitis. Pleural effusions in the course of acute pancreatitis develop in 3-17% of patients. Pancreaticopleural fistula is commonly associated with both disruption of main pancreatic duct and pseudocyst formation. The fistula develops either by direct passage through a natural diaphragmatic hiatus (oesophageal or aortic) or by direct fistulation through the dome of diaphragm (Wakefield et al. 1996; Cameron 1978; Cameron et al. 1976). It usually presents as a large recurrent pleural effusion in either pleural space but left sided effusions are more common and are reported to account for 76% of cases. Pancreaticopleural fistula as a complication of chronic pancreatitis has an incidence of 0.4 – 4.5% being reported (Safadi, Marks 2000; Hastier et al. 1992). In most cases, patients complain of chest symptoms (68%), abdominal symptoms are less frequent (24%) (Uchyijama et al. 1992).

ERCP leads to diagnosis in 80% of cases and demonstrates the fistulous tract in 59% (Safadi, Marks 2000; Ridgeway, Stabile 1996). Magnetic resonance cholangio-pancreatography (MRCP) and CT scan offers an effective diagnostic method for the anatomic evaluation of the intrathoracic route of pancreatic fistula (Fulcher et al. 1999).

MRCP can demonstrate pancreaticopleural fistula even when the ductal disruption site is located distally from ductal obstruction site (Akahane et al. 2003).

A pancreaticopleural fistulous route can be clearly demonstrated by CT scan following pancreatography (Fijiwara et al. 2006).

A combination of transpapillary or transgastric endoscopic drainage procedures and pleural drainage with additional octreotide therapy is the treatment of choice (Neumann et al. 2004). Surgical treatment is only indicated if conservative or endoscopic treatment fails and consists of resection of the fistula and drainage of the pancreatic duct via a lateral pancreticojejunostomy or resection of the part of the pancreas where fistula originates (Lamme et al. 2003).

PATIENTS AND METHODS

We treated 6 patients with history of chronic alcohol--associated pancreatitis in whom pancreaticopleural fistula arised always with left--sided pleural cavity. All the patients were males, median age was 45 (range 36 -- 57) years. Abdominal symptomatology was insignificant. Dyspnoea and chest pain were dominant. Paracentesis revealed sanguinolent or brownish fluid that refilled rapidly. Effusion had high content of amylases and there was a high level of serum amylases as well.

In all patients pancreaticopleural fistula with disruption of panreatic duct was confirmed by means of ERCP and/or CT and perioperative fistulography. Visualisation of anatomy and location of pancreatic duct obstruction was important. In one patient with proximal pancreatic duct obstruction successful duodenopancreatic drainage was performed by endoscopic stent placement. Five patients were operated on after initial conservative treatment failure. In 2 patients we created latero--lateral fistulopancreaticojejunostomy Roux--en--Y. In one patient we made segmental(central) resection of the proximal part of pancreas body and termino--terminal pancreaticojejunostomy Roux--en--Y. Two patients with communicating pancreatic pseudocyst were solved by pseudocysto--gastrostomy.

CASE #1

41 years old patient. Chest X--ray revealed massive left--sided fludothorax. ERCP showed amputation of the pancreatic duct in the region of the pancreas body. CT demonstrated bilateral fludothorax and fistulous tract in the posterior mediastinum. We performed segmental (central) pancreatic resection with terminolateral pancreatico-jejunostomy Roux--Y (Figure 1, 2, 3).

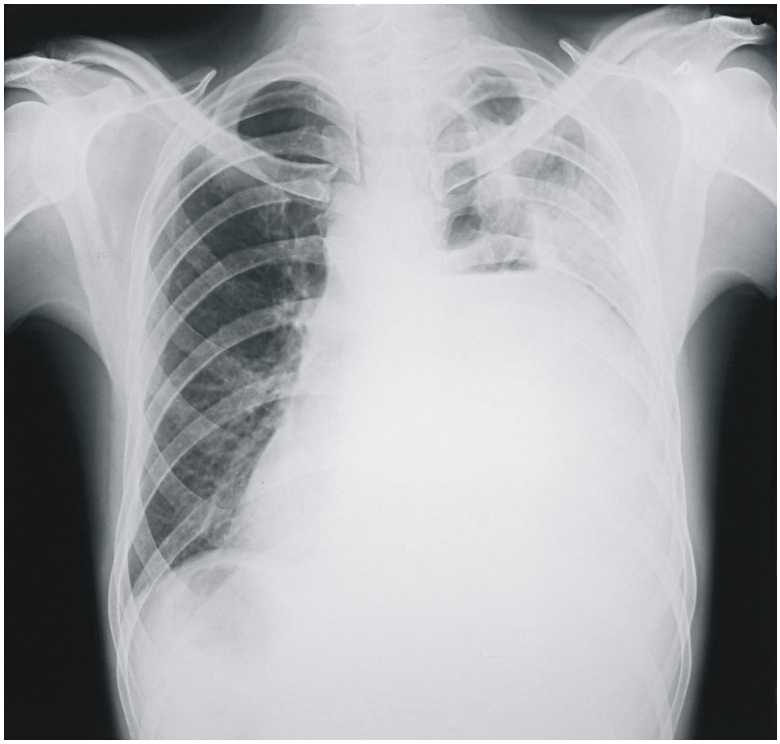

Figure1. Chest X--ray with pancreatic fluidothorax.

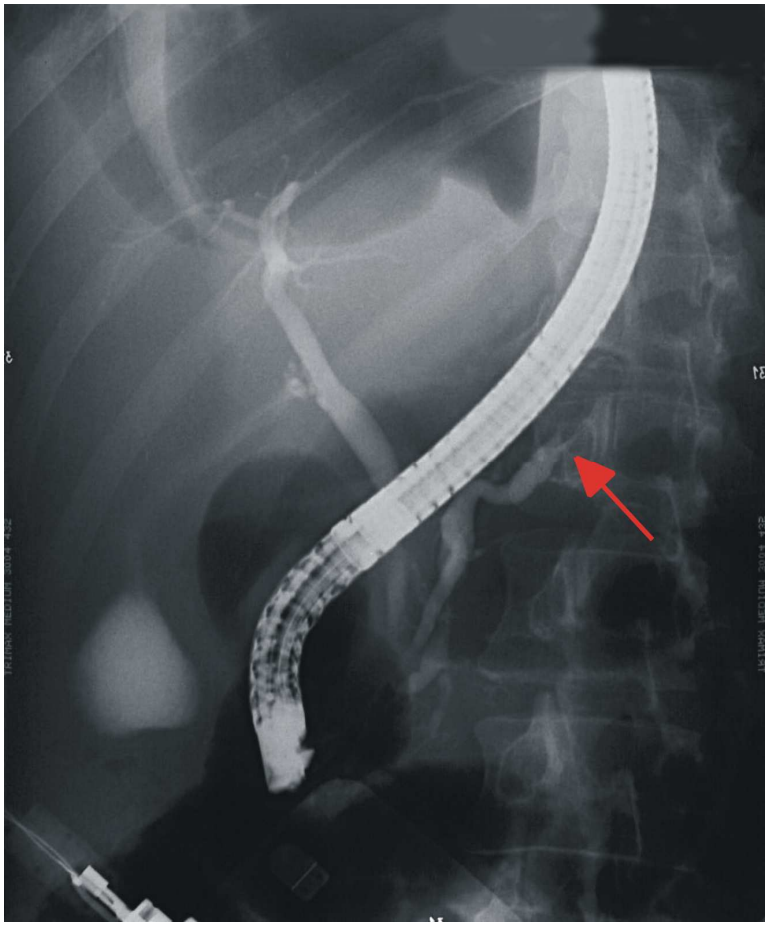

Figure 2. ERCP amputation of the pancreatic duct in the region of the pancreas body.

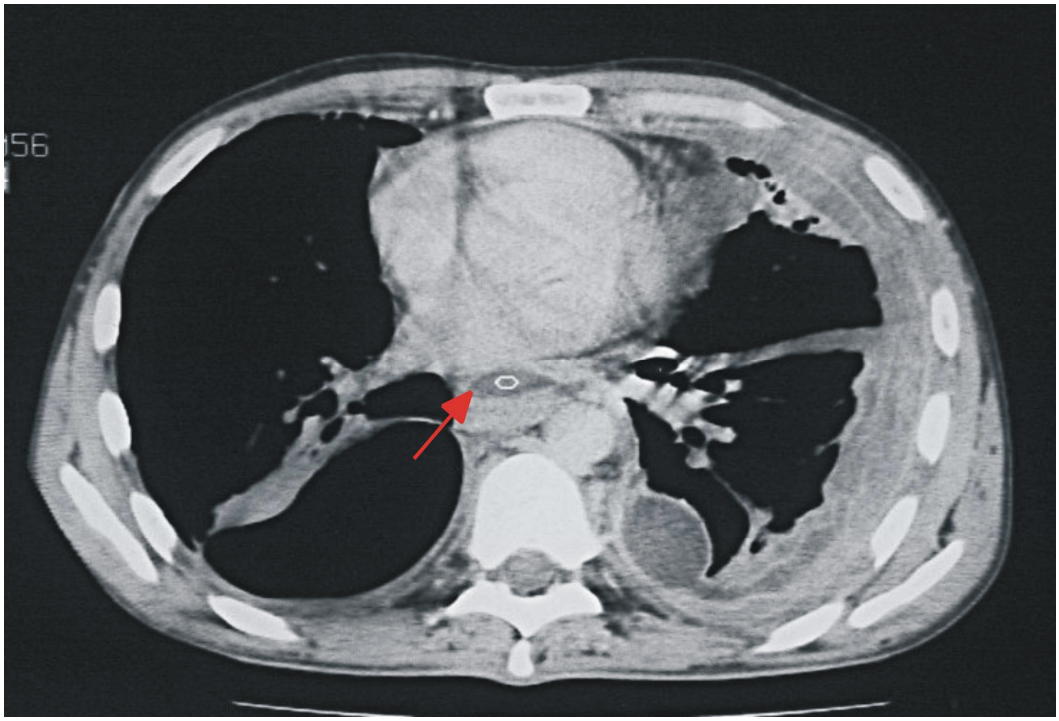

Figure 3. CT bilateral fluidothorax, fistulous tract in the mediastinum.

CASE #2

45 years old patient with left--sided fluidothorax. CT revealed communicating pseudocyst in the pancreas body. Patient underwent pseudocystogastrostomy (Figure 4, 5).

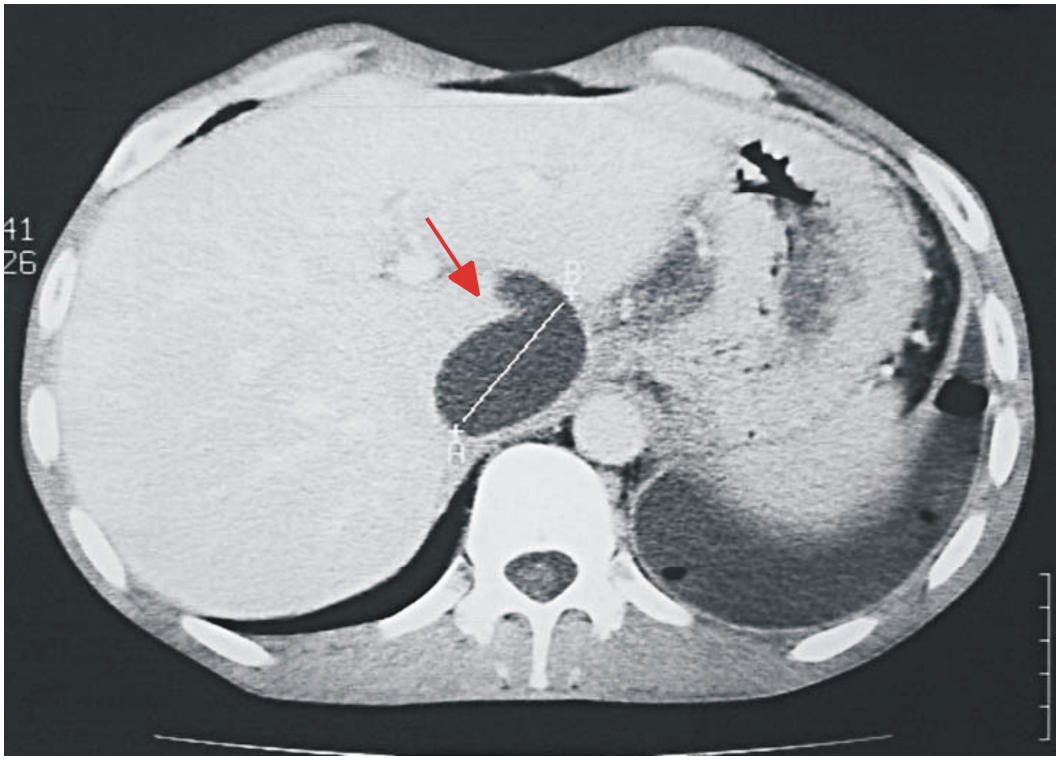

Figure 4. CT -- left--sided fluidothorax, subhepatic pseudocyst proximally communicating with the mediastinum.

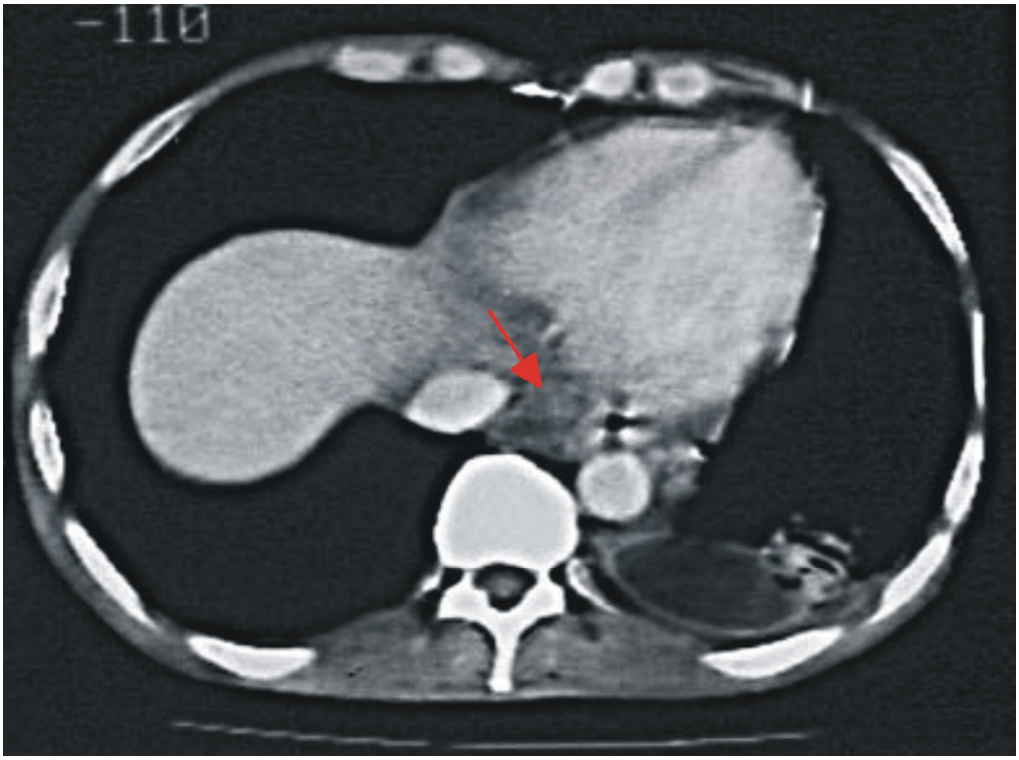

Figure 5. Left--sided fluidothorax. Prevertebral fistulous tract (red arrow).

