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Reviews

THE SCIENTIFIC JOURNAL OF THE HELLENIC REGULATORY BODY OF NURSES

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editorial

The Scientific Journal of the Hellenic Regulatory Body of Nurses, in the framework of its constant effort for improvement, announces that in the new year 2010 and with the Third Volume (Volume 3) it will start the proper procedures that are necessary in order for the Scientific Publication to receive an ISO (International Organization for Standardization) certification for the quality of its operation.

This particular effort is unique for a Scientific Journal and moves forward towards a further strengthening of the quality of nursing science in our country.

At the same time, all of us that participate from the beginning in the creation of the Scientific Journal, that literally started from point 0, we would like to thank all of you that supported this effort in such an energetic and vivid way.

Dr. Kyriakos Kouveliotis
Editor - in - Chief

Clinical Symptoms of Cranium-Cerebral Lesions Caused by the Entrance of Missiles in the Cranium of the Human Body and Nursing Confrontation

Alexandropoulou Christina–Athanasia
Undergraduate Student, Department of Nursing,
Technological Educational Institute of Patras, Patras, Greece

Dr. Panagiotopoulos Elias
Lecturer of Ballistic (P.D. 407/80), Department of Mathematics and Science of Engineer, Hellenic Military Academy, Vari, Attiki, Athens

ABSTRACT

The aim of the present inquiring work is the study and the analysis of clinical signs and symptoms of cranium-cerebral lesions, which are caused by the missile's entrance in the human brain. The importance of lesions which are created depends significantly on the zones of missile's way in the interior of cranium proportionally to its speed of entrance into this. The direct nursing and medical intervention are considered very important, because the cranium-cerebral lesions can lead to permanent infirmities. The medical and nursing staff should be suitably educated at the recognition of symptoms, which will place suspicions for existence of cranium-cerebral lesions, as well as at the correct confrontation of cranium-cerebral lesions with suitable handlings. The results of the research showed that the outcome of patients with cranium-cerebral lesion is unexpected and depends significantly on the direct and correct medical and nursing intervention.

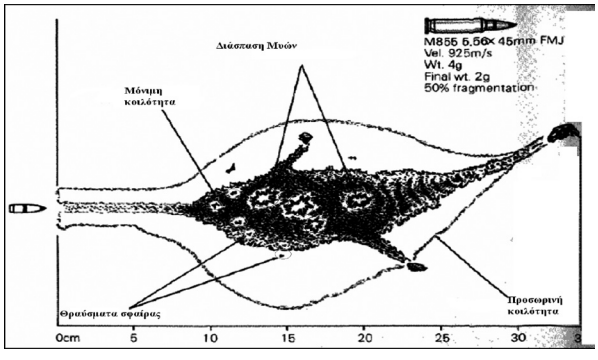
Key – Words: cranium-cerebral lesion, entry's wound, exit's wound, hematoma, scale of Glaskovy, zones of missile's way.

Introduction

The ballistics is the science that deals with the launch, the movement, the behaviour and the results which are caused on the objectives of various types of missiles, like bullets, missiles of artillery, bombs, rockets etc. It is separated into three main stages: (a) internal ballistics, (b) external ballistics, and (c) terminal ballistics (Malcolm J.D., 2006).

The sector of terminal ballistics studies the results that the missile's shock brings about in the human organism. When the missile reaches the human organism, it is caused damage either by the entire missile either by its items (Ann H. Ross, 1995). With the missile's hitting, it is caused the permanent cavity (namely volume of space in the human body that was occupied by tissue, which was destroyed due to the way of missile's entry), while the temporary cavity (namely extension of permanent cavity by virtue of the kinetic energy which is transported in the tissues by the missile) is shaped by the continuous forward acceleration of air immediately afterwards the missile, forcing the cavity to be tensed externally (Picture I). The shock's waves compress the air and "travel" front from the missile, as well as at the sides and can reach up to 200 atmospheres pressure (Alexandropoulou C.E. et. al., 2009).

The present work examines the parameters that contribute to the creation of cranium-cerebral lesions due to the "violent" missile's entrance in the human brain. The most important clinical symptoms of damages, which are caused when a missile penetrates the cranium and enters



Picture I Creation of temporary and permanent cavity at the missile's entrance in the human body.

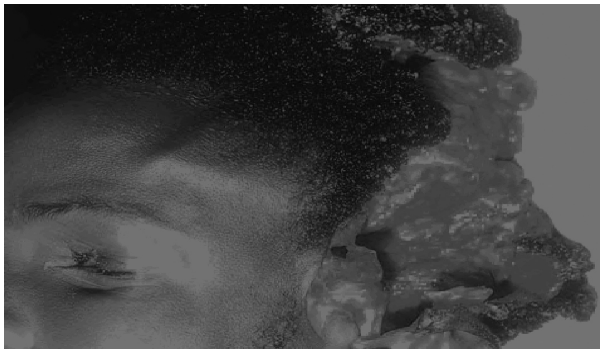
into this, are analyzed. Ways of direct medical and nursing intervention are proposed that aim at the prevention of complications of cranium-cerebral lesions, which threaten directly the life of wounded person, as well as at the complete cure of head's lesions in period of months or even years.

Zones of Missile's Way

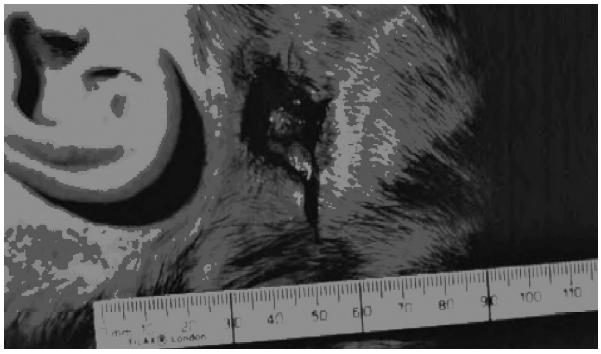
After the detonation, the missile's way, proportional to its speed, is discriminated into three zones that vary on the various arms: (a) rupture's zone, (b) perforation's zone and (c) fracture's zone (Murphy G., 1980).

At the rupture's zone, rupture's wounds are created due to the big missile's speed and to the revolving movement, which places in movement the liquids of tissues and as a result the movement propagates circularly and multiples. Consequently, the entry's wound (namely the wound, which is created due to the missile's contact with the human tissues) is equal or smaller than the missile's size (Picture 2), except for wounds that were created from absolute contact or minimum distance. The exit's wound (namely the wound, which is created in the body's interior at the exit of missile from the human body) is much bigger than the missile's size (Picture 3). The duct of wound has figure of truncated cone with the base turned to the exit's orifice. In order to be shaped the rupture's zone, the missile should have speed bigger than 60 m/s (Picture 4).

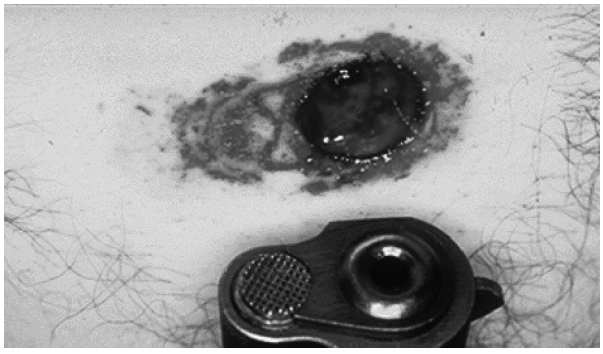
At the perforation's zone, the rupture's wounds are not created, because the revolving movement of missile is absent. The entry's orifice is equal or smaller than the missile's diameter, while the exit's orifice initially is double than the entry's orifice, but at the end of perforation's zone the exit's orifice is equalized with the entry's orifice. The duct of wound has cylindrical figure (Druid H. et. al., 2000). The fracture's zone begins from the end of perforation's zone and reaches up to the missile's fall. At this zone the missile maintains small speed and as a result does not cause wounds in the tissues, but simply fracture (Murphy G., 1980).



Picture 3: *: Depiction of exit's wound, which is bigger than the missile's size.*



Picture 2: *Depiction of entry's wound, which is equal or smaller than the missile's size.*



Picture 4: *Depiction of rupture's zone created from missile entrance with a velocity of 60 m/s.*

Pathological Physiology of Cranium-Cerebral Lesions

The cranium-cerebral lesions are created when the head gets powerful knock or when in the battlefield a missile penetrates the cranium and enters into this. As a result, the wound can bring about locomotion of brain in the cranium, causing rupture of blood vessels and consequently profuse cerebral haemorrhage (Nteros K. et. al., 1999).

When a compressive fracture of cranium happens, it is possible to be developed hematoma, fracture or rupture of the cerebral tissue with all the inflammatory activities that are presented in each wound. One minor fracture of head can cause concussion. The concussion is term, which is used in order to describe a closed cranium-cerebral lesion at which there is disturbance of conscience's level of short duration, amnesia relative with the event and headache (Susan C. deWit, 2009).

In the cerebral fracture, the brain's tissues are mauled, the blood is added up from the destroyed blood vessels and it is possible to be developed swelling, which causes increased pressure into the cranium.

The hematoma under the hard meninx is a usual result of cranium-cerebral lesion. The hematoma is swelling from blood. A missile that penetrates the head can cause rupture

of blood vessels, which are found between the thin spidery membrane that covers the brain and the hard fibrous meninx. While the blood gushes under the hard meninx, the hematoma is increased in size, pressing the softer spider meninx and the cerebral tissue that the meninx covers (Gardika K.D., 2005).

The hematoma up the hard meninx happens rarely. When it happens, it is caused from rapid leak of blood from the medium of meninx's artery and as a result the pressure into the cranium is increased. It recommends urgent medical situation. In order to be corrected the damage in the destroyed vessel and to be eased the rapidly developing pressure, before the death befalls by virtue of the increased pressure into the cranium, it must be executed incision at the cranium (Sachini - Kardasi A. et. al., 1993).

Points and Symptoms of Cranium-Cerebral Lesions

The importance of cerebral damage from a cranium-cerebral lesion is evaluated by the symptoms that the patient presents, by the neurological examination and by the chronicle period that was intervened from the moment that the wounded person lost his conscience after the missile's entrance in the brain (Papanikolaou P., 2005).

The exterior symptoms of cranium-cerebral lesion are enough obvious. These symptoms are the ecchymosis, the swelling and the haemorrhage. It is possible to be found fractures with ecchymosis or ecchymosis behind the ear. In addition, it can be observed effusion of liquid from the ear or the nose, difficulty in the sense of hearing, paralysis of face's muscles and declination of eyes to a side. The effusion of liquid from the ear or the nose should be examined further in order to be determined if there is effusion of cerebro-spinal liquid (Perel P. et. al., 2008).

The concussion can cause short disturbance in the physiologic level of conscience, amnesia relative with the event and headache. The cerebral fracture can cause change in the conscience's level and epileptic fit (Steyerberg EW et. al., 2008).

In the points of the hematoma up the hard meninx are included the loss of senses the moment of wound, one short lucid interval that is followed by reduction of conscience's level, headache, nausea and vomiting. The patient should be watched for points that mean increase of pressure into the cranium and for other points that mean damage in the brain (Perel P. et. al., 2008).

Diagnosis and Cure of Cranium-Cerebral Lesions

The Glaskovy's scale (Table I) is a diagnostic means of recognition of prognosis and of importance of cranium-cerebral lesions and of brain's wounds. As long as bigger is the score, so much better is the prognosis of patient's situation (Malcolm J.D., 2006).

The diagnostic tests that are usually used for the determination of extent of a cranium-cerebral lesion are the cranium's radiograph, the axial tomography, the magnetic tomography, the tomography of emission of positrons and the electroencephalogram (Prahlow J.A et. al., 1999).

The patient with cranium-cerebral lesion is usually faced conservatively. If the lesion causes increase of pressure into the cranium or if the lesion includes crushing fracture of cranium, it must be realized surgical cleaning of wound and removal of bone's departments from the cerebral tissue or restoration of cranium's fragment in its place. In serious cranium-cerebral lesions, all the existing means are used in order to be prevented the increase of pressure into the cranium (Patel HC et. al., 2002).

The head should be raised at 30 with 45 degrees. This raising helps at the reduction of pressure into the cranium. In addition, the patient should be closely watched for the appearance of neurological points (Papanikolaou P., 2005). It is imported an intravenous line to the patient for the possibility of need of diuretic medicines and for the issuing of liquids. The intravenous liquids are imported very slowly, in order to not exist overloading with liquids, which will increase the pressure into the cranium. The diuretic medicines are used for the reduction of vessel's volume and for the maintenance of pressure into the cranium as long as lower (Athanatou K.E., 2007).