CASE #3

48 years old patient. Chest X--ray showed left--sided fluidothorax. Dilated pancreatic duct was displayed by means of ERCP. There was a pseudocystic dilatation in the region of pancreas body communicating via the channel of the diameter of 15 mm with left pleural cavity. Endoscopic papillosphincterotomy and drainage of pancreatic duct by duodeno-pancreatic stent placement was performed. Stent bypassed the fistula (Figure 6, 7a, 7b, 8, 9).

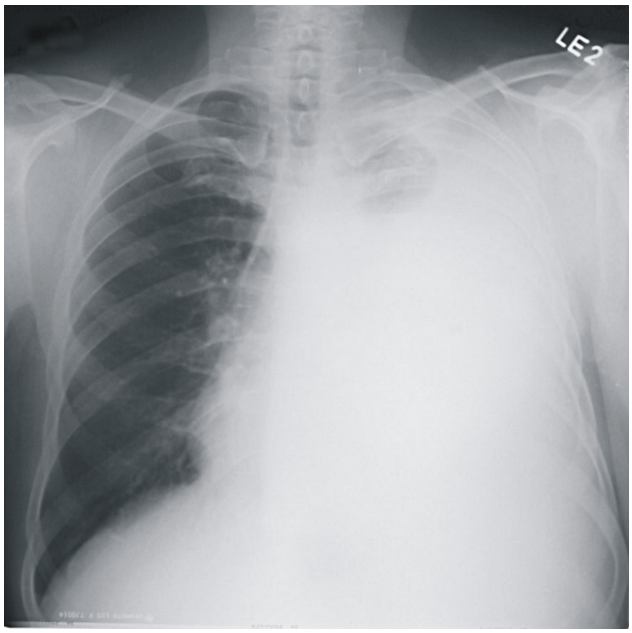

Figure 6. Massive fluidothorax.

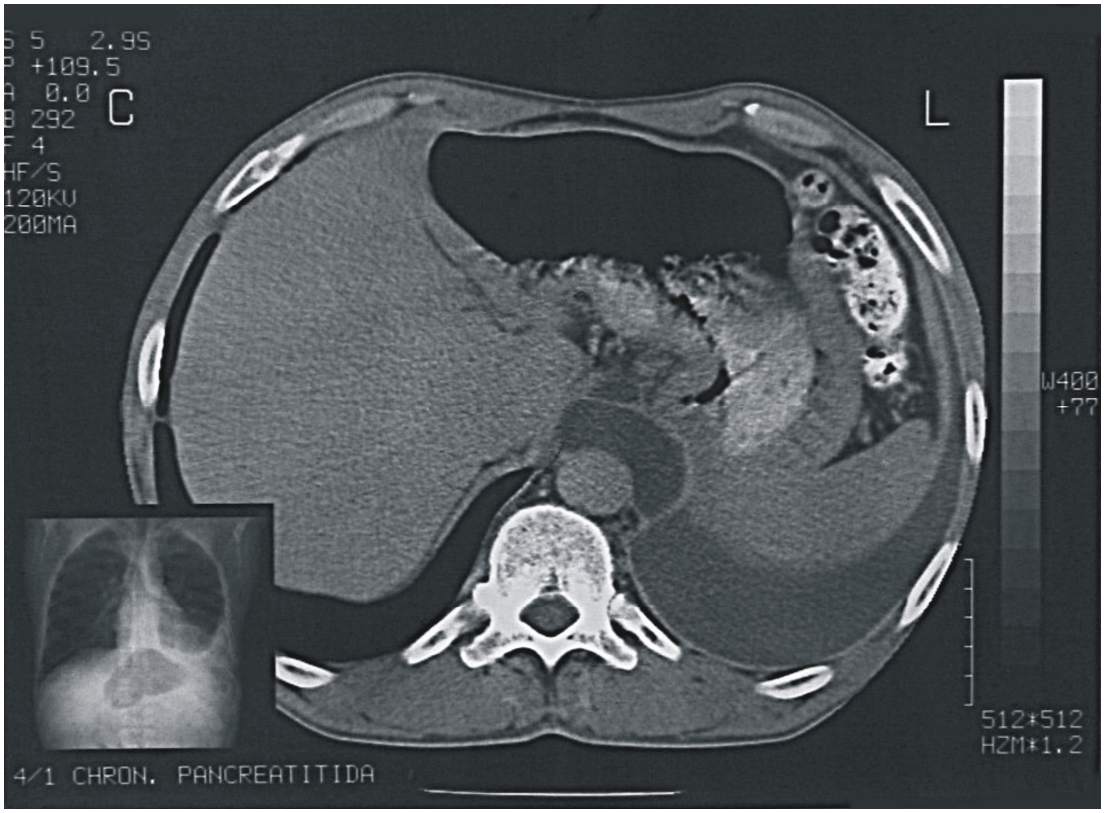

Figure 7a. CT -- chronic pancreatitis with creation of paraaortal and paraoesophageal pseudocysts (in the retroperitoneum and mediastinum) with left--sided fluidothorax.

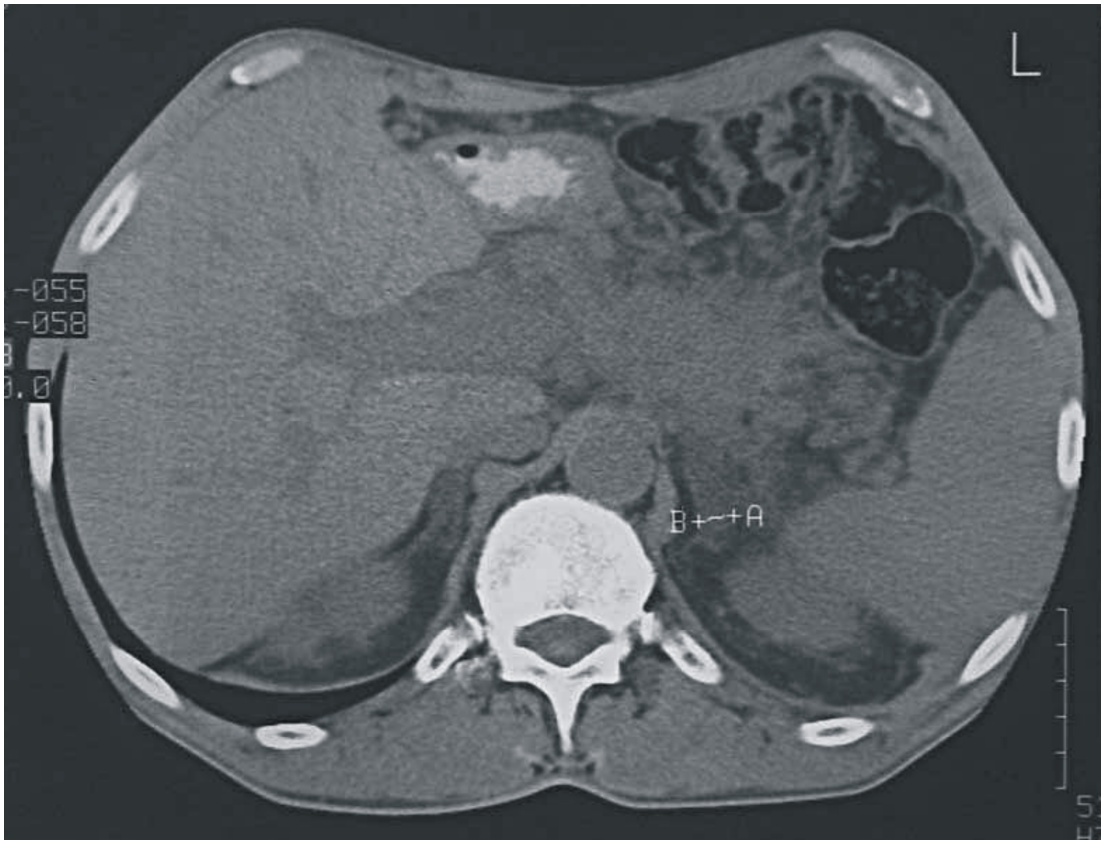

Figure 7b. CT -- chronic pancreatitis with creation of paraaortal and paraoesophageal pseudocysts (in the retroperitoneum and mediastinum) with left--sided fluidothorax.

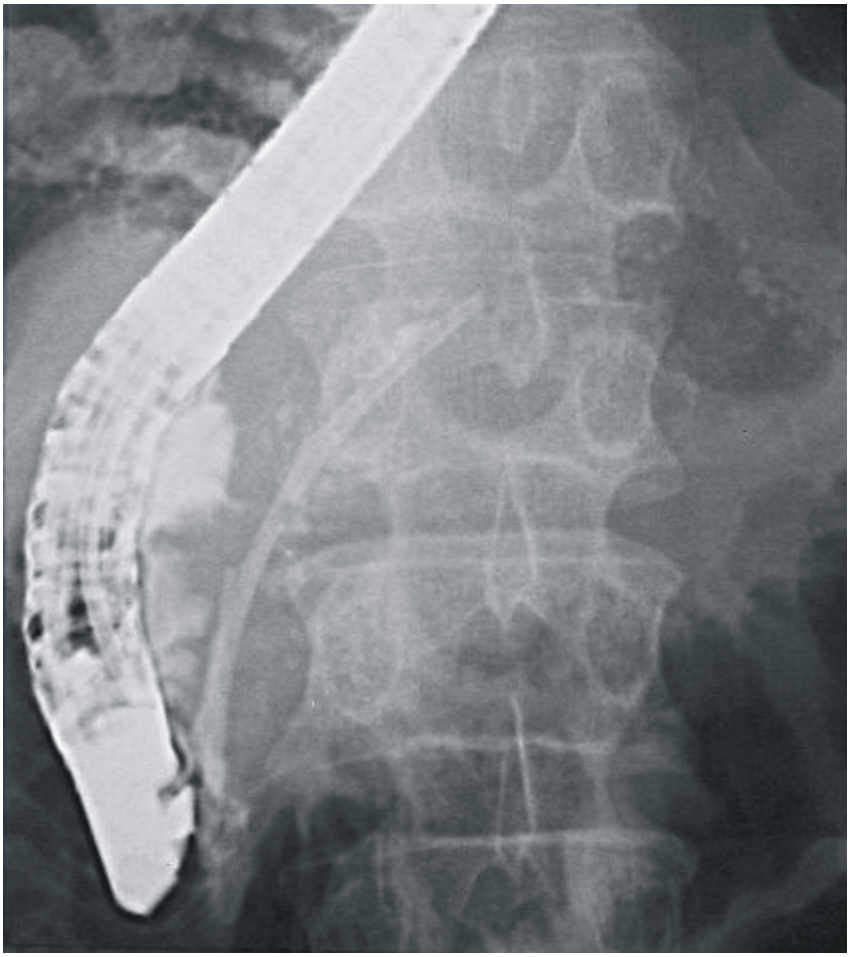

Figure 8. Endoscopic stent placement into the pancreatic duct.

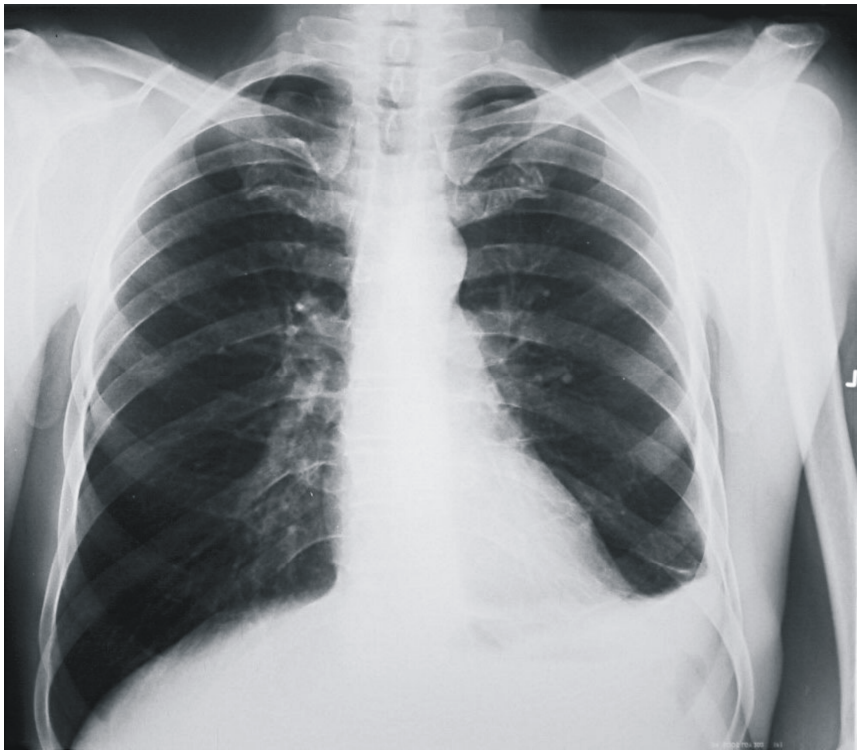

Figure 9. Status after healed pancreaticopleural fistula.

CASE #4

48 old years patient with chronic calcific pancreatitis. Direct communication of the fistula with pancreatic duct in the region of the pancreas body was verified peroperatively. We performed latero--lateral pancreaticojejunostomy sec. Partington--Rochelle (Figure 10, 11, 12, 13).

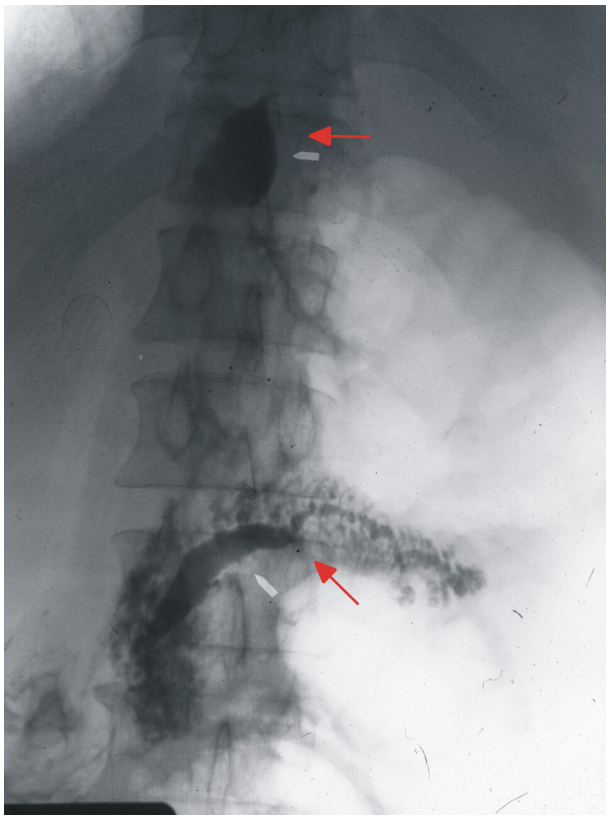

Figure 10. ERCP dilated pancreatic duct is filling, there is a „stop“ in the region of the body, then fistula channel is filling, pseudocystic cavity between aortic and oesophageal hiatus.