Table 1: Glaskovy's scale: As long as bigger is the score, so much better is the prognosis of patient£s situation.

MOVEMENT OF EYES	SCORE
Automatically	4
In the speech	3
In the pain	2
No movement	1
MOVEMENT OF BODY'S LIMBS	SCORE
He is hearing the orders	6
He locates pain	5
Physiologic bending	4
Defective bending	3
Stretching	2
No movement	1
SPEECH	SCORE
Directed speech	5
Confused speech	4
Ineffective words	3
Gibberish	2
No speech	1

Nursing Confrontation of Cranium-Cerebral Lesions

The nursing intervention is very important for the control and treatment of cranium-cerebral lesions. If the nurse locates leak of cerebro-spinal liquid from the nose, the ear or the open wound, he ought to inform the doctor and take special measures for the prevention of wound's contamination. The precautionary measures include the following:

(a) The patient should remain absolutely laid up with the bed's head raised at 30 until 45 degrees, in order to be promoted the venous channelling from the head.

(b) The ear, by which the liquid effuses, should be covered with sterilized gauze, which should be changed periodically, so as the extent of channelling to be watched.

(c) The patient should be advised not to give his nose a blow and to avoid the contact with the hands. The blow can increase the pressure into the cranium and the contact with the hands can cause the entrance of micro-organisms.

(d) The nurse reminds to the patient that he should not change place in the bed for the prevention of increase of pressure into the cranium (Roupa - Daribaki Z. et. al., 2005).

The observation of patient, who is in the department of urgent incidents by virtue of cranium-cerebral lesion and returns in the house, requires specifics instructions. These instructions are given in the family of the wounded person (Table 2)

Table 2: Instructions of patient£s care with cranium-cerebral lesion given to his family.

INSTRUCTIONS OF PATIENT'S CARE WITH CRANIUM-CEREBRAL LESION	
FOR THE FIRST 24 HOURS	FOR THE NEXT 48 HOURS
1. The patient should be awaked per 2 hours in order to be confirmed that he is awaked with facility.	1. Patient's observation for change of conscience's level (e.g. drowsiness, difficulty in the awakening, confusion)
2. The patient should be asked where he is, who is his interlocutor, so as to be checked his orientation.	2. Observation for vomiting without nausea.
3. Control of eyes with a torch in order to be confirmed if the size is equal and if the eyes react.	3. Observation for dizziness, loss of balance or fall.
4. The patient should avoid the intense activity for 24 hours.	4. Observation for changes in the eye-sight (e.g. diplopia, dazzle of sight).
5. Placement of ice-pack at the points where there is swelling	5. Observation for retrograde movements of eyes.
	6. Observation for headache increasing intensity, which is worsened with the removal.
	7. Observation for spastic movements of hands or legs that cannot be checked.
	8. Observation for changes in the speech or in the ability of finding of words.
	9. Observation for unusual behaviour.

Conclusions

According to the analysis that was realised in the previous units, it is obvious that the cranium-cerebral lesions are brain's damages, which are caused by knocks at the head or by the missile's entrance into the cranium. The cranium-cerebral lesions cause loss of conscience for hours or some days, which is followed by loss of memory. The cranium is possible to have fracture and it is possible to be developed hematoma into the cranium, up or under the hard meninx. As a result, these hematomas compress the brain and the pressure into the cranium is increased. The hematomas are recognized by the neurologists and the neurosurgeons with diagnostic tests that were referred in the previous. The long-lasting outcome of patients with serious cranium-cerebral lesion is unexpected. The recovery is a long process and in some patients the improvement can happen after a lot of months. It is also possible the infirmities to remain forever. In every case, the direct medical and nursing intervention is essential that aims at the prevention of complications of cranium-cerebral lesions, which threaten the life of wounded person, as well as at the complete cure of head's lesions in interval of months or even years.

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"Voluntary & Municipal Community Care Services for Older People on Island Rural areas" (Case study of the island Tinos)

Maria Delatola- Paganelis
Undergraduate Student, Department of Nursing,
Technological Educational Institute of Patras, Patras, Greece

ABSTRACT

Objectives: This paper will examine features that usually characterize the community care services that exist in the Greek island rural areas, case study of the island Tinos, and affect the role of these services on local community. It is hypothesized that these features affect the objectives of community services to meet the needs of older people (the majority of users) and their carers.

Design: Qualitative data were collected through individual in-depth interviews and focus groups of 64 persons (older people, carers, staff and providers). A new framework is used, based on prior theoretical models, to present various enabling and obstructing factors[1] which are derived from different resources and affect the role of local care services.

Results: The findings suggest that endogenous factors that are shaped by the services themselves may include coverage of needs and quality of services combined with staff attitudes towards older people in need. These influencing factors impact on intermediate and final outputs from community services. Actually, the enabling and obstructing factors impact on the provision and delivery of services, the accessibility and utilisation of provided care services, as well as on the perceived benefits of these services.

Conclusions: Certain factors, like the features of the community care services themselves facilitate or impede the role of community care services in the Greek rural island context. It is essential that policy makers take into account the most influential local parameters and needs when designing effective local care services.

I. Introduction

Community care provision is a means to help people in need (e.g. vulnerable older people) to remain in their own community surrounded by their own informal networks comprising of kin, friends and neighbours. What constitutes the provision and delivery of community care may be dependent on the local society in which it is provided; on the needs that should be met; the actions that may be implemented and the stakeholders who may be involved.

In Greece, provision of community care services has increased in the last decade. Local community initiatives have been established to address local needs, with voluntary organisations and local municipalities being the main providers of services. The community of the Greek island of Tinos has tried developing its own solutions to respond to local needs. Actually, prior to 1999, older people on Tinos, were not provided with formal community care. The self-funding voluntary organization, 'Association for the Support of the Health Centre in Tinos', was established and has run the 'Nursing at Home' unit for almost ten years. The municipal community care services provided by the Municipality of Exombourgo have been provided for seven years. These services involve a Home-Care Service Unit from which domiciliary services are delivered and a Day Care Centre.

The aims of this paper are:

- to illustrate the history, establishment, objectives and aims, as well as the current status of both municipal and voluntary community care provision on Tinos
- to consider the main findings and offer interventions (suggestions) for both policy and practice regarding island rural areas based on the study's findings.