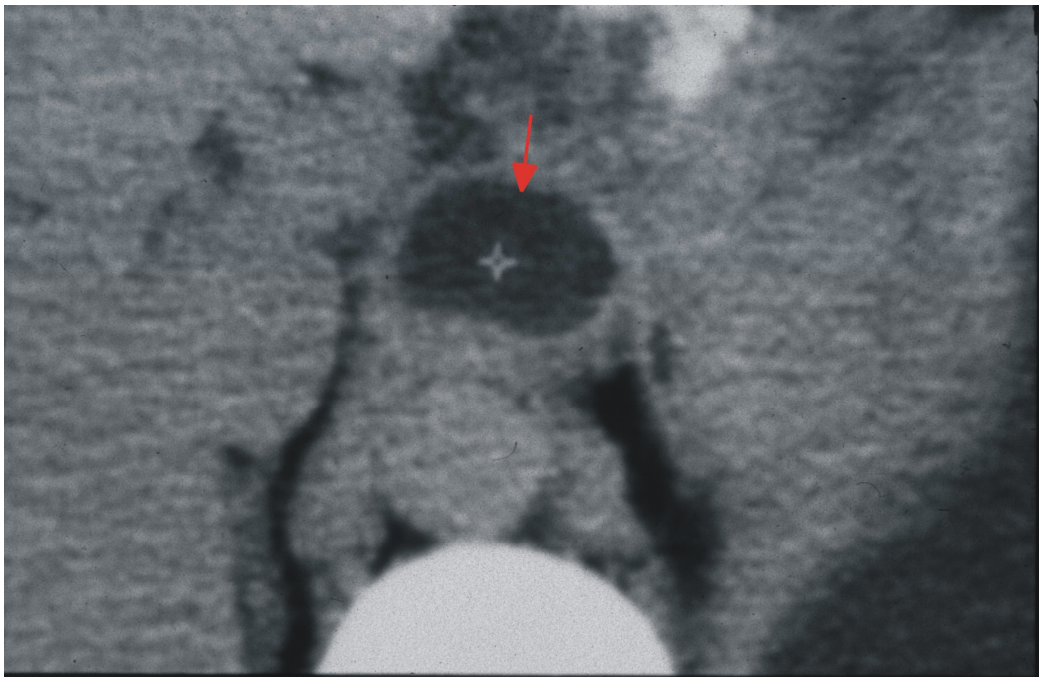

Figure 11. CT -- collection tracking from the body in cranial direction.

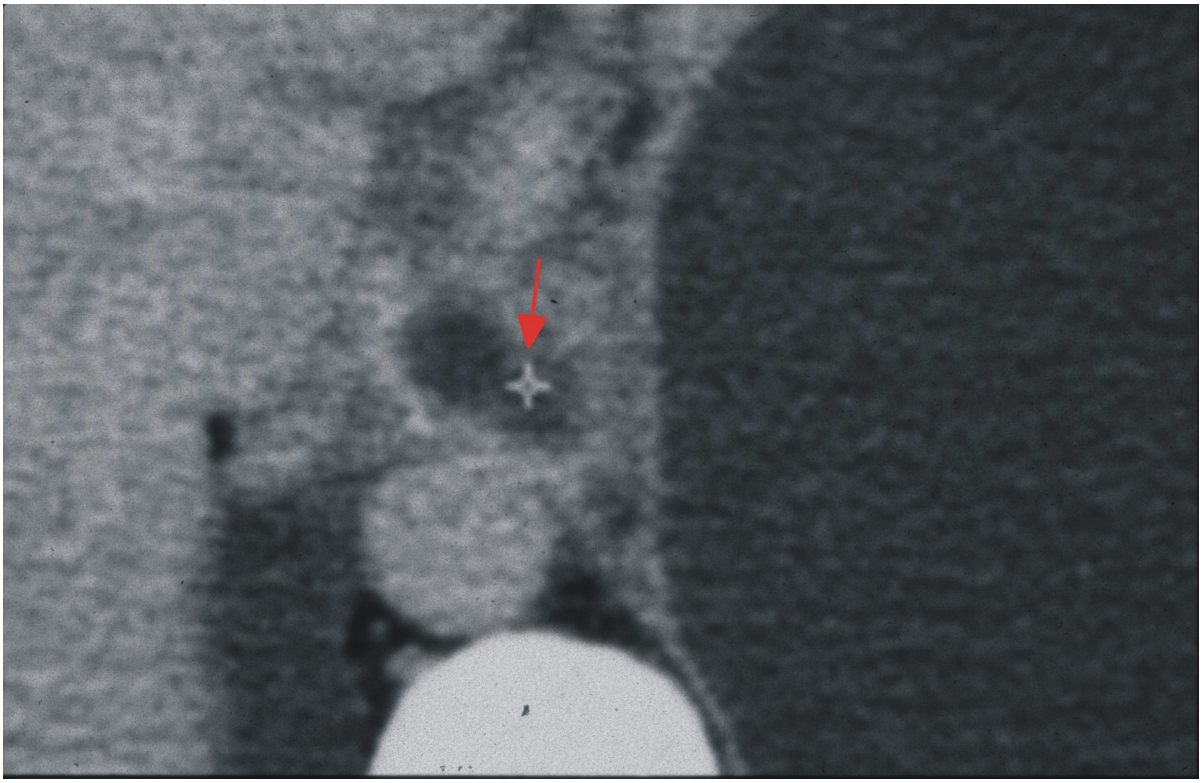

Figure 12. CT -- on the 5 cm more cranial scan fistula is situated between aortic and oesophageal hiatus.

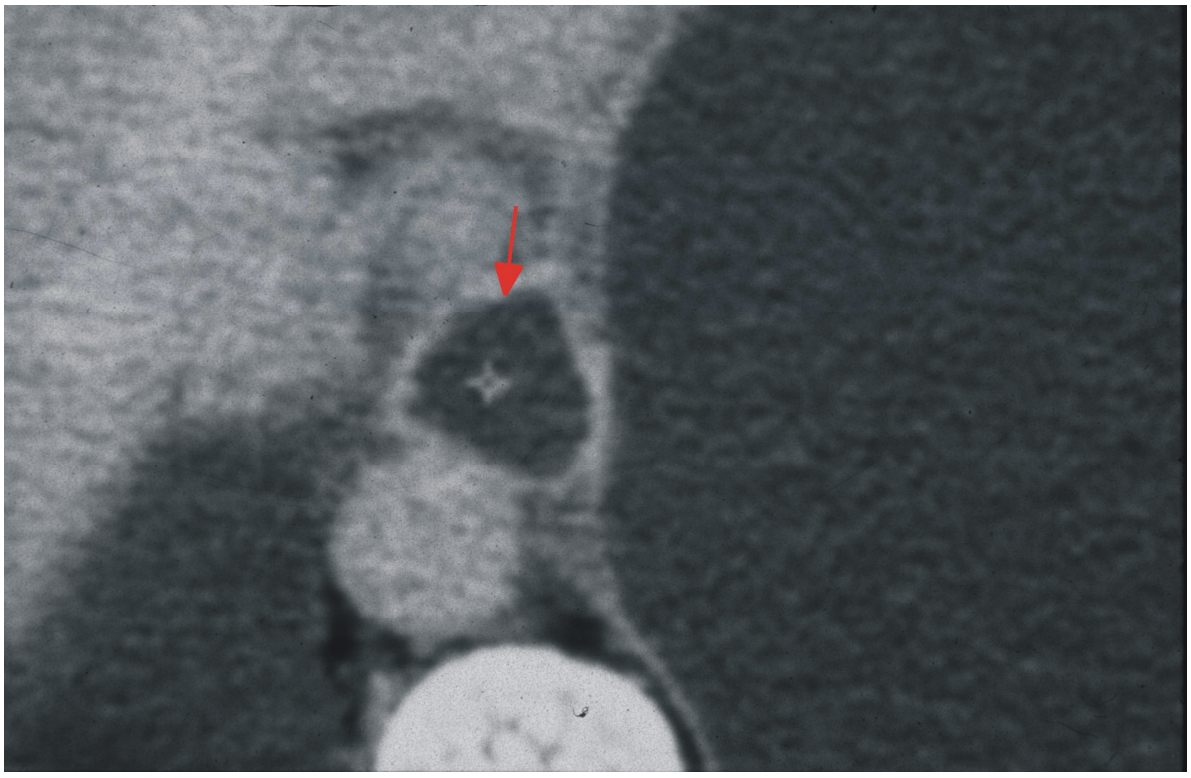

Figure 13. CT -- above the diaphragm fistulous channel is enlarging, it passes through the posterior mediastinum and adheres to mediastinal pleura. Bilateral fluidothorax is present.

CASE #5

57 years old patient with ERCP confirmed pancreaticopleural fistula. CT proved fistulous route into the mediastinum. Patient underwent laterolateral fistulo--pancreaticojejunostomy (Figure 14, 15, 16, 17).

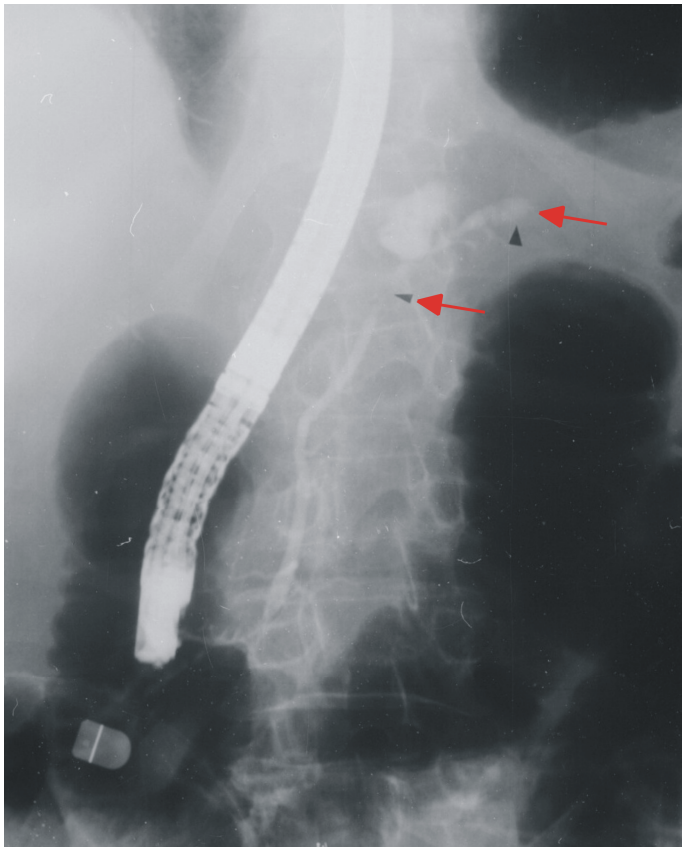

Figure 14. ERCP -- in the pancreatic region initial part of pancreatico--pleural fistula is filling, stricture of the pancreatic duct is displayed, in its distal part pancreatic duct is dilated.

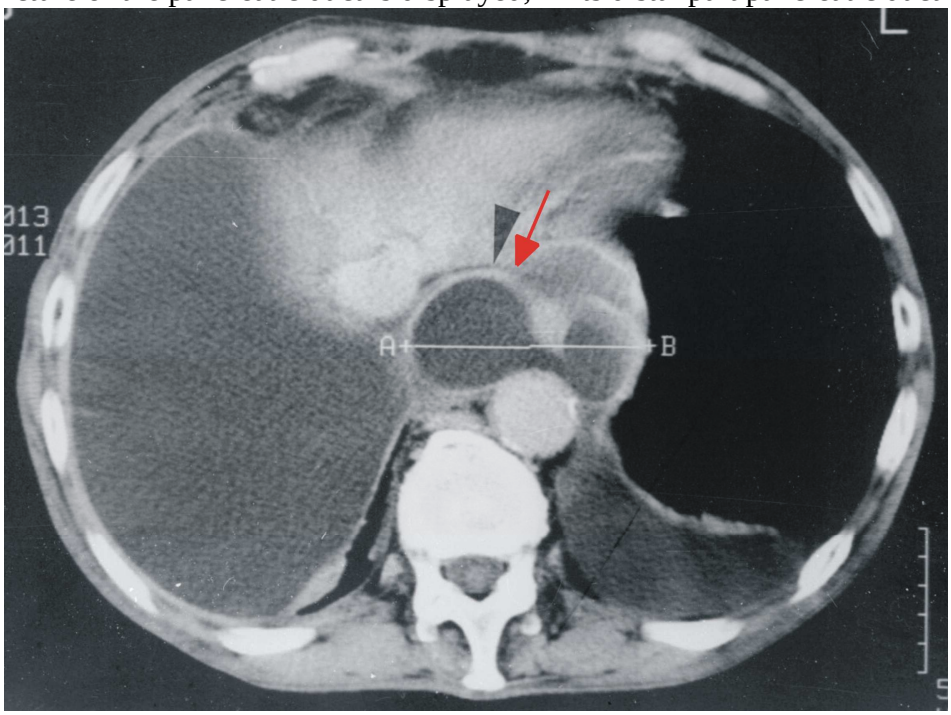

Figure 15. CT-- course of fistula in the mediastinum and bilateral fluidothorax.

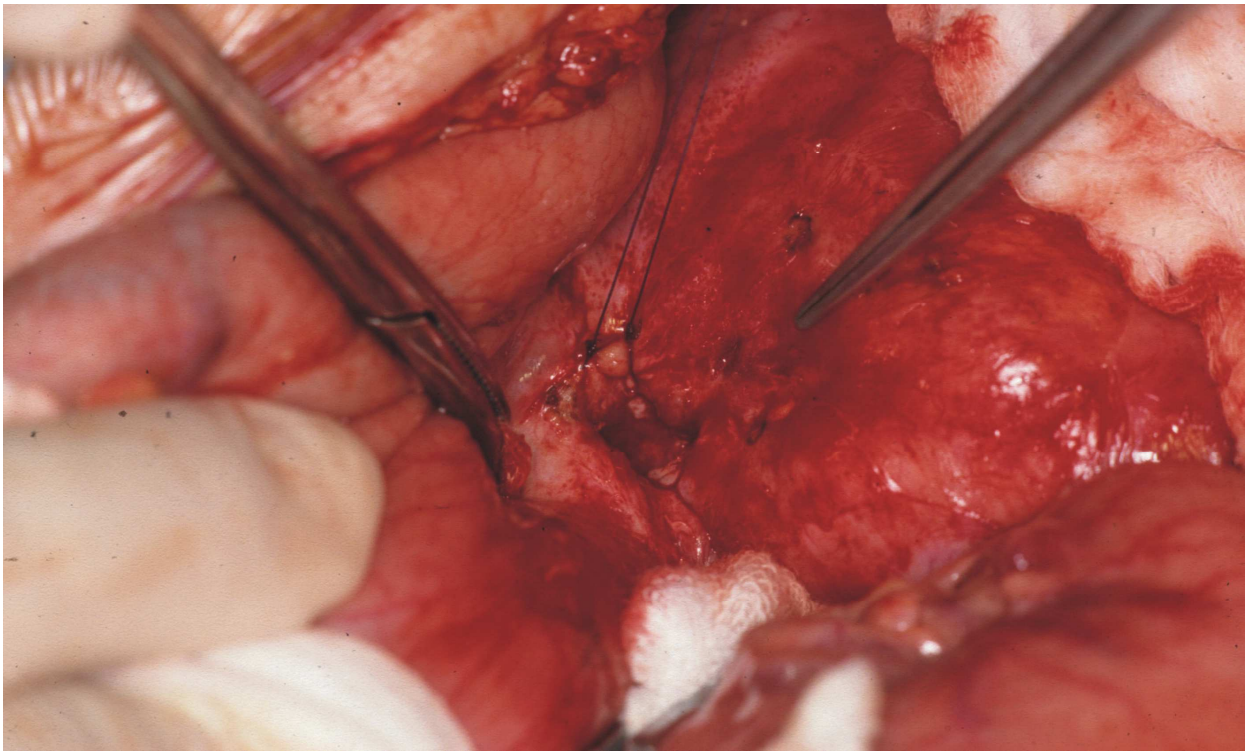

Figure 16. Peroperative picture with bare fistulous channel above the superior border of the pancreatic body.