The main findings of the study, with regard to features of the

1. In the study, more factors were examined except those than that have been referred in this paper, like individual characteristics of older users and their carers, as well as the locational features of the community. Those factors were characterized as exogenous, in spite of the features of the community care services that are characterized as endogenous and are presented on this paper.

community care services, are presented in this report which is divided into fifth sections. Four of the sections provide a relevant literature review, details of the study location, the methodology used in the study and the findings. The fifth section discusses the findings and offers some interventions regarding the future of community care services on Tinos.

2. Community care services in rural areas (Literature)

This section reviews the existing knowledge about the features that usually characterize the provision of community care services in rural areas.

Recruitment, Retention and Training

Rural areas, for example, rural islands, are characterised by features that result in a falling population due to outward migration, particularly of young people. In turn, it results in a shortage in the qualified workforce that affect the provision and delivery of services, as young people often remain in urban areas where they have been trained. Some of the most important gaps identified in rural care delivery surround the recruitment and retention of professionals (i.e., nursing staff, home care and allied health professionals) as well as their ongoing education. As a result, staff become overworked due to the lack of staff and provision of care becomes insufficient leading to low quality services (Haaren & Williams, 2000; Cho, 2005). There is a lack of evidence about the reality of providing care services on the micro-level (e.g. in rural areas). This may entail providing services in isolation from other professionals, with limited professional and team support (Walker, 2000; Steenbergen & Mackenzie, 2004; Burau & Kröger, 2004).

Six main themes have been found to affect recruitment and retention in community care services (Denham & Shaddock, 2004; Williams et al., 2003):

- lifestyle and personal factors
- various management issues / uneven distribution and limited resources
- pay
- support needed for professional development / regular professional supervision
- team size (in particular the need for a 'critical mass' of staff
- the disincentive of the flat career structure

Initiatives in various countries have tried to fill some of the gaps in community care services which have been caused by poor recruitment and retention. For example, staff training and ongoing education have been identified as key issues in maintaining standards and improving quality of rural care services (Parry-Jones et al., 2000). Thus, staff retention may be improved in rural areas if community care services focus on training community members. This could comprise an initial period of clinical training in small regional hospitals followed by advanced education in universities. Participants could be encouraged to take part in professional development (Gibb et al., 2004). Some initiatives provide education through short modules. This means staff can share their time between work and training (Haaren & Williams, 2000). Other programmes have focused on training rural professionals in specific services, such as services for people with dementia (Connell et al., 2002).

3. Tinos: the study location

This section, firstly, gives information about Tinos' 'island identity'. Secondly, it explores informal familial care provision for older people on Tinos. Finally, the organisations which have provided health and social care services to Tinos' elderly population are described.

3.1 Tinos's identity

Tinos is affected by disadvantages which frequently characterise island regions. The island general features (CEC report, 2003), are:

- isolation from the mainland
- restricted area of usable land due to mountainous terrain
- high costs of sea transport
- difficulties with and the high cost of communications and infrastructure due to natural and climate-related obstacles
- difficult access to health services
- lower level of education due to the limited facilities and disconnection with the mainland

Tinos has additional features that are salient to its identity. For example, the distribution of villages across the island is related to significant differences which characterise villages as alive or dead according to their inhabitants. This characterisation depends on the age range of a village's population and the existence or not of some institutions and basic facilities.

According to the national census, Tinos' population has gradually increased in the last two decades. The majority of people are concentrated in the city of Tinos. There has also been an increase in the population of older people aged 60 and over and those aged 70-79. There is migration of the working population to the city of Tinos, or other urban centres, where young people have found jobs in the construction or tourism and service sector. This means that most villages are hard hit by falling employment rates and an increase in the number of older inhabitants.

3.2 Informal familial care provision for older people on Tinos island

There is a myth that informal care in rural areas is better than in cities (Mestheneos; 1996). However, the reality is that young relatives are usually not present in rural areas, as they have migrated, a demographic phenomenon for the majority of the Greece's islands (Mpalourdos et al., 1996). Older people tend to remain in their homes and may become gradually dependent on the support of spouses (if they are married), or on support from others (e.g. children, siblings,

nieces or less intimate social networks). In the case of villages, reciprocal exchanges of support exist among villagers (Triantafillou & Mestheneos, 2001; Eurofamcare, 2005; Mpalourdos et al., 1996).

Informal familial care provision for older people on Tinos is usually lacking as many young relatives have migrated. However, older relatives are supported and provided with care services through other ways. For example, children travel from the town of Tinos or further afield (e.g. Athens) to provide care or they pay for a private live-in home carer to live with a relative. In the latter instance, immigrant women, usually from the Eastern European countries provide home care. This phenomenon has been identified throughout Greece (Eurofamcare, 2004; Sissouras et al., 2004; Van der Geest et al., 2004). The procurement of private live-in home carers only happens when older people are very dependent and this private service depends on their preferences and the financial status of the user and the main carer (Van der Geest et al., 2004).

3.3 Community care services on Tinos island

3.3.1 Voluntary community care services

The voluntary organization "Association of Support of the Health Centre in Tinos" was established in 1995. Its first aim was to support the health centre in Tinos. In 1999, the voluntary organization, established a community care service called 'Nursing at Home', that provided services around the island. Once municipal care services were established, the voluntary organisation was responsible for covering the Municipality of Tinos and the rural Community of Panormos.

3.3.2 Municipal community care services

In 2000, Exombourgo Tinos was the first municipality, in the Prefecture of Cyclades, to submit proposals to the Southern Aegean Region for two community care service schemes consisting of domiciliary care and a day centre. These have been in operation since 2002.

4. The study

Data was obtained from people's perspectives (primary data) and existing official documents (secondary data). The collection of data was carried out in March 2005. The target populations were users (older people), their family carers (spouses and children), care services staff and local providers. Individual in-depth interviews and focus interviews were undertaken, with a total sample of 64 participants (users, carers, staff and providers). Interviews were tape-recorded and fully transcribed.

5. Findings

The overall findings are categorised into three key themes that highlight issues pertinent to the role of community care services in island rural areas like Tinos. In this paper, one theme will be presented, the features of these services (endogenous factors).