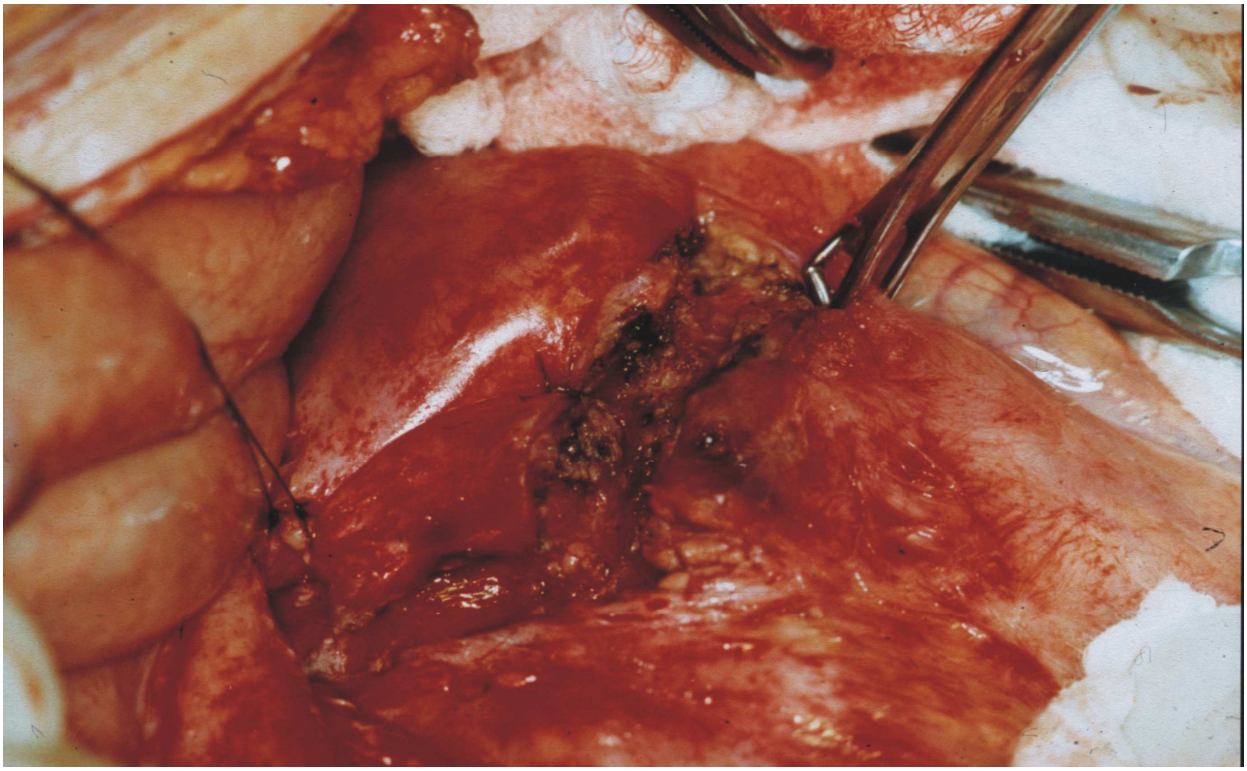

Figure 17. Opened fistulous channel with dilated part of the pancreatic duct in the distal part of the pancreatic body.

CASE #6

36 years old patient with pseudocystic formation in the region of pancreas body. Fistulous tract tracked through oesophageal hiatus. ERCP was unsuccessful. A fistulo--psedocystogastrostomy was performed (Figure 18 a,b, 19, 20).

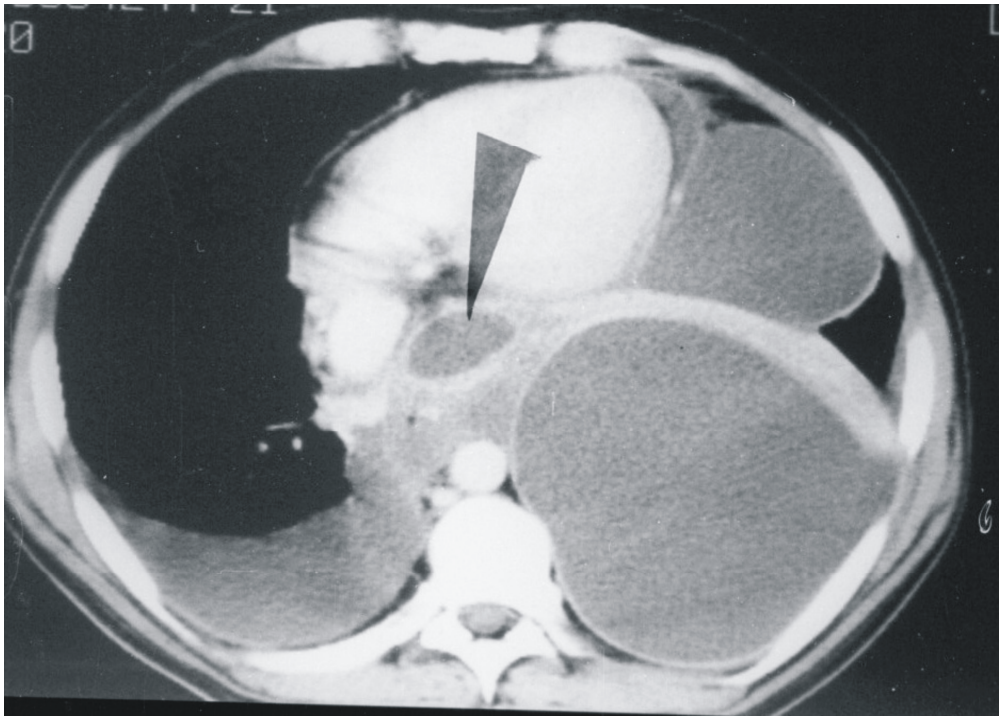

Figure 18a. CT Pseudocystic formation is displayed above the pancreatic body, on the more cranial scan fistulous tract can be seen in oesophageal hiatus, bilateral fluidothorax. Circumscribed collections in the left hemithorax.

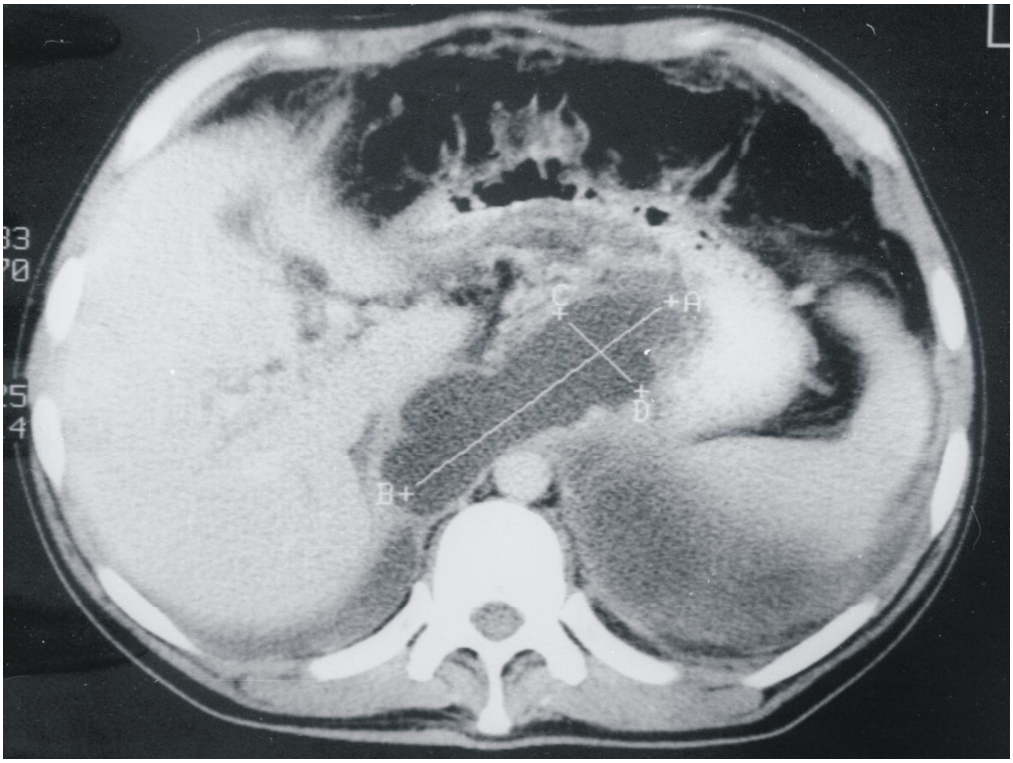

Figure 18b. CT Pseudocystic formation is displayed above the pancreatic body, on the more cranial scan fistulous tract can be seen in oesophageal hiatus, bilateral fluidothorax. Circumscribed collections in the left hemithorax.

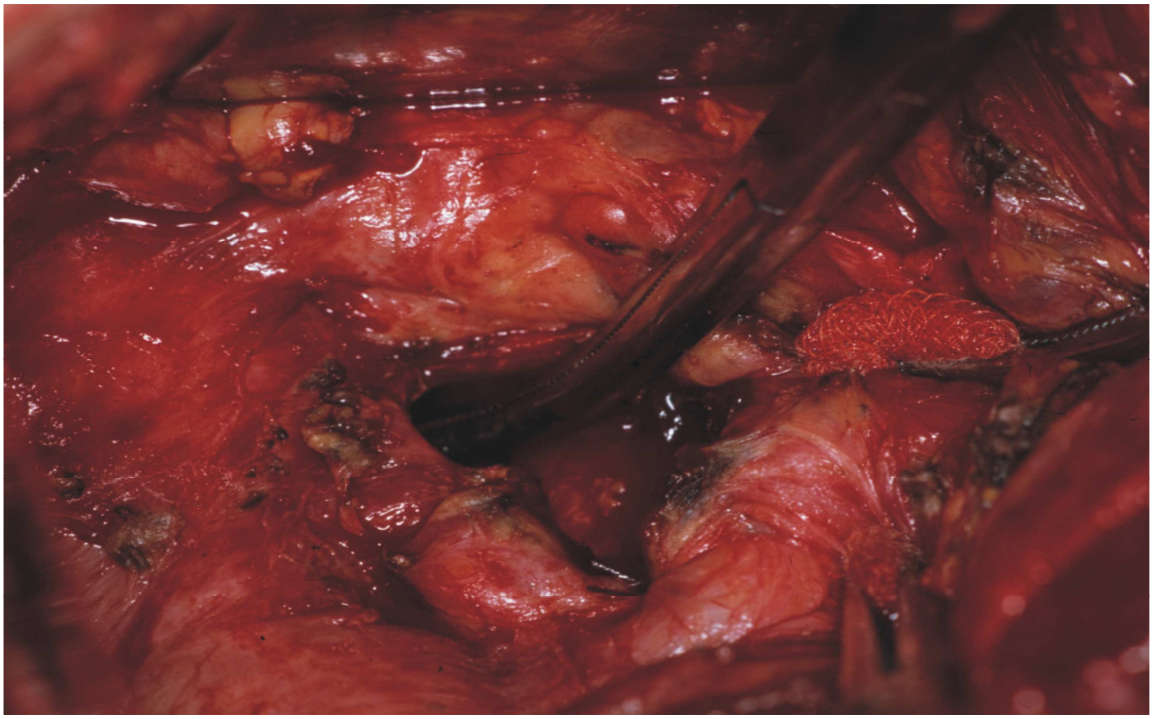

Figure 19. Peroperative picture of pseudocystic formation is identified on the superior border of the pancreatic body. After its opening we revealed communicating pseudocyst. Catheter is placed into the channel of pancreaticopleural fistula through pseudocyst cavity.

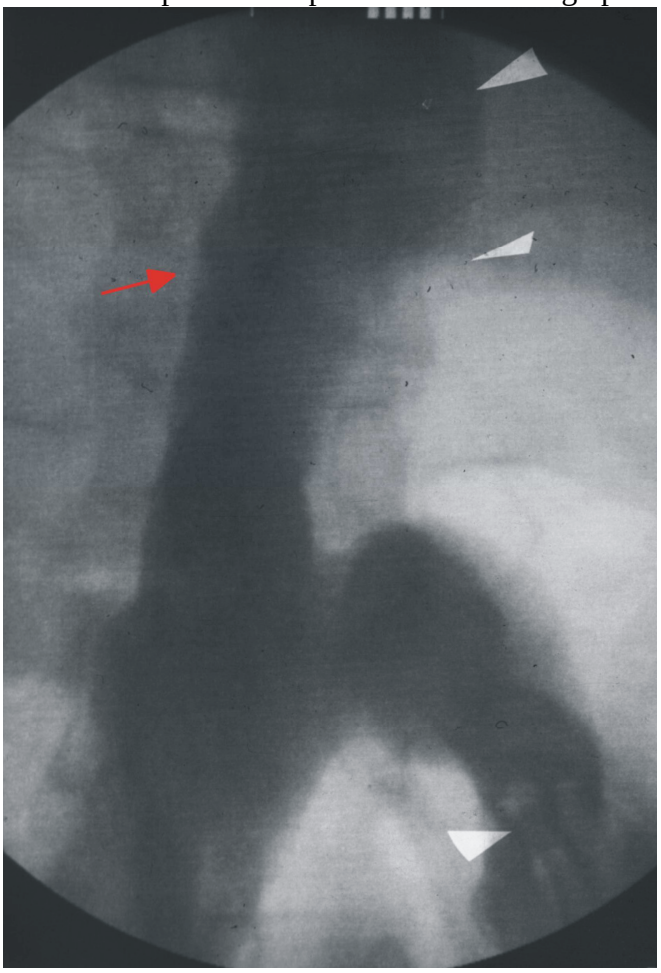

Figure 20. Peroperative filling of pseudocyst and pancreatico--pleural fistula with contrast medium. Fistulous tract passing into the mediastinum (red arrow).

Pathomorphologic findings of pancreatic ductal system in our patients can be divided into three types. From the surgical strategy point of view and character of pathomorphologic finding of pancreatic duct we classified pancreaticopleural fistula into 3 types:

Type 1 -- Proximal occlusion of the main pancreatic duct with its diffuse dilatation as well as secondary tributaries.

Type 2 -- Peripheral (distal) stricture of the main pancreatic duct with communicating fistulous tract tracking into the mediastinum.

Type 3 -- Obstruction (stricture) of the main pancreatic duct with formation of communicating pseudocyst.

RESULTS

Postoperative course in all patients was complications free. Postoperative mortality was 0.0 %. During the follow--up after 5, 6, 7 and 9 years we recorded no exacerbation of pancreatitis, patients have good performance status, there were no abdominal pain nor fluidothorax. CT revealed stabilized condition.

DISCUSSION

The most common (99%) underlying cause of pancreaticopleural fistula is chronic alcoholic pancreatitis (Uchyijama et al 1992. The presentation is often confusing, with a predominance of pulmonary symptoms and a relative absence of abdominal complaints. A pancreaticopleural fistula should be suspected in a patient with a history of alcoholism and a chronic pleural effusion (Iglesias et al. 1996). The overall mortality rate from pancreaticopleural fistula is approximately 5% (Zabiaurre et al. 2005).

Pancreatic pleural effusion results from pancreatic duct disruption with leakage of pancreatic juice into pleural cavity.If the ductal leakage is anterior, pancreatic ascites develops, if posterior pleural effusion results. Pancreatic juice escapes into retroperitoneal space, moving upward and entering the mediastinum through oesophageal or aortic hiatus, less commonly directly through the dome of diaphragm (Semba et al. 1990).

Anatomy of the main pancreatic duct can directly determine the choice of treatment modality of pancreaticopleural fistulas: either endoscopic drainage or surgery. Pathomorphology of pancreatic duct anatomy should be taken into consideration when choosing modality of surgery. Solely non--operative approach is tentative. Postponement of surgical intervention may lead to the following serious complications:

Repeated punctures or prolonged drainage of pleural effusions, empyema, pyopneumothorax and pachypleura formation

Does not resolve the underlying cause of fistula – drainage of the pancreatic duct.

When dealing with pancreatic duct obstruction it is neccessary to exclude pancreatic malignancy. Endoscopic ultrasonography is an advisable complement of other diagnostic methods.