Theme: Community care services – Characteristics (Enabling &Obstructing Factors)

This theme presents findings that are refered to human community care services' characteristics. Both providers and staff describe organisational factors which impact on the provision of care services. The quantity and quality of services are understood by older people and their carers through their experiences and interactions with staff. The main points of this theme are:

- IRecruitment & Retention
- ITraining & professional support
- IInteraction process

5.1 Recruitment & Retention

The staff and providers focus on the recruitment and retention that influence the provision of services to older people especially the extent of coverage and the number of staff hours spent providing services. Staff worry about the consequences of staff shortages in terms of low levels of service development. Poor staff recruitment has been an important issue for a long time. Although there are difficulties in recruiting professionals there is no pressure from the community to employ more, as users are unaware of their eligibility to receive community care services and thus, do not demand them. As a result, there are unmet needs in the community.

Users and carers did not usually refer to shortages of services. This may be because of a variety of factors, such as:

- Istoic personality of local people
- Ilevel of education
- Ilocation
- Iunawareness of their rights to care services.

Location and education may be factors that change the stoic behaviour of people, as highly educated people in the town and those who have decided to return to their home area are more demanding. The latter think that they might be entitled to better services with some of them complaining directly about urban and rural inequalities.

Providers see the consequences of low recruitment as affecting the working life of existing staff. Staff cover gaps that should be filled by other specialised workers and as a result, they do more than they are contracted to do. Providers talk about overworked staff with no limit on their working hours. Providers of both organisations state that the care service staff do not limit their tasks to those for which they have been contracted to perform. Home care staff have participated on a voluntary basis in large campaigns (e.g. cardiological and blood check ups) on

Tinos, collaborating with staff of the health centre, and some rural doctors of the district surgeries. For staff, voluntary participation in these campaigns is important as they consider that their local knowledge improves the quality of the services provided.

From provider's point of view, the services are of good quality due to the staff's altruistic behaviour. Therefore, these personal qualities of home care workers need to be considered when taking on new employees. These criteria considerably limit the field of potential employees. However, while providers trust the existing employees to complete the tasks that they are contracted to do, they do not have documented evidence of what has actually been done.

Decisions about community services (e.g. kind and level of provided services) are made by external bureaucrats rather than by the local authorities, who, according to staff and providers, are usually interested in the number of cases and financial affairs rather than the quality of service provision. Until now, staff has not been asked for their perceptions of the services by service managers and there is a poor relationship between them; something that is likely to affect the self-esteem of employees.

5.2 Training & professional support

Quality and standards of care may be influenced partly by the factors and circumstances mentioned before (namely, low recruitment of some professionals). However, providers and staff mention a number of additional issues, such as training, professional and teamwork support, which also affect the intensity, quality and style of care that is provided by current community care services.

Behaviour of staff towards older people is an important issue as it has affected the interaction process between them and subsequently the reputation of the services. Staff discussions are dominated by their previous inexperience of working with older people. Actually, employees acknowledge that understanding and responding appropriately to older users is not a simple issue. However, this was not an obstacle to their recruitment and employment by the community care services. All staff agree that because their qualifications are not specific to the ageing process, or to older people, regular and updated training would be very important.

The absence of training is identified as a major problem for three reasons:

- impacts on their ability to cover a range of tasks
- influences the ability of staff to respond to questions from clients
- affects the behaviour of the staff towards older people

As low recruitment may be a permanent issue for island rural community care services, training should be a primary concern, especially, as staff are called on every day by users and their carers to give advice on various affairs. Although staff have limited qualifications and a low level of experience of working with older people, they feel that they have achieved a substantial amount in delivering community care services. However, they also feel that they should offer more than they currently do

The issue of training is more complicated than it seems, as, on the one hand, existing personnel recognise that they require more training and professional support. On the other hand, despite their inexperience in some fields, staff feel personally obliged to accomplish other professionals' duties and fulfill users' needs. Despite the need for training, there are problems with obtaining education. Going on a training course or attending workshops, only for two days, entails an additional staff shortage. This in turn impacts on the quantity and quality of the services provided in the short-term. However, investment in this area is likely to improve services in the long-term, especially in areas like Tinos.

5.3 Interaction process

Interaction between home care workers and older people is also important. Staff chat to their clients as well as undertaking nursing and household tasks. The hours spent talking with older people is associated with clients' social, emotional and psychological needs. In addition, staff have taken time to ensure that the delivery of services (in terms of the time of the appointments) are appropriate for older people and their co-resident carers. Older people and their carers note their appreciation of a regular time for visits and are happy with the level of cooperation in arranging appointments.

For staff, frequency of visits is more important than the number of clients that they visit. There are a number of factors that create a variety of health and social needs for older people, which impose frequent visits. For example, the distances between villages and town, shortages of local health services as well as absence of informal care enforce often older people to relocate to other areas. The frequently mentioned reasons are either to receive formal appropriate care (e.g. going into the local health centre or the regional hospital), or to receive informal care moving near their children (e.g. in Athens). In effect, staff try to remedy this situation by providing frequent services for older people in their own homes so that they do not have to move away from the communities although it increases the workload for staff.

The quality of interaction between staff, users and their carers appears to have lead them to describe relationships in terms of friendships, rather than within a formal care capacity. Staff seem to be a part of the older peoples' lives especially when interaction is over a protracted period of time. For example, when housebound older adults calculate the number of friends that have visited them during one month, they also include the visits of staff.

In the case of the day centre, users mention relationships that have been developed between themselves and staff. Older people voluntarily participate in the kitchen or with other tasks and feel satisfied to think that they help the day centre staff. On the other hand, staff at the day centre devote time to discussing older people's personal affairs

which is appreciated by the clients. Furthermore, staff in the day centre provide some activities that are over and above those that are called for in the course of their defined job (e.g. daily excursions around the island, drama performances during the year, handicrafts). However, some users state a preference for more activities and have been unaware that the staff are already providing these activities voluntarily. Moreover, some day centre users wanted to be asked about their opinion of the day centre and felt that their suggestions would improve service provision.

Further evidence of the quality of relationships between home care workers and older people is found in the identification of the service with the name of the professional. For example, many of the participants do not know the name of the units which provide their community care services. Instead, they are familiar with front-line staff only. There is a general ignorance about the organisations that run these services despite personal relationships with the staff. This personal interaction between older adults and staff also has its risks, as the former usually attribute shortcomings in the services to the front-line staff.

Many shortcomings of the community care services in Tinos have been alleviated by the altruistic behaviour of the care staff and relationships that have been developed between existing employees and users of these services during their interaction. However, these relationships would be at risk, if organisational shortages are sustained.

6. Discussion - Interventions

This section synthesises the main findings of the study, of the voluntary and municipal community care services on the Greek island of Tinos, together with interventions.

6.1 Discussion

On Tinos Island, some progress has been made over the last decade in the development and provision of community care services to help vulnerable older people. Even though changes have taken place, services have experienced continuous staff shortages.

Staff and providers do not see themselves as simply deliverers of community care but feel responsible for these services. Issues, such as insufficient services, overworked staff and frustrated providers characterize current provision. They focus on the gaps in care services and are very concerned about the overall quality of provision and their future existence. Discussions with staff and providers revolved around recruitment, retention, training.

Interaction between staff and older people (users) may be affected by shortages in the number of staff and may lead to constraints in the time that staff have at their disposal to interact with older people and their carers. Whereas it is important for staff to be on time for appointments, this is often difficult to achieve because of the large geographically dispersed area that is covered. Closely related to these issues is lack of training for employees. Employees acknowledge their limited training and an absence of updated information when they have to deal with people with different needs. Being a qualified and altruistic nurse or a polite and supportive member of the domestic staff is not enough, instead staff feel that they should know more about basic gerontological issues.

Staff report that they do not have problems undertaking social tasks, such as chatting. However, they do not seem at ease taking the responsibility for other professional duties without some basic training and formal recognition that they are undertaking these. Actually, staff feel unsafe and at a risk doing things for which they are not trained. These deficiencies may lead to negative attitudes and perceptions about the inadequacy of staff by users. Training, either to update studies or to acquire other professional skills, is not widespread in Greece. Also, if training sessions are offered outside of Tinos, attendance is difficult due to the limited availability of staff. Thus, staff reveal a sense of isolation because they do not work in teams with other professionals. In addition they do not provide the full range of services that should be available.

In effect, shortages in the existing provided community care services impact on and shape their current outcomes. Responsibilities for the shortages of the services and their outcomes can not be attributed to the local staff and providers but to those who design and develop community care services for rural areas. Policy-makers should understand the implications that may arise when services are inadequately staffed or the existing staff do not have the opportunity to undertake regular training and strengthen local community services.

6.2 Interventions

Recruitment of a sufficient number of professional staff could solve a number of services shortages and meet a variety of local rural needs. Rural provision of care should be designed and implemented according to local needs. For example, it is clear that home visits by nurses should be more frequent and of a longer duration. Also, older people in the community could be provided with a simple but effective service, through the community care services, in order to acquire their medicine. However, there is not feasible solution at present.

Locality of staff is a sensitive issue in the provision of community care on Tinos. Efforts should be made to recruit and retain health and care workers from the local community. There is a need to recognise:

- the importance of the locality of the staff
- the existence of health and care profession within the community
- the importance of carers lessons in the local high school
- the stimulation of students to undertake professional development in their local area.

Training of existing staff could be the most effective supplement to insufficient services. In the absence of other specialists, it may be hard for the existing staff to undertake a wider range of interventions, from preventive tasks to those that treat impairments. However, if care services aim to be more effective, staff need to be trained in such a way that this will give them a key role in Tinos' community. In effect, training of staff is important and should be corresponded to local needs and demands, such as emotional and social support (e.g. befriending) and instrumental support (e.g. shopping, help to go to the church)

Training of staff could be achieved through:

- Comprehensive training provided in the form of online education (e.g.using the Open University model).
- Flexible training sessions delivered on the island.

These solutions would overcome the island's disconnection with relevant educated centres and professionals that usually are located in the mainland. Existing staff could acquire further qualifications and strengthen their psycho-social skills.

- Training sessions that include staff from other relevant local settings

For example, participants could be community care services staff, those of the open care community centre (KAPI), staff of the residential home and employees of the Health Centre. Thus, different perspectives would be discussed among staff including local socio-cultural issues and case studies of older people in need. Participants would acquire experience from different settings. Local services could develop common strategies and actions encompassing provision of care and case management for older people and their carers on the entire island. Overall, meeting local needs could be achieved through integration of the fragmented and limited provision of local health and social care services.

- Training sessions could be attended by staff, informal carers, volunteers and providers

Creating opportunities for mutual support and incorporation of abilities and skills between a number of stakeholders could be significant for rural care services with low recruitment. This would provide opportunities for increasing the skills in the local human resources. Moreover, involvement and cooperation of all stakeholders in common training may give them opportunities to understand each other's needs and to formulate practical solutions to overcome local rural difficulties.

In conclusion, the role of rural community care services in particular rural contexts, such as Tinos island should be considered as a continuous process. In that process, services should have the flexibility to apply new strategies and actions in order to adjust to community and individual characteristics.

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Can the Healthcare Services Market be a Competitive Market?

Kyriaki Sotiriadou
Captain, Hellenic Army,
MSc Economics and Management

ABSTRACT

In this paper, is commented the view that health services can operate on a competitive model. Initially a reference is made to the famous article by Kenneth Arrow, which first raised the question of the special characteristics of health services provision. Some points that have raised disagreements on whether competition in the market for health services can result in efficient solutions and optimization of social welfare are then presented. Particular reference is made in the U.S. health system, which although is the most competitive in the western world does not seem to have achieved the targets, and this resulted in criticisms and call to avoid emulating this bad example.

Keywords: competition, health care services market

I. Introduction

In economics competitive is a market in which there are large numbers of buyers and sellers, each of whom has no power to influence prices, which are freely determined through supply and demand, there are no government restrictions on prices and quantities, and both sides, buyers and sellers, have full information about the conditions prevailing in the market, i.e. prices, quantities and qualities of products. The product of each producer is homogeneous, i.e. identical to that of other producers and there is free entry and exit from the market. Given some assumptions about preferences, income distribution and economies of scale, competition is the ideal model, in the sense that if it prevails in all markets it leads to socially optimal allocation of resources.

The question is whether the provision of health services can or should be a competitive market. The debate stems from the publication of the seminal[1] article by Nobel Laureate Professor Kenneth Arrow "Uncertainty and the Welfare Economics of Medical Care" in the American Economic Review in 1963.

2. Arrow's arguments

Arrow focuses on specific characteristics of the provision of health services (particularly medical care), which create gaps in the market and place the health sector at a distance from the competitive model.