In the case of its proximal obstruction (Type 1) endoscopic drainage is appropriate. However, endoscopic drainage can be accompanied by certain complications, particularly

stent reaction(transformation of dilated pancreatic duct to a narrow one resulting from a reaction to foreign material could limit or even exclude pancreaticojejunostomy in the case of neccessity in the future. Relaps of pancreatitis and other general complications of endoscopic drainage can appear as well. We do prefer primary pancreaticojejunostomy because in indicated cases we achieve excellent results in our patients with chronic pancreatitis.

In the case of peripheral stricture (Type 2) we do not consider resection of fistulous tract itself as sufficient because drainage of the distal part of the pancreas has to be solved too. In two our patients we performed laterolateral fistulo--pancreaticojeunostomy, in one our patient segmental (central) pancreatic resection and pancreaticojejunostomy with the distal remnant of pancreas was done. We prefer pancreatic parenchyma preserving approach because this disease is characterized by chronic progressive destruction of the gland parenchyma.

In the type 3 we utilise the pseudocyst for the drainage of obstructed pancreatic duct and for the drainage of the fistulous tract as well.

On the basis of our experiences we prefer active approach by means of endoscopic drainage and surgical intervention as have been above mentioned.

Unnecessary delay of surgery and extension of unsuccessful conservative treatment increases the risk of serious complication , such as pyothorax and pachypleura formation, sepsis and further worsening of malnutrition. We faced this situation in one our patient who had refused the operation for 6 weeks, during this period just repeated punctures of pleural effusion and left pleural drainage were made. After 6 weeks we proceed with the operation: left--sided pachypleura and chronic thoracic empyema was removed via thoracotomy and laterolateral fistulopancreaticojejunostomy was performed simultaneously. After long follow--up the result is excellent, without relaps of fistula or chronic pancreatitis.

CONCLUSION

Concerning the management of pancreaticopleural fistulas surgeons´ experiences are limited to a smaller number of patients mostly case reports rather than great cohorts.
In our group of 6 patients we present our own practice.

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ASPECTS OF THE THEORETICAL APPLICATION OF THE IDENTITY TRIANGLE OF INSTITUTIONS TO THE THREE TYPES OF MEDICAL CARE CENTRES

ASPEKTE DER THEORETISCHEN ANWENDUNG DES IDENTITÄTS-DREIECKES DER INSTITUTIONEN AUF DIE DREI ARTEN VON MEDIZINISCHER VERSORGUNGSZENTREN

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Abstract

Introduction: Studies relating to the topic of "medical care centres" clearly reveal that there are fundamentally three different types of health medical care centre in Germany. The usual medical care centre/partnership company, the usual medical care centre/corporation and the medical care centre of the company.

Objectives: The aim of this paper is to explore the topic more deeply on the basis of fundamental institution-theory principles and to illustrate interrelationships between the three types and institutional economics.

Methodology: As a research method, a deductive approach is taken to eveal model-theory interrelationships and to present them descriptively.

Conclusion: This paper is able to demonstrate economic interrelationships for the medical care centre; it should also be emphasised that the medical care centre constitutes a forward-thinking structure in the German healthcare system that can, however, also serve as a future model for other European countries.

Keywords: usual medical care centre/private company, usual medical care centre/corporation, medical care centre of the company, institutional economics, identity triangle of institutions, model-theory interrelationships

Abstrakt

Einführung: Durch Untersuchungen zum Thema „Medizinisches Versorgungs-zentrum" wird klar ersichtlich, dass es sich um drei grundsätzlich verschiedene Typen von Medizinischen Versorgungszentren in Deutschland handelt. Das usuelle Medizinische Versorgungszentrum / Personengesellschaft, das usuelle Medizinische Versorgungszentrum / Kapitalgesellschaft und das Medizinische Versorgungszentrum der Gesellschaft.

Ziele: Ziel dieses Artikels ist, auf den Grundlagen institutionstheoretischer Überlegungen tiefer in die Thematik einzudringen und Zusammenhänge zwischen den drei Typen und Institutionsökonomik darzulegen.
Methodik: Hierbei wird als Untersuchungsmethode auf deduktivem Weg versucht, modelltheoretische Zusammenhänge herauszustellen und diese deskriptiv zu vermitteln.
Abschluss: Es gelingt mit diesem Artikel, ökonomische Zusammenhänge für das Medizinische Versorgungszentrum aufzuzeigen und es ist unterstreichend zu sagen, dass das Medizinische Versorgungszentrum eine zukunftsweisende Struktur im deutschen Gesundheitssystem ist, aber auch als Zukunftsmodell für andere europäische Länder dienen kann.

Schlüsselwörter: usuelles Medizinisches Versorgungszentrum/ Personengesellschaft, usuelles Medizinisches Versorgungszentrum/ Kapitalgesellschaft, Medizinisches Versorgungszentrum der Gesellschaft, Institutionsökonomie, Identitätsdreieck der Institutionen, modelltheoretische Zusammenhänge

1 PREFACE

The three identified types, “usual medical care centre/partnership company”, “usual medical care centre/corporation” and “company medical care centre”, differ most significantly in their size in terms of the number of employees and in the choice of legal form (Renger 2014a; Renger 2014b; Hulkova, Renger, Czifusz 2017). While the usual medical care centre is to be considered a medium-sized medical care centre in both legal forms, in the case of the company medical care centre, the size of the entity concerned becomes apparent. This is reflected in the number of employees and also the fact that the choice of a company constituted under civil law (GbR) as legal form seems unlikely for an entity of such size (Czirfusz, Pöschl 2016). On the basis of these interpretations, in practice it can be assumed that structural considerations concerning the healthcare system in Germany, and in particular medical care centres, will reveal that the medical care centres are medium-sized and large entities (> 50 employees) (Kluge 2000).

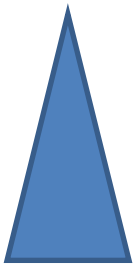
1.1 FURTHER DEVELOPMENT OF THE IDENTITY TRIANGLE OF INSTITUTIONS

The institution triangle according to Jäger (Jäger, 2008, p. 249) and Renger (Renger, 2014a; Renger 2014b) is further developed as follows:

Figure 1: Institution triangle further developed

Obedience (based on ideology) → vertical company

Tendency towards company medical care centre



Tendency towards usual medical care / Corporation

Exchange/autonomy

(based on market mechanisms) → dispersed company

Tendency towards usual medical care / private company

Sharing

(based on ethics) →horizontal company

1.2 EXPLANATION OF SOCIAL PHENOMENA

Alongside physical phenomena, social phenomena also play a role in academic study. The methods for explaining such phenomena are presented below; firstly, methodological collectivism, and secondly, methodological individualism.

1.2.1 METHODOLOGICAL COLLECTIVISM

Methodological collectivism involves explaining the dynamics of social processes and changes through recourse to “collective entities”. (Popper 1984, p. 348, Renger, Czirfusz 2017b)

In this context, two essential criteria play a central role. Firstly, the conclusions derived from the assumption that social phenomena take the form of entities, and secondly, the concept of the “emergence” of new types of phenomena in the course of human individuals forming interconnections. (Vanberg 1972)

1.2.2 INDEPENDENT SOCIOLOGY

The use of the concept of entity evokes the following formula: “The whole is more than the sum of its parts.” (Durkheim 1976) Durkheim uses this phrase as a substantial argument for explaining the necessity of an independent sociology. This phrase is applied

indirectly when the relationship between individual and society is also seen as a connection between a part and the whole. (Durkheim 1976) “While social phenomena are contingent upon the existence and properties of individuals, they are not identical with them nor do they contain them as significant parts” (Meran 1979; Renger, Czirfusz 2017a; Renger, Czirfusz 2017b).

1.3 THE THREE MEDICAL CARE CENTRE TYPES INTEGRATED INTO THE INSTITUTION TRIANGLE

1.3.1 TYPE 1: COMPANY MEDICAL CARE CENTRE / HIERARCHICAL PRICIPLE

In the obedience society, identification is straightforward: the subordinate group member obeys in order to consume certain privileges, mostly in the form of public goods (e.g. safety); if the member fails to obey, it will be punished, either physically or by having the privileges (e.g. protection) withheld. This system can make the resources of a group accessible to the members in a very direct form, but leaves the members little incentive to act independently. This hierarchical organisation is run by a principal (Hobbes 1651), with subordinates that rank lower at various levels differing in depth. This organisational form is facilitated by the lower costs of transmitting information, which are what makes it possible for the “depth” of the hierarchy to be overcome. The ideal foundation is an ideology, and loyalty results from the principle of command and obedience, which is also secured by an individual ethics. The system is safeguarded by the ownership rights of the principal and the enforcement of these rights. Language is also an instrument of power and can be declared a private good by the principal; Nietzsche had good reason to assign a central power function to the content definition of language: “In the twentieth century, true power will be exerted by those who determine how language is used” (Nietzsche 1896).

Today, this is still evident in the language elements of the language of Norman rule in English. Often, the principal in these hierarchical structures also bears the external (systematic) risk, e.g. as entrepreneurs do with the prospect of liable capital. While the rulers in African dictatorships have a high quality of life, the people bear the risk of good or bad harvest conditions or economic cycles (Blum et. al. 2005; Renger, Czirfusz 2017b).

1.3.2 TYPE 2: USUAL MEDICAL CARE CENTRE / PARTNERSHIP COMPANY: SHARING PRINCIPLE

In the sharing society, identification is primarily marked by rites of passage, which are simultaneously “sunk costs” for each member, i.e. costs that cannot be recovered if the member leaves the group. Persons who are not members are not given access to the group’s common goods. Persons who are members of the group but who are not prepared to share are often stigmatised. In the most simple case, the rite of passage may be a baptism (or the “Jugendweihe” civic initiation ceremony in communist-socialist society) and, as a possible sanction, excommunication. This flat organisation also has a principal; all subordinates, however, have the same rank. It is facilitated by the low costs of saving information (only

made possible by decentralised information retention). The ideal background comprises the right to moral behaviour on the part of humanity (von Rotterdam, in: Schultz 1998) on the basis of various ethics, for example, religion, humanism, but also utopian socialism: loyalty arises from reciprocal altruism among equals ("do ut des"), which is why this organisation can also be seen as an insurance community. A club is formed that can also be defined by means of language (dialect, group code). In any event, a differentiation vis-à-vis other (competing) groups is forged to ensure that the club's resources are not destroyed by free riders who have not made any contribution. (Renger, Czirfusz 2017b)

1.3.3 TYPE 3 USUAL MEDICAL CARE CENTRE / CORPORATION: EXCHANGE

In the autonomous society, market interactions occur when both or all parties see this as being to their advantage. It is clear that incentive mechanisms for exchange must be in place. In order to make contact, there needs to be a network in terms of communication between the participants. Those who have no access to the network are logically excluded. A dispersed organisation as described only involves persons with the same formal rights and is supported by low costs of knowledge production from information (which is what enables the individual's autonomy). The ideal foundation is the market and the contract, via which all types of exchange take place. Loyalty therefore only arises on the basis of reputation. This system requires trust in others as the ideal foundation, such that agreed rules – in the sense of a self-stabilising minimal morality – are complied with. At the same time, each person must mostly bear the opportunity costs of their actions themselves. The openness of the system requires language to be a public good (Blum et. al. 2005; Renger, Czirfusz 2017b).

2 SUMMARY AND CLOSING REMARKS

It is thus clear that principles of institutional economics can be applied to the practical reality of medical care centres.

It can be said, as goes for all typologies, that it is in fact hybrids that occur, with "pure" types being virtually non-existent in the real world. These hybrids are positioned along a continuum within the institution triangle and their properties enable them to be examined.

By illuminating the medical care centre structure in Germany, it can, in general, be said that structures of this type are by all means worthy of promotion, as they not only often bring about new working advantages but also enable a transfer of knowledge.

The medical care centre provides a future-proof structure with the possibility of improvements in the quality of medical care, in patient satisfaction and in profitability (Renger, Czirfusz 2017b).

It is to be hoped that research on the topic of medical care centres will develop and implement further academic and practical analyses.

A typological approach should also be integrated in order to understand the medical care centre situation in Germany (Renger 2014a; Renger 2014b).

The business-management view of regarding medical care centres as institutions – and thus as micro-economic elements – could yield new structural knowledge.

This knowledge of the structure and its specific properties greatly facilitates the development of recommendations for action in the academic area of public health and thus fulfils the requirements of real-life applications.

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AMENDMENT TO ACT No. 96/2004 COLL., THE NON-MEDICAL HEALTHCARE PROFESSIONS ACT

NOVELIZÁCIA ZÁKONA 96/2004 Sb. ZÁKON O NELEKÁRSKYCH ZDRAVOTNICKÝCH POVOLANIACH

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Abstract

Objective: The aim of the contribution is to define the main reasons for the implementation of amendment and the selected changes brought in by the amendment of the Healthcare Non-Medical Professions Act within the context concerning the education of nurses and the lifelong learning.

Methods: Statistic Analysis of Health Care workers (nurses) in Czech Republic, Analysis and comparison of Act.

Conclusion: The author of the contribution assumes that the implementation of changes within amendment of the Healthcare Non-Medical Professions Act has brought and in the future will surely bring many changes in education of nurses as well as lifelong education and the field of registration of paramedical staff. The real result of the changes brought in by the amendment to the Act will be realistically assessed at least after the expiration of 5 (five) years after its entry into efficiency.

Keywords: Nurse. Health. Legislation. Amendment. Qualification.

Abstrakt

Cieľ: Cieľom príspevku je vymedziť hlavné dôvody implementácie zmien a doplnení a vybrané zmeny, ktoré priniesla novelizácia zákona o zdravotnej starostlivosti o nelekárske povolania v kontexte vzdelávania sestier a celoživotného vzdelávania.

Metódy: Štatistická analýza zdravotníckych pracovníkov (zdravotných sestier) v Českej republike, Analýza a porovnanie zákona.

Záver: Autor príspevku predpokladá, že implementácia zmien v rámci novelizácie zákona o zdravotnej starostlivosti pre nemedicínske povolania priniesla a v budúcnosti určite prinesie viaceré zmeny vo vzdelávaní sestier, ako aj celoživotnom vzdelávaní a v oblasti registrácie mimolekárskeho personálu. Skutočný výsledok, ktorý vyplýva zo zmien a novelizácie zákona, bude reálne zhodnotený po uplynutí najmenej piatich rokov od nadobudnutia jeho účinnosti.

Kľúčové slová: Sestra. Zdravotníctvo. Legislatíva. Novela. Kvalifikácia.

INTRODUCTION

The aim of this paper is to define the selected changes brought by the amendment to Act No. 96/2004 Coll., the Act on Paramedical Healthcare Professions (hereinafter referred to as the "Act"). The legislative process itself concerned with the creation of the amendment was accompanied by rather controversial discussions at the level of individual professional healthcare organisations, political clubs and the public. The submitted draft amendment to the Act was approved by the Legislative Council of the Government of the Czech Republic on 2 June 2016, the amendment to the Act was signed by the President of the Czech Republic on 21 June 2017, the amendment was published in the Collection of Laws on 12 July 2017 and it has been effective as Act No. 201/2017 since 1 September 2017.

This article also presents a brief summary of results arising from the statistical data analysis of the number of general nurses and midwives in the period from 2009 to 2016.

In the paper, the author focuses only on the changes that she considers to be the most important in comparison with the original text of the Act before the amendment came into effect. Specifically, this concerns changes in the acquisition of the professional competence of a general, child and practical nurse and changes in the lifelong learning of non-medical healthcare professionals. The content focus of the individual subject areas will be as follows:

- Professional competence to practice the profession of a general nurse
- Professional competence to practice the profession of a practical nurse
- Lifelong learning

STATISTICAL DATA ANALYSIS OF THE NUMBER OF GENERAL NURSES AND MIDWIVES - THE REASON FOR CHANGING EDUCATION?