These distinguishing characteristics are the following (Arrow, 1963:pp. 948-954):

- the nature of demand for medical services, which is unstable and unpredictable. The event of disease is a deviation from the normal state of affairs and the cost of the disease does not refer just to the costs for medical care but is also icluding the cost of having the risk of impairment or even death. Therefore, there is a peculiarity in medical care compared to any other usual commodity.
- the expected behavior of doctors, which is not the typical behavior expected of all other traders, who seek the maximization of their profit.
- product uncertainty, as the recovery from the disease is so unpredictable as it is the fact of its occurrence (1963:p. 951). Furthermore, there exists a significant difference in the uncertainty levels of the two sides, the patient and doctor.
- the information asymmetry, because the information the doctor possesses about the consequences of disease

1. It is a compact text that "demands from readers nothing less than the academic analogue of Talmudic scholarship", as Reinhardt notes (2001: p. 967). It is striking that the selective use of arguments serves both the proponents and opponents of free market of health services (Savedoff, 2004; Robinson, 2001).

and treatment options, is significantly higher than that of the patient, or at least, so believe both parties, as Arrow points out. Also, both parties are aware that there exists asymmetry of information and the fact of this knowledge colours their relationship in a special way (1963:p. 951).

- the limited availability of medical services, as there are significant entry restrictions[2] in the medical profession (this also happens in other professions as well). The cost of training students in a medical school is many times the cost of education at other schools. This fact, that the education of doctors is subsidized by society, should mean that prices for medical services would be low, because the doctor did not undertake the high cost of his education himself. However, doctors are the highest paid professionals. Finally, a characteristic of supply for a usual commodity is that it is offered at a wide variety of quality for respective prices, which is not the case with medical services.
- pricing practices, which for medical services can range from zero (for customers who are unable to pay), up to very high levels. Also, usually there is no price competition, as for usual commodities in other competitive markets.
- the issue of moral[3] hazard, i.e. the damage suffered by insurers from the overuse of medical actions[4]

Arrow concludes that "... we recognize the incomplete description of reality supplied by the impersonal price system" (1963:p. 967).

3. Can the health services market be competitive?

Arrow's article had enormous impact on health economics (indeed it marked the creation of the discipline) and established a framework for discussion which is still active for over 40 years.

Of course, during these years many things have changed and the health sector today is very different from 1963 (Chernew, 2001; Hammer et al., 2001; Sloan, 2001).

Thus, by a single doctor treating a single patient, we moved to a system based on the operation of very complex institutions. Medical technology has evolved rapidly. Public intervention has increased with programs such as Medicare and Medicaid[5] in the U.S. or National Health Systems in many European countries. An effort to promote competition (Pauly, 1988), took place in the U.S. by adopting in 1973 schemes such as the Health Maintanance Organizations (HMO), belonging to the so-called managed care.

When in the mid-70s the cost of Medicare has started to soar a possible solution was the encouragement of many elderly people to enroll in a private HMO. However, as Woolhandler and Himmelstein6 (2007) thoroughly explain, private contracts with the HMOs under the Medicare program have failed. Very quickly HMO executives realized that profit is in the attraction of healthy elderly, and by various marketing techniques they did exactly this, sending back to Medicare people who have severe health problems and, of course, a high cost for their care is required[7] . By acting thus, the HMOs managed to realize huge profits[8] and acquire strong political influence, which it is used to prevent efforts to end the practices they follow.

Arrow received strong criticism for his view that the market for health services is different from other markets. Robinson (2001:p. 1046) argues that many borrowed the

2. Friedman and Kuznets (1945:pp. 118-137) argue that entry restrictions to the medical profession is one of the reasons doctors have higher income. Arrow, however, questioned the assumptions underlying their calculations (1963:p. 955, fn 29). Friedman argues further (1962:p. 158), that "licensure should be eliminated as a requirement for the practice of medicine". Many authors question the relationship between licensure and quality of care (Svorny, 2004). Arrow himself (1963:p. 956), recognizes that certain medical procedures could be performed by a non-physician at a lower cost.

3.The term "moral" has a negative connotation, as it refers to immoral behavior, suggesting that there is some form of cheating or deception. It is often used in this sense by insurers or by politicians, especially in the U.S. where there is a highly charged debate on compulsory insurance and its social and economic effectiveness. However, in practice, economists by this term merely refer to the inefficiency and failure which may occur in the insurance market, and not something which is immoral (Hale, 2009). Indeed, as Pauly argues (1968:pp. 531, 535), moral hazard has nothing to do with ethics or morality, but is simply rational economic behavior, in which both the doctor and the patient have no incentive to cut the cost of medical care since it is undertaken by the insurance company. However, the logic of Pauly has led to the U.S. insistence on the moral hazard fear, which has led to the non-proliferation of health insurance for the entire population.

4. The existence of moral hazard was confirmed by the large (and unique) experimental study RAND Health Insurance Experiment, conducted in the U.S. from 1971 to 1982 under the direction of Joseph Newhouse (http://www.rand.org/health/projects/hie/).

5. These are two major public health programs in the United States signed by President Lyndon Johnson on 30/7/1965 in order to meet the health care needs of the elderly (over 65 years of age) (http://www.cms.hhs.gov/MedicareGenInfo/), and of the people of all ages with low income (http://www.cms.hhs.gov/MedicaidGenInfo/), respectively. Today these programs meet the health care needs for one third of the U.S. population.

6 Professors of the Medical School of Harvard University and co-founders of the organization Physicians for a National Health Program (http://www.pnhp.org), which since 1986 struggles for the establishment of a health system in the U.S., that will consider health care a public good accessible to all and not a commodity bought and sold like any other commodity.

7. The title of a relevant article is quite accurate: "The Medicare – HMO revolving door – The healthy go in and the sick go out" (Morgan et al., 1997). Angell (2008), points out that the U.S. is the only country in the world with a health system which is trying to avoid patients (p. 917). Comparing the U.S. with Canada, Angell concludes that the problem in Canada is not its health system but under-funding of the system, while the U.S. problem is exactly the opposite (p. 918).

8. Many HMOs have become gigantic organizations, with huge profits and very high administrative costs, thus removing resources from true health care (Woolhandler and Himmelstein, 2004).

ideas (and the authority) of Arrow to justify every singularity and inefficiency in the health market. However, there still exist many features that constitute a deviation from the competitive model. The failure of the competitive model can be clearly seen in the U.S. where even though the per capita expenditure on healthcare is around double the average of OECD countries[9], health indicators in many cases are modest and there are millions of uninsured[10] .