The numbers of nurses and midwives are declining. According to the data obtained from the UZIS from 2009 to 2016, the decrease within the numbers of general nurses and midwives is noticeable by up to 790 employees (see Figure 1 Number of Nurses and Midwives 2009-2016)

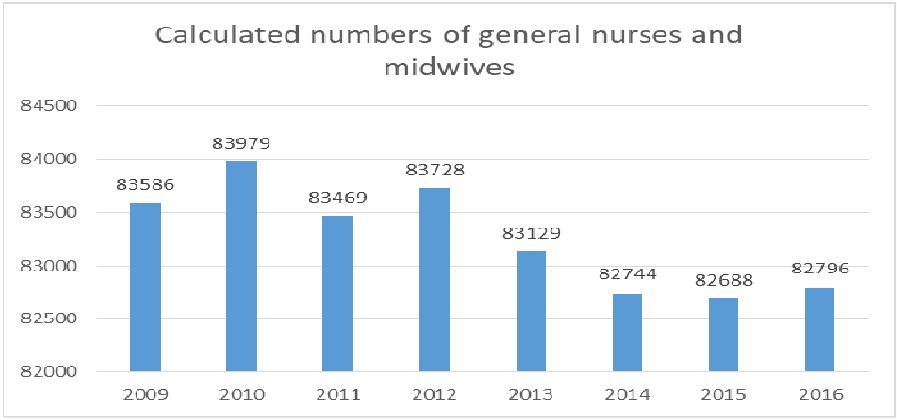

Figure 1 Calculated number of nurses and midwives 2009 – 2016
Source: UZIS ČR, 2016

Subsequently, the author analyzed the numbers of general nurses and midwives in main segments of medical care in 2011-2016. (See Figure 2 Numbers of nurses and midwives by main segments of medical care.)

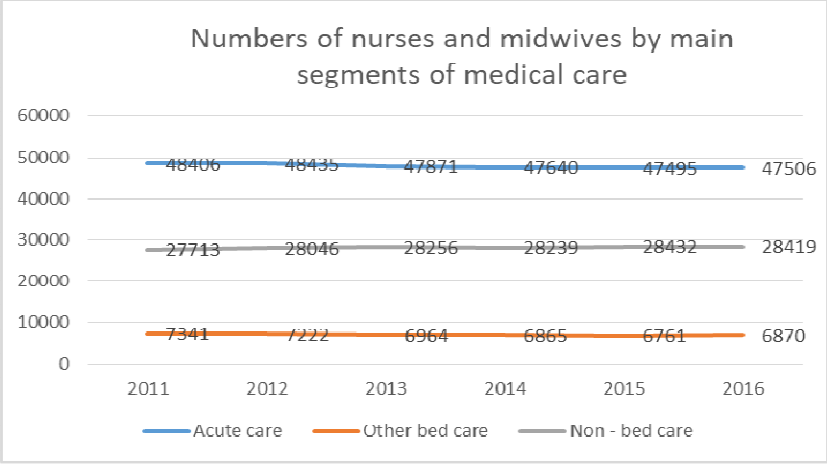

Figure 2 Numbers of nurses and midwives by main segments of medical care. Source: UZIS ČR, 2016

The above table clearly shows that the number of nurses and midwives has decreased in acute care from 2011 to 2016 by 900, in other-bed care by 471, while the number of nurses and midwives has increased from 2011 to 2016 by 706.

Stagnation in the acute-care segment is evident - after its long-term slump in 2016, the numbers stabilized at the level of 2015. In comparison with 2015 the numbers have increased only by 11, which represents a 0.02% increase. The author likewise sees stagnation within the other-bed care segment. In comparison with 2015 the numbers have decreased only by 13, which represents a 0.05% decrease.

It follows that the downward trend in the number of general nurses and midwives is one of the reasons for changing the education of nurses.

REASONS OF IMPLEMENTATION OF AMENDMENT TO ACT NO. 96/2004 COLL., THE NON – MEDICAL HEALTHCARE PROFESSIONS ACT

According to the authors of the explanatory report to the amendment, the proposed Act aims to stabilize and improve the existing system of qualification education, mainly nursing professions of general nurses, children's nurses, practical nurses (medical nurse), in line with the current needs within the field of health care system. Another objective is to allow the practicing of a nurse profession without professional supervision to facilitate the real integration of relevant graduates into working multidisciplinary teams. The proposed Act also reflects the need to perform the medical profession without necessity of issuing the certification for the medical profession without professional supervision. These needs are based on the requirements and needs of the practice (improving motivational, working, educational and employing "non-medical healthcare professionals"). Within the field of

accreditation, there is an adjustment concerning its transfer and duties, the documents submitted by the applicant to the accreditation application are refined.

PROFESSIONAL COMPETENCE TO PRACTICE THE PROFESSION OF A GENERAL NURSE

A significant change of the Act was brought by the amended version of the provision of Section 5(1)(c), in which, especially with a view to increasing the quantity of general nurses within the Czech Republic, it is possible to obtain professional competence to practice the profession of a general nurse by selected groups of healthcare professionals who successfully complete a four-year study at a secondary medical school ("SMS") in the major of practical nurse (former medical assistant), midwife, paramedic or child nurse and then successfully complete at least one (1) year at a higher vocational school ("HVS") in the health education field. The Explanatory memorandum to the relevant amendment, as well as the actual wording of the provision, automatically assume a significant degree of compliance within the training plans of the individual programmes at SMS and HVS. During the legislative process, this learning model was unofficially referred to as "4+1". The change mentioned above extends the group of healthcare professionals who will be qualified to practice the general nursing profession. Professional competence to practice general nursing profession within the meaning of Section 5(1) of the Act, apart from the above, can be obtained by completing:

- To at least a 3-year accredited medical bachelor's study for the training of general nurses;
- To at least 3-year study for a graduate general nurse at HVS in the medical education field;

The professional competence to practice general nursing profession also belongs to graduates of educational programmes according to the wording of the Act before the amendment came into effect, which has not been modified by the amendment, as follows:

- university study started at the latest in 2003/2004 in study programs and fields of psychology – care for the sick, pedagogy – nursing, pedagogy – care for the sick or the teaching of vocational subjects in secondary medical schools;
- study started at the latest in the school year 2003/2004, three-year study in the field of a graduate child nurse or a graduate psychiatric nurse at HVS in the medical education field;
- study at SMS started at the latest in 2003/2004, major of general nurse at SMS;
- study at "SMS" started at the latest in 1996/1997, subject of study a nurse, a child nurse, a psychiatric nurse, a nurse for intensive care, a nurse for women or a midwife;
- study started at the latest in 2003/2004, three-year study in the field of graduate midwife at HVS in the medical education field.

In the amended version of the Act, the provisions of Section 5(2), which regulated the profession of a general nurse without professional supervision is left out, which *de facto* confirms the intention of the amendment, namely to create an equal position for health care professionals performing the profession of a general nurse, regardless of the level of education (university, HVS, SMS). The original wording of the Act prior to the effect of the

amendment defined the profession of a general nurse without professional supervision for health care workers with secondary school education after 3 years of practise of general nursing profession. This obligation did not apply to general nurses who, after gaining professional competence, have finished university studies of nursing care or have acquired specialised competence under the provisions of Section 96(3). The amendment to the Act stipulates that a general nurse, in cooperation with a physician / dental practitioner, is also involved in the provision of palliative care in addition to the original range of diagnostic, rehabilitative, urgent and permanent (dispensary) care.

PROFESSIONAL COMPETENCE TO PRACTICE THE PROFESSION OF A PRACTICAL NURSE

After the amendment to the Act has taken effect, the term "medical assistant" was deleted and replaced by the term "practical nurse". One of the main reasons for the change in terminology was also the requirement of the professional public due to common addressing / perception of such personnel by clients of healthcare providers. According to the provisions of Section 21(b) of the Act, that graduate becomes a practical nurse who has completed:

- SMS in the major of practical nurse;
- SMS in the major of medical assistant, if the study started at the latest in the school year 2018/2019;
- an accredited qualification course for a practical nurse after graduation at a secondary school and acquiring professional competence to practice nursing care profession;
- an accredited qualification course for a medical assistant after graduation at a secondary school and acquiring professional competence to perform the profession of a hospital attendant provided that the accredited course started before the end of 2018;
- six (6) semesters of an accredited medical bachelor programme for the preparation of a general nurses or of three years at HVS in the major of general nurse.

The Act also provides that a professional competence to practice practical nursing profession is held also by a healthcare professional – a paramedic and a midwife. Practice of general nursing profession differs from the practice of practical nursing profession in the fact that the qualification requirement is to complete secondary education or an accredited qualification course. The competence to practice nursing profession will be automatically available to all who at the date of effect of the amendment to the Act had acquired qualification as a medical assistant or who are currently studying or who will start studying in the next two (2) years. The medical assistant profession will be terminated and replaced by the practical nurse profession from the school year 2019/2020. The practice of practical nursing profession is carried out according to the amended version to the Act without professional supervision.

LIFELONG LEARNING

The amendment to the Act brings a fundamental change by abolishing the so called "credit system", making changes in lifelong learning records, not only for nurses but for all

non-medical healthcare professions. Therefore, it will be explicitly dependent on an individual decision by particular healthcare providers how they implement the control system and the subsequent evacuation of that control. According to the provision of Section 53 of the Act, lifelong learning is defined as the continuous renewal, enhancement, deepening and expanding of the knowledge, skills and competences of healthcare professionals and other professionals in the relevant field in accordance with the development of the field and the latest scientific knowledge in order to maintain the safe and effective exercise of the corresponding profession.

Lifelong learning is considered to be a follow-up study program of – an accredited doctoral study programme, an accredited master study programme or an accredited bachelor study programme or study programme of HVS in the medical education field and is completed after previous acquiring of professional competence for the practise of a healthcare profession and further:

- Specialised training provided by accredited facilities; Certified courses provided by accredited facilities; Innovatory courses in accredited facilities; Professional internship programmes in accredited facilities; Participation in training events, conferences, congresses and symposia; Publication, pedagogical and scientific research activities, development of a standard or new procedure; E-learning course; Independent study of professional literature.

Lifelong learning in points 1-5 is considered to be a deepening of qualification under Act No. 262/2006 Coll., Labour Code, as amended. This form of education is planned and paid by the healthcare provider as the employer. The organiser issues a certificate of having completed the above-mentioned forms of lifelong learning, as mentioned in points 1 to 5. The organiser keeps records of the participants of its lifelong programmes and upon the request of the Ministry, or an organization authorised by the Ministry, provides data from this record.

CONCLUSION

The aim of the amendment to the Act was, in particular, to set up a legal framework to stabilise the system of qualification education while preserving its quality, especially in the nursing professions of general nurses, child nurses and practical nurses in accordance with the current needs in the field of healthcare. The amendment extended the possibility of acquiring professional competence to perform a general nursing profession through a shortened study at HVS in the medical education field, and for healthcare professionals within the professions of a practical nurse, midwife and paramedic. The amendment abolished the credit system that served to monitor lifelong learning, as it did not represent a sufficient stimulus to education both for healthcare professionals and healthcare providers as employers. In connection with the abolition of the credit system, the issue of certificates for the exercise of the medical profession without professional supervision was also abolished, following the entry in the register of healthcare professionals entitled to practise the medical profession without professional supervision and the records in the professional card. The amendment also abolished the obligation to keep the register of healthcare professionals qualified to practise the medical profession without professional supervision, which had been a "torso" of the

previous system and did not meet the current requirements of the registration system for non-medical healthcare professionals. The amendment to the Act simplifies the possibility to pass a qualification exam for foreigners by the availability of the written part of the qualification exam not only in Czech but also in English, French, German or Russian. The amendment also brings new non-medical healthcare professions, namely: traditional Chinese medicine therapist, traditional Chinese medicine specialist, behavioural analyst, assistant to behavioural analyst and behavioural technician. What the real benefits of the amendment to the Act will be, and whether it will really bring the benefits into practice, is questionable and only the time will tell. However, the author herself does not assume that the amendment to the Act will solve a long-standing problem, namely the lack of nurses in the healthcare system in the Czech Republic.

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USING OCCUPATIONAL THERAPY TO IMPROVE THE QUALITY OF LIFE OF PEOPLE WITH LEARNING DISABILITIES

VYUŽITIE ERGOTERAPIE NA ZVÝŠENIE KVALITY ŽIVOTA ĽUDÍ S MENTÁLNYM POSTIHNUTÍM

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Abstract

Introduction: Occupational therapy is the most often used in social services for people with learning disabilities to makes them more independent and self-developed. It is important to support personal development and achievement of life skills of these people instead of encouraging the social dependence of clients in a social service. It is the most effective form of achieving the stated objectives at intellectually disabled, implemented with the direct participation of the client, and coordinating several experts.

Methods: The research study is focused on analysing impacts of ergotherapy on the quality of life those who are disabled, the data were collected by structured interviews and results analysed by open coding. The object of research are people with learning disabilities involved in the ergotherapy programme providing by The Social Care Institution The Danube.

Results: The research presents the main dimension as a result: 1. impact on personal growth and functional ability – 2. the support of psychical and physical harmony - 3. the development of soft skills and personality – 4. the empowerment of daily life living – 5. the impact on the quality of life. The research has shown correlation between occupational therapy and the specific dimensions of the quality of life and between individual planning and self-development and activism of clients in needs.

Discussion and conclusion: It is important to support vulnerable people in the daily life activities and involved them to independent living. The vulnerable people don't need blame or shames, the most of them are aware of their weaknesses, that why it is worth to make them empowered.

Keywords: learning disability, occupational therapy, personal development

Abstrakt

Úvod: Najčastejšie sa ergoterapia využíva v sociálny službách pre mentálne postihnutých na zvýšenie ich nezávislosti a sebarozvoja. Je dôležité u mentálne postihnutých podporovať osobnostný rozvoj a získavanie životných zručností k nezávislosti skôr ako zvyšovať ich odkázanosť na sociálne služby. Považujeme ju za efektívnu formu dosahovania cieľov v spolupráci so samotným klientom vrátane zapojenia zainteresovaných odborníkov.

Metódy: Cieľom výskumu je analyzovať dopad ergoterapie na kvalitu života ľudí s ľahkým mentálnym postihnutím, zbet dát bol realizovaný pomocou štruktúrovaných rozhovorov a výsledky analzovanéotvoreným kódovaním. Objektom výskumu boli mentálne postihnutí zapojení do programu ergoterapie v rámci starostlivosti v zariadení sociálnych služieb Dunaj.
Výsledky: Výsledkom výskumu je identifikácia týchto hlavných domém: 1. Dopad na personálny rozvoj a funkčné schopnosti – 2. Podpora psychickej a fyzickej rovnováhy - 3. Rozvoj mäkkých zručností – 4. Nezávislosť v každodennom živote – 5. Dopad na kvalitu života. Zistili sme silný vplyv ergoterapie na špecifické dimenzie kvality života a vzťah medzi ergoterapiou a premennými osobnostný rozvoj a osobné naplnenie klienta.
Diskusia a záver: Prioritou práce so zraniteľnými skupinami by mali byť každodenné aktivity smerované na posilňovanie ich samostatnosti v bežnom živote. Mentálne postihnutí nepotrebujú ľútosť, väčšina z nich si je vedomá svojich slabých stránok, potrebujú zmocnenie a posilňovanie vo všetkých sférach života.

Keywords: mentálne postihnutie, pracovná terapia a ergoterapia, osobnostný rozvoj

INTRODUCTION

According to the American Occupational Therapy Association, occupational therapy is “skilled treatment that helps individuals achieve independence in all aspects of their lives. Occupational therapy assists people in developing the skills for the job of living necessary for independent and satisfying lives” (Dachs 2018).

Occupational therapy is the art and science of enabling engagement in everyday living, through occupation; of enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life (Townsend & Polatajko 2007, p. 372).

The most important aim of occupational therapy is to maximise functional ability. A person needs various abilities and skills at the same time if he is to plan, organise and perform activities:

- physical (such as walking, gripping, carrying things);
- cognitive (such as planning or powers of concentration);
- emotional (such as motivation and drive);
- social and interactive (such as body language, regulating proximity and distance).

Despite the fact the number of studies objectifying the favourable effect of dance on many physical and mental functions in the last decade, the research still owes to clinical practice a lot. Bigger attention is paid to dance contribution to physical area, while the objectification of cognitive, social and emotion improvements connected with dance is disregarded (Čelko, Gúth 2017).

In psychiatric units, occupational therapists might focus on successful community integration by teaching new strategies and providing graded activities. Attention might be directed to: (1) increasing energy; (2) finding a balance among self-care, productivity, and

leisure; (3) social participation; (4) decision making and priority setting; and (5) productivity options that decrease stress (Law 2010).

Baková (2015, s.160) highlights the importance of interview as a tool of occupational therapy based on mutual trust and respect between professional and client. The interview should not be only tool of giving information to the client, but needs to be focused on the understanding of the individual. Speaking with people with learning disabilities has to be adapted to the mental level and health conditions of vulnerable client in order to increase self-confidence and obtain his/her personal development.

RESEARCH METHODS AND SAMPLE

The basic research procedural routine has involved four stages: 1. identifying the research questions; 2. gathering the information to answer the questions; 3. analyzing and interpreting the research data by using coding and 4. sharing results and research outcomes.
The research study is based on the process of coding qualitative data as an important part of developing and refining interpretations in interview with sample. Coding is the process of organizing and sorting data. Codes serve as a way to label, compile and organize research data. In linking data collection and interpreting the data, coding becomes the basis for developing the analysis. These initial codes derive from the conceptual framework, list of research questions, problem areas, etc. Data was coded according to categories and sub-categories identified by reading and re-reading the data collected. Categories and sub-categories provide information relevant to the topic studied and used to help explore and clarify the research question.

The research sample is consisted of people with learning disabilities who are clients of the social services providing in the Danube Social Care Centre. The eight of them were included in the research study aimed at showing influence of occupational therapy on different aspects of their daily lives and on the quality of life as well.

RESULTS AND DISCUSSION

People with learning disabilities or mental illness are in the centre of research study based on importance of occupational therapy to achieve their self-development, support self-care and independence in their daily living and improve the quality of life by changing the labelling of disabled people and increasing their social inclusion and working integration.

Research question:
How occupational therapy influences people with learning disabilities in specific fields?

Self-care activities of daily living

Activities of daily living (ADLs) are basic self-care tasks, akin to the kinds of skills that people usually learn in childhood. They include healthy eating habits, selecting proper attire, grooming, putting on clothes and others to maintain a higher level of independence.
The activities carrying out occupational therapy are focused on increasing skills of people with mental illness or learning disabilities in different areas of daily living. The research

study has shown these main skills to be developed of clients with disabilities identifying these areas:

- ✓ *Housework and household management*
- ✓ *Preparing meals and easy cooking*
- ✓ *Taking responsibility for health*
- ✓ *Managing finances and increasing financial literacy*
- ✓ *Shopping for groceries or clothing*
- ✓ *Use of telephone or other form of communication*
- ✓ *Transportation within the community*

The clients with disabilities find occupational therapy as useful for their lives due to different kind of interactive activities helping them to obtain new skills, learn new things in the keeping housework, managing money or doing shopping in rational way.

Jana: "I am not skilled girl and my parents used to help me a lot, but there is good in the centre to learn to be more independent. I do a lot of new things and activities good for daily living such as baking cakes or making hand-made products to be sold.

Adam: If I want to go to the city, I have to go by bus. At the beginning I did not know how to travel and use public transport. Now I buy a ticket by myself and I know the bus stop".

Ivan:" In the care centre we learn things that are helpful to us, they teach us to be more independent. When I came here, I was hardly taught at home because my parents and siblings helped me very much"

Maroš:"I have learned to better manage with money and maintain a household, I have learned to behave responsibly and to spend money wisely. I think I am more considerate"

Ján: "It was first time I cooked myself in the care centre. I was not used to it at home and there was no space to do housework or to cook what I would like to. I am not keen on running household because my parents do it better".

Irena: We go on various trips and events with people from the care centre, and so I learned to travel by public transport ... before I was afraid of people looking at me as being scarecrow. The bus driver also did not understand me when I wanted to buy a ticket or asked for information how to get to the city.

It is focused on activities needed in daily living and helps them to take care of the activities particularly important to them that are partly determined by the roles the disabled assumes in the surrounding environment.

Productivity

The personal development plan is based on activities achieving e.g. the physical (gross, fine and graphomotor), cognitive (e.g. concentration), emotional (e.g. motivation) and social skills and abilities needed for attending protected workplace or for integration in open labour market.

Eva: *"I like working in the garden and a social worker helped me with it. Now I'm working in horticulture and I enjoy it. Every day is something new and I'm satisfied".*

Jana: *"I felt less useful, I did not do anything. I had no motivation to work for so little money I want more money so I can buy what I want"*.

Adam: *"I started to work as a helper in the public kitchen. At the care centre, I got opportunity to obtain new skills and be better at cooking"*.

Irena: *"I like doing activities at occupational therapy, I am not bored and I do meaningful activities during my free time"*.

Ján: *"I got opportunity to develop working skills and it helped me to get a job out of the care centre on part time. It is important to be employed and I feel happy I can do something"*.

Jozef: *"I'm more skilled than before due to making hand-made products and participating on ergotherapy activities"*.

The functional ability

Activities are of great personal and sociocultural importance: being able to do what you would like to do and need to do in your daily living is important for your health and quality of life. By being active the person can change his environment and make a contribution to the society in which he lives: activities enable participation in society and in various spheres of life. (Dachs: 2018)

Eva: "*I put on weight I have to play sports to lose weight, but I do not like any of them. I am motive due to long walk. I am helping others at the care centre It helps me to be more active and I feel useful*".

Ivan: "*We make handmade products at protected sheltered workshop that have been sold on market. I like doing things from different materials and selling them because I meet new people*".

Adam: *"I have learnt to work by hand and I am more skilful. I have no opportunity to do such things before. I am involved in activities of occupational therapy and social workers are opened to teach us as much as possible"*.

Maroš: "*I have learnt to use computer at sheltered workshop and they help me to be more independent in going outside on wheelchair. I can easily move from one place to another on wheelchair and I am more able to go where I want without feeling anxiety*".

The social environment

The environment influences the personal relevancy of the activities in a person's daily living. It can have the effect of impeding or promoting his functional ability. Changing the environment can, thus, have a positive influence on the person's ability to carry out tasks and on his health: a building that can only be accessed via steps is - for a wheelchair user at least - inaccessible, but a ramp would enable him to surmount this obstacle; or an ergonomically designed workplace will help to prevent postural deformities.

Jozef: *"If you are disabled It is very hard to get a job, because there are no suitable working placements to take part in"*.

Adam: *"The most of the people do not know how to get in touch with people with learning disabilities. They think we are dangerous or strange people"*.

Lenka: *"It takes time If I get in touch with other people, I do not like a lot of people on one place and It is difficult for me to assimilate in new social environment"*.

Jana: *"Some of people are scared of us and they looked at us with pity or compassion"*.

Maroš: *"If you are a wheelchair user it is difficult to get where you want. There are many obstacles and no wheelchair free access to public places, banks or restaurant. First you have to plan and think about places for people on wheelchair and then you can ask friends to go with you"*.

Irena: *"If I go to the restaurant the most of the people look at me strange. I got used to it. It is pity that people do not know how to communicate with us or help us. Instead of trying to understand our needs they turn back"*.

Ivan: *"I meet with many barriers in daily life that are difficult to overcome. There are no working opportunities for disabled people, there is lack of equality in society and I feel sad about having low quality of life"*.

The Quality of life

Maroš: *"I am not able to find good job due to wheelchair. I haven't got enough money to buy what I need or to go on holiday. I struggle with problems every day"*.

Ján: "*There is no large range of accessible accommodation. I wish I have own flat to live with friends and have privacy*".

Lenka: *"I have couple of friends at the care centre, but I have no boyfriend and it makes me unhappy. I would like to connect with people through online dating or face to face dating"*.

Eva: "*I wish I feel better and have enough energy to do activities I like*".

Ivan: "*I haven´t got enough money to go shopping and buy things that I wish*".

Adam: "*I miss normal way of life to do what I want and I go anywhere*".

Jozef: "*I have more friends thanks to my job placement. I would feel alone without my colleagues I can speak with*".

Irena: "*I have no time and money to go to the cinema or to the restaurant with my friends. I feel excluded from the community*".

Information on disability and how it affected their life was also obtained either from the disabled people or from their caregivers in the care centre by interviewing them.

The study revealed that disability had a devastating effect on the quality of life of the disabled people with a particularly negative effect on their personal development, educational attainment, employment, and emotional state or level of social inclusion.

The people with learning disabilities have lower quality of life than another people. Surveys reveal that people with disabilities consistently report a worse quality of life. The most of them are not satisfied with the way of life and the opportunities to spend free time outside of care centre. They feel pity about not having enough money to go anywhere and do what they want. There is no free wheelchair access for the disabled people what makes them depressed and dependent on other people. Unemployment and worse living conditions are the biggest problem.

Research question: The most important aim of occupational therapy is to maximise functional ability. Which areas are used to achieve this mission in the best way?

Functional ability	Activities	The level of concentration
Physical	walking, gripping, carrying things, self-care abilities, rehabilitation	43%
Cognitive	planning or powers of concentration, working together, group work, decision taking, problem-solving	28%
Emotional	Higher self-confidence, self-esteem, motivation, breaking psychical barriers	10%
Social and interactive	Communication skills, social and life skills, body language	19%

The occupational therapy is more focused on improving functional abilities than on supporting social inclusion and socialization. 28% of activities are based on supporting cognitive skills including mechanisms of how we learn, remember, problem-solve, and pay attention, rather than with any actual knowledge and 10% on empowering emotional abilities. They are less likely to be educated, employed, or rehabilitated comparing to the others without disabilities. Social segregation of disabled people is extremely widespread. Moreover, social welfare services do not still provide special privileges for the disabled. As a result, most disabled people usually face insensitivity, cruelty, and often pity. The dominance of a medical model of disability has tended to blame the victim' which shows people with disabilities as 'inferior, dependent and of little or no value.

CONCLUSION

This paper provides an introduction and overview of meaning of self-care and supporting daily living theory as it is used in occupational therapy practice for people with developmental or learning disabilities and research study is aimed at individual development plan of people with learning disabilities or/and with mental illness. Disability also negatively influences their personal, family and social life. More than half of the disabled people were looked at negatively by society. Disabled people suffered more from negative attitudes of others, resulting in critical adverse effects on their psychological and social health.

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SEXUAL DEVIATIONS IN PERCEPTION OF SOCIAL WORK

SEXUÁLNE DEVIÁCIE V PERCEPCII SOCIÁLNEJ PRÁCE

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Abstract

Introduction: Sexual deviations (or paraphilias) are multidisciplinary issues. To help these people there participate a wide range of professionals from various professions. Among the most prominent sexologists, psychologists and social workers are included. When working with paraphilliants, social work plays an irreplaceable role.

Core: Paraphilias are a qualitative deviation of the structure of sexual motivational system. A multidisciplinary team participates on help to paraphilicians. Their goal is to help the client understand their deviation and learn to live with this disorder. This approach therefore aims to help the client improve the quality of their life and to protect society from sexual delinquency committed by some paraphilic individuals.

Treatment of paraphilia is carried out within psychiatric care, both in the form of outpatient and constitutional forms. Institutional care for these clients is usually ordered by the court and is carried out at sexological departments of psychiatric facilities.

A social worker plays an important role in the provision of benefits, empowers the client, encourages client's reflection before starting treatment and significantly contributes to the client's own re-socialization.

Conclusion: Social work is a field supporting reflexion of the life of paraphilia clients and its indispensable role is to re-socialize sexually deviant clients back into society.

Keywords: Sexual deviations, social work, resocialization, psychiatric care.

Abstrakt

Úvod: Sexuální deviace (parafilie) jsou problematikou, která má multidisciplinární charakter. Na pomoci těmto osobám se podílí široké spektrum odborníků různých profesí. Mezi ty nejvýznamnější patří sexuologové, psychologové a sociální pracovníci. Při práci s parafilními osobami hraje sociální práce nezastupitelnou úlohu.

Jádro práce: Parafilie jsou kvalitativní odchylkou struktury sexuálního motivačního systému. Na pomoci parafilním osobám se podílí celý multidisciplinární tým, jehož cílem je pomoci klientovi pochopit svou deviaci a naučit jej s touto poruchou žít. Tento přístup má tedy za cíl, jak pomoci klientovi zvýšit kvalitu jeho života, tak i ochránit společnost před sexuální delikvencí páchanou některými parafilními jedinci.

Léčba parafilií je realizována v rámci psychiatrické péče a to jak formou ambulantní, tak i formou ústavní. Ústavní péče o tyto klienty bývá zpravidla soudně nařízena a je realizována na sexuologických odděleních psychiatrických zařízení.
Sociální pracovník hraje významnou úlohu při zprostředkování dávek, zmocňování klienta, podporuje reflexi života klienta před zahájením léčby a významným způsobem se podílí na vlastní resocializaci klienta.
Závěr: Sociální práce je oborem, který podporuje reflexi dosavadního života parafilních klientů a své nezastupitelné místo má zejména při resocializaci sexuálně deviantních klientů zpět do společnosti.

Klíčová slova: Sexuální deviace, sociální práce, resocializace, psychiatrická péče

INTRODUCTION

Sexual deviations (or paraphilias) are multidisciplinary issues. To help these people there participate a wide range of professionals from different professions. Among the most prominent specialists, sexologists, psychologists and social workers are included. When working with paraphiliacs, social workers play an irreplaceable role.

Paraphilias are qualitative deviations of the structure of sexual motivational system. A multidisciplinary team participates on help to paraphiliacs. Their goal is to help the client understand their deviation and toteachthem how to live with this disorder. This approach therefore aims to help the client improve the quality of their life and to protect society from sexual delinquency committed by some paraphiliac individuals.

Treatment of paraphilia is carried out within psychiatric care, both in the form of outpatient and constitutional forms. Institutional care for these clients is usually ordered by the court and is carried out at sexological departments of psychiatric facilities.

A social worker plays an important role in the provision of benefits, empowers the client, encourages client’s reflection before starting treatment and significantly contributes to the client's own re-socialization.

RESEARCH METHODOLOGY AND RESEARCH GROUP

Under the auspices of the internal grant of College of Polytechnics Jihlava No. 1170/4/1713, a qualitative research focused on the life of persons with paraphilia was carried out. An interview was chosen as a data collection technique. The research was carried out between 2015 and 2017.

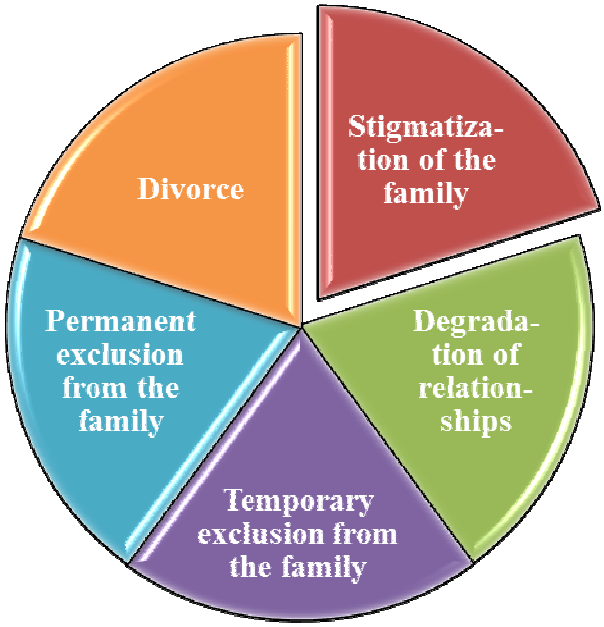
The research group consisted of persons with a diagnosis of paraphilia. Data collection was conducted at the sexological departments of psychiatric facilities and clients of outpatient sexologists. The research group consisted of 62 individuals with different types of paraphilia.

RESULTS

From a social worker's perspective, paraphilia may interfere with the three main areas of this individual's life. The first area is a family, the second is a job and the last is their social life.

Paraphilias may have consequences in relation to the family life (see Diagram 1). If a family finds that a member suffers from a disorder of sexual preference, family relationships often break. In some families, this may lead to the exclusion of the family member or divorce of a marriage. In case of extending this information to the wider social environment, the whole family can face the risk of stigmatization.

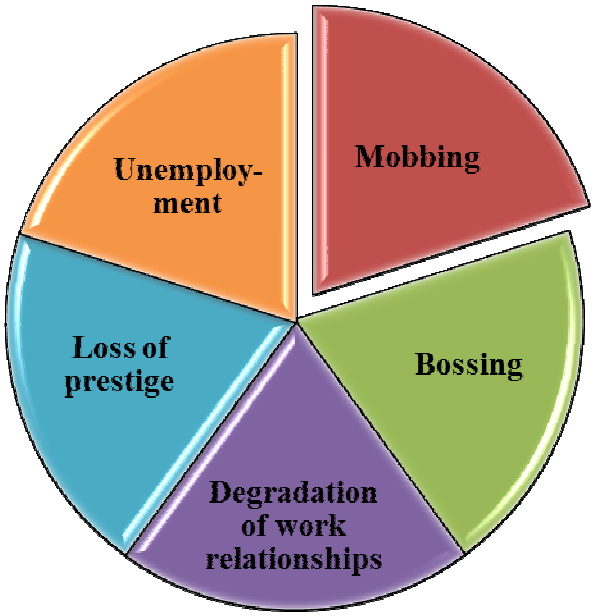
Diagram 1: Paraphilias in the family context



Source: Own research

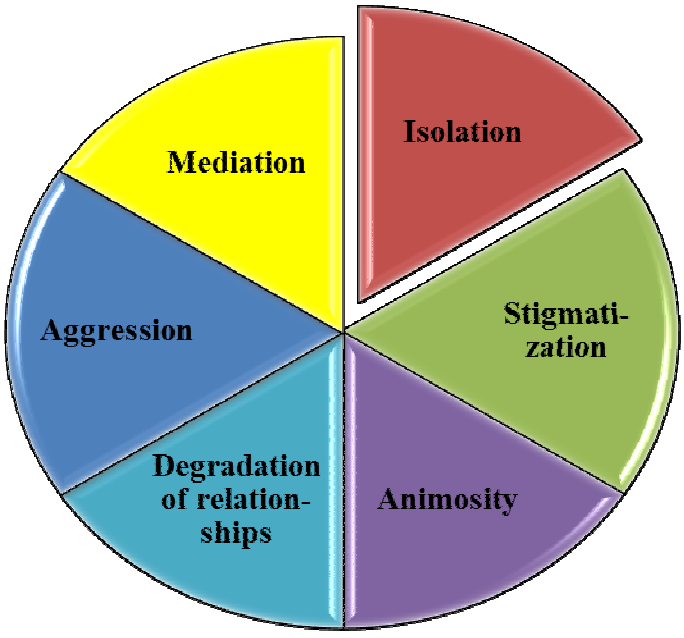
Another important area is employment (see Diagram 2). If an employer learns about a worker's paraphilia, these individuals often encounter mobbing or bossing. Another problem in relation to employment is the risk of degradation of coworkers' relationships or loss of prestige, for example, by entrepreneurs or managers. The most serious problem in this area is unemployment, especially a long-term one, often related to constitutional sexological therapy and subsequent problems finding a new job.

Diagram 2: Paraphilias in the context of employment



Source: Own research

Diagram 3: Paraphilias in the context of society



Source: Own research

Another studied area was the social life of the paraphiliac persons. The main problem encountered by these people in the context of society is once again stigmatization which is evident in some paraphilias, for example in pedophilia. It is also about isolation, degradation

of relations in the wider social environment. Also, these people are often exposed to animosity or aggression of the individuals from the near and wider social environment. The last significant area that primarily concerns offenders of sexual delinquency is mediation. It is the mediation of sexual delinquency that leads to complications in the resocialization of this individual.

CONCLUSION

Social work is a field supporting reflexion of the life of paraphilia clients and its indispensable role is to re-socialize sexually deviant clients back into society.

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WITHDRAWAL METHOD OUTSIDE OF THE CONCEPT OF NATURAL FAMILY PLANNING

STOSUNEK PRZERYWANY POZA PORZĄDKIEM NATURALNEGO PLANOWANIA RODZINY

COITUS INTERRUPTUS NEPATRÍ MEDZI PRIRODZENÉ METÓDY PLÁNOVANIA RODIČOVSTVA

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Abstract

Introduction: Natural family planning is a way of life employed by married couples who respect it's physical sphere. Natural methods that take account of woman's fertile days, which serve this purpose, are based on reading the signs of fertility (temperature, mucus, cervix) and refraining from sexual intercourse during fertile window when you do not want to conceive a child. Withdrawal method, mentioned in the title, means pulling the penis out of the vagina before ejaculation to prevent pregnancy. This study aims to answer the following question: Can the popular withdrawal method be included in natural methods and thereby in natural family planning due to the lack of necessity to use external chemical or mechanical means hampering conception of a child?

Method: Analytical method will be used for purposes of this study. Analysis will include the substance of natural family planning and the withdrawal method.

Conclusions: The analysis will show why withdrawal method cannot be included in natural family planning. This study will additionally mention the possibility of non-consummation of marriage, due to the method used, in the light of the Canon Law of the Catholic Church.

Keywords: withdrawal method, natural family planning, canon law.

Abstrakt

Wstęp: Naturalne planowanie rodziny jest sposobem życia małżonków darzących szacunkiem jego fizyczną płaszczyznę. Służące temu naturalne metody uwzględniające cykliczną płodność kobiety, polegają na obserwacji objawów płodności (temperatury, śluzu, szyjki macicy) oraz powstrzymywaniu się od współżycia seksualnego w czasie płodnym wtedy, kiedy nie chce się doprowadzić do poczęcia dziecka. Wspomniany w temacie seksualny stosunek przerywany polega na wycofaniu z pochwy kobiety prącia mężczyzny jeszcze przed wytryskiem, które to działanie ma zapobiegać ciąży. Celem opracowania jest odpowiedź na pytanie czy cieszący się popularnością stosunek przerywany, z uwagi na brak konieczności stosowania zewnętrznych środków

chemicznych lub mechanicznych utrudniających poczęcie dziecka, może być wpisany w metody naturalne, a tym samym w naturalne planowanie rodziny?
Metoda: W ramach opracowania tematu zostanie wykorzystana metoda analityczna. Analiza obejmie zagadnienia istoty naturalnego planowania rodziny oraz seksualnego stosunku przerywanego.
Wnioski: Efektem analizy będzie wykazanie, dlaczego seksualny stosunek przerywany nie może być wymieniany w porządku naturalnego planowania rodziny. Uzupełniająco wspomniany zostanie wątek możliwości – z uwagi na stosowaną metodę - niedopełnienia małżeństwa w świetle małżeńskiego prawa kanonicznego obowiązującego w Kościele katolickim.

Słowa kluczowe: seksualny stosunek przerywany, naturalne planowania rodziny, prawo kanoniczne

Abstrakt
Úvod: Prirodzené plánovanie rodičovstva je spôsob života manželov, ktorý rešpektuje biologické dannosti. Prirodzené metódy zohľadňujú cyklickú plodnosť žien, spoliehajú na pozorovanie príznakov plodnosti (meranie teploty, hlien krčka maternice) a vyhýbanie sa pohlavnému styku počas plodných dní, kedy neccú počať dieta. Prerušovaný styk má za cieľ zabrániť tehotenstvu jeho prerušením pred ejakuláciou. Cieľom tejto štúdie je nájsť odpoveď či je možno populárnu metódu přerušovaného styku zaradiť medzi prirodzené metódy a tým aj prirodzené plánovanie rodičovstva?
Metóda: V rámci riešenia témy sa použila analytická metóda. Analýza pokryva podstatu prirodzeného plánovania rodiny a coitus interruptus.
Záver: v našej analýze poukazujeme, prečo metóda coitus interruptus nemôže byť zaradená medzi metódy prirodzeného plánovania a rodičovstva. Ako doplnok k téme uvádzame výklad kanonického práva podľa náuky Katolíckej Cirkvi.

Kľúčové slová: prerušovaný styk, prirodzené plánovanie rodičovstva, cirkevné právo

INTRODUCTION

Human beings, created as social beings, achieve their communal identities through relationships of love. To love is to strive for kindness, which is fully expressed through marriage – devoting oneself completely to another person and accepting the gift of their love. In everyday life, it gives a sense of purpose, safety, and tranquility. However, due to human weaknesses, love is often incomplete, limited only to some of its many ingredients, like self-love, passing feeling, or sexual relations (Dembski 2013). Those elements, without the others, do not allow us to feel real love, and make us vulnerable.

Natural family planning, referred to in the subject of the paper, is a way of meeting basic human needs through deepening of one's awareness of how their organism functions, which, however, should not be separated from other aspects of one's life, but integrated with them. We shall elaborate on that subject in an attempt to answer the following question: is the withdrawal method one of the methods of natural family planning? This issue shall be

discussed using the analytical method. The analysis shall include the principle of natural family planning and the withdrawal method. Appropriate references shall be used.

NATURAL FAMILY PLANNING

Natural family planning, including methods of recognizing fertility, is not a technique, but a way of living of a man and a woman (often associated with such notions as belief or choice of life) (Kornas-Biela 2013); it is a way of life of a married couple respecting its physical aspects, strictly related to e.g. psychology and ecology, and for religious persons – also with theological anthropology.

Natural family planning methods, taking into account woman's cyclical fertility, consist in observing fertility symptoms (temperature, mucus, cervix), interpreting them and using the knowledge thus obtained when deciding on sexual intercourse: whether to have it or restrain from it during fertile periods, if a couple do not want to conceive. If those methods are applied correctly, they eliminate anxiety related to unplanned conception, and, through the necessity of communication, deepen the connection between a man and a woman, thus strengthening their relationship. The result of natural family planning is not only the ability to monitor fertility symptoms, but also acceptance and increase of the sense of responsibility for oneself and for the other person, controlling one's instinct and drives, subjecting them to higher values, and consequently, equanimity, serenity, trust, and a sense of security. By choosing natural family planning, one can develop their sexual sphere, being part of a person's psycho-physical structure, in which all sexual intercourse serves union and procreation. Each sexual intercourse demanding a dialogue prepares us for future conversations with our children concerning human sexuality (Kornas-Biela 2013).

Natural family planning with such positive outcome is not easy – as Włodzimierz Fijałkowski (Polish obstetrician gynecologist) wrote – it requires "transferring one's behavior and actions from entertainment to self-improvement" (Fijałkowski 2013).

WITHDRAWAL METHOD

Withdrawal method consists in withdrawing, in a sexual intercourse, of a man's penis from a woman's vagina seconds before ejaculation. The purpose of the method is to avoid conception. Due to the possibility of pre-ejaculation, it is ineffective. The Pearl Index indicating effectiveness of withdrawal method is, in theory, 20.0, whereas in practice it is 25.0 (Dmochowski et al 2013; Wołoszczowie 2012). It means that, within a year, out of 100 couples using that method, 25 should be expected to conceive.

Withdrawal method requires concentration of people having intercourse (especially man's) in order to withdraw the penis from the vagina in time. Stress caused by this type of intercourse may entail irritation and neurotic behavior in both the man and the woman. The nature of the withdrawal method is the exact opposite of that of intercourses of people who cannot conceive despite many attempts; however, the tendency is the same: to separate two purposes of a sexual act and strive only for one of them. A man and a woman, when deciding on an intercourse, seek union, but if they exclude procreation, they prove that their devotion and acceptance is not absolute. Fear takes place of the other purpose: fear of conception, so strong that it renders satisfaction impossible. Fear accompanies them before, during, and after

the intercourse, if they are forced to wait for menstruation starting a new cycle and confirming that the previous cycle did not result in conception – as the withdrawal itself, even before ejaculation, does not guarantee avoidance of pregnancy due to presence of sperm in the mucus, i.e. pre-ejaculate, which is released by the man's urethra before ejaculation (Ombach 2002). Constant emotional tension does not deepen the connection between spouses – on the contrary: becomes a basis for conflict and their slowly coming apart (Dmochowski 2013). Intercourses based on withdrawal may cause erectile dysfunctions, inability to experience orgasms, and, in the case of women, lack of interest in sexual relations (Gratkowski 2013). Lack of positive experiences may entail infertility caused, in fact, by a mechanism based on an intense, unreleased emotional tension causing, among other things, persistent oviduct contractions (Dmochowski 2013). Close correlation between stress hormones (adrenaline, noradrenaline, dopamine) and sexual hormones may disturb the feedback chain which may later cause conception problems (Dmochowski 2013).

CONCLUSIONS

The withdrawal method described above is a brutal disruption of the natural course of a sexual act (Ombach 2002), because "an important moment of building a union of a married couple is interrupted, disturbed at the most significant point of satisfaction and sinking in one another" (Knotz 2009). If used to exclude procreation, it will never deepen the love between a man and a woman, as it clearly shows that they do not accept, respect, and love each other completely. If used to satisfy one's selfish needs, it may cause exclusion of offspring, and it clearly excludes care for the other person's well-being. Apart from those consequences, it should be remembered, that sperm, composed of many different biologically active compounds, absorbed by a woman's circulatory system, positively affects her entire organism. Already a hundred years ago, based on research by a British scholar, Maria Stopes, sperm deficiency was linked to frustration, malaise, anxiety, depression, and neurotic disorders in women who did not have contact with it i.a. because of the use of withdrawal method (quite often, when they changed intercourse methods, they regained their mental balance and life energy). Research, first conducted only in Philadelphia, and later in other institutions, showed as early as in 1980 that a certain amount of sperm left by a man in a woman's vagina may protect her from breast cancer. It was also observed that, with average breast cancer morbidity of 3.9%, among women using the withdrawal method, the indicator rises to 17.4%. We are also aware of the influence of semen on the development of uterus and its important role in preparing a woman for receiving the child's organism, i.e. its separate tissue inherited from its father. A proper contact with the sperm prevents eclampsia (the more contact with the semen of the future child's father, the earlier the chance to know and accept his antigens. Women using withdrawal method and condoms have 2.37 times higher eclampsia tendency). As a consequence of deficiency of prostaglandins present in the ejaculate, postpartum depression may set in, as prostaglandins strongly affect women's neurohormonal systems (Matyjek 2013).

In an attempt to answer the question posed at the beginning of this analysis, we may say that withdrawal methods are on the antipodes of natural family planning, and therefore can never be accepted as one of its methods. Natural family planning takes into account an

integral vision of a human being, thus excluding limiting oneself to one or several selected dimensions of humanity. When referring to human sexuality, one should take into account the contribution of biophysiology, sexuology, medicine, psychology, and theology (Nagórny 2009). Withdrawal method, resulting in difficulties in all those domains, goes against humanity and, as such, although it does not involve chemical or mechanical contraceptives, it cannot be considered as natural and serving humanity. Natural family planning includes specific methods consisting in observing fertility markers and interpreting them in order to recognize fertile and infertile periods. That knowledge later requires a responsible decision of a man and a woman on commencement of sexual relations, which should always be focused on deepening of the connection, and sometimes on conceiving progeny; however, the latter should never be fully excluded. Each sexual act should be an expression of true love, which is impossible when using the withdrawal method.

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