There was a lot of discussion around Arrow's view that the market gaps are covered by social institutions outside the market (1963:p. 947), meaning basically the trust which is supposed to be enjoyed by doctors (Arrow, 1963:pp. 949-951, 965-966). The criticism focused on the fact that the world was never as described by Arrow[11] (Pauly, 1988; 2001; Robinson, 2001). Admittedly, much of what Arrow said on the fact that the medical profession regulates itself has actually faded by the facts. The position and strength of the medical profession has been questioned because of examples of bad practice and the doctor and patient relationship has undergone significant changes. Moreover, the proliferation of the Internet, through the facilitation of the dissemination of information, breaks off the control of the flow of information on health issues that traditionally belonged to the doctor (Hardey, 2001:p. 404). Patients have the opportunity to become better informed and thus obtain more freedom of choice. However, regardless of how easily available information has become, it is questionable as to whether and to what extent patients can manage this information to make their own choices about their treatment regardless of their doctor's instructions (Haas-Wilson, 2001:p. 1042). The information asymmetry remains a central feature of the relationship[12] between doctor and patient, and therefore, as alleged by Fuchs (1988:p. 22), this relationship should remain a relationship of trust[13].

The high cost of market forces in the health sector is also a big problem. Woolhandler and Himmelstein (1997), show that the administrative costs[14] in private hospitals is 34%, compared to 22.9% in public hospitals. Woolhandler et al. (2003), indicate that the administrative costs of the entire health sector in the U.S. reaches 31% almost double the Canadian, 16.7%. High executives also drain resources from care with the huge salaries and bonuses (stock options, etc.) they get, even in the case their company is convicted for unlawful acts (Woolhandler and Himmelstein, 2004). The decision to "unleash" market forces in health diverts money from health care to the administrative bureaucracy (Woolhandler and Himmelstein, 2007:p. 1128) and this probably affects the quality of care[15] .

In the view of the opponents of the competitive model, the failure of competition to reduce costs stems from the fact that private companies in health care follow a profit-maximizing behavior rather than a minimizing-costs behavior. Moreover, to consider patients as "consumers of health services" may sound well in modern economics jargon, but a seriously ill person can not go for "shopping" for health services nor compare prices or reduce the quantity demanded when suppliers raise prices, or, finally, accurately assess the quality of the "product"[16].

Furthermore, in many cases there are monopolistic situations, as more than half of Americans live in areas where the population size would not allow the development of healthy competition[17]. For example, as Fuchs (1988:p. 21) asks, how many hospitals could we have in a population of 100,000 inhabitants; A maximum of two. How many cardiosurgery specialist teams can we have per million of population; A maximum of two as well. Even in

9. In 2007 health spending in the U.S. was 16% of GDP, while the average health spending in the other OECD countries were at 8.7% (OECD, Health Data 2009).

10. According to the latest figures published on 10/9/2009, in 2007 there were 45.7 million uninsured, while in 2008 the relevant figure was 46.3 million (US Census Bureau, 2009).

11. Robinson believes that "Arrow's article experienced the fate of many seminal writings, to describe as the presence a world that already was past" (2001:p. 1052).

12. Williams (1988), describes this relationship in a schematic way: In theory, the patient and doctor relationship is a principal (patient) – agent (doctor) relationship. If the doctor were a perfect agent their relationship would then be as follows:
The DOCTOR is there to give the PATIENT all the information the PATIENT needs in order that the PATIENT can make a decision, and the DOCTOR should then implement that decision once the PATIENT has made it.
However, reversing the words DOCTOR and PATIENT:
The PATIENT is there to give the DOCTOR all the information the DOCTOR needs in order that the DOCTOR can make a decision, and the PATIENT should then implement that decision once the DOCTOR has made it.
Obviously in practice we have the second case, therefore doctors are not a perfect agents and this is certainly a consequence of information asymmetry, which is responsible for the phenomenon of the physician-induced demand.

13. As Nobel Laureate Professor Paul Krugman noted recently (25/7/2009) in his regular column in New York Times, "…you can't rely on experience or comparison shopping. That's why we expect more from doctors than from bakers or grocers" (http://krugman.blogs.nytimes.com/2009/07/25/why-markets-cant-cure-healthcare/).

14. "... I am not sure we have a nurse per (each) bed, but we have a billing clerk per bed…it's obscene" (Dr. Uwe Reinhardt, hearing on healthcare reform, U.S. Senate Finance Committee, 19/11/2008).

15. A large meta-analysis (Deveraux et al., 2002), with data on 38 million patients in thousands of U.S. hospitals for the period 1982-1995 shows that the treatment at a private hospital has a higher risk of death compared with treatment in a public hospital.

16. These are essentially the points made by Arrow (1963). As Paul Krugman notes satirically: "…you can't rely on experience or comprison shopping. ('I hear they've got a real deal on stents over at St. Mary's!')", Krugman, op. cit.

17. The organization Health Care for America Now, using data from the American Medical Association for 2008, estimates that 95% of the U.S. insurance market is concentrated to a point that requires the activation of the antitrust law (http://healthcareforamericanow.org/).

large populations, it is doubtful that public interest is served by having doctors and hospitals compete. "Patients can benefit from cooperation among physicians and hospitals, in both reduced costs and better service" (Fuchs, 1988:p. 21).

Moreover, the production function of health services is a "peculiar" function: usually requires the cooperation of patients and health professionals, rather than acting as buyers and sellers who have opposing interests. Mutual trust contributes to the effectiveness of the "production", i.e. to the therapeutic effort.

In conclusion, many believe that the views expressed by Arrow are still relevant and strong. For example, Krugman writes: "... Arrow has demonstrated that ... ... the health care can't be marketed like bread or TVs"[18] , while Joseph Stiglitz says, "what we've seen is that the private healthcare insurers do not know how to deliver an efficient way"[19], and Fuchs (1988:p. 22), concludes that "the model of atomistic competition usually set as the ideal in economics textbooks often is not the right goal for health".

4. Conclusion

The issue of the operation of the competitive model in the provision of health services creates controversy. This is natural, as it is an issue that can not be analyzed by positive economics, but belongs to normative economics, i.e. it is not a question of the type "how" but a question of the type "how well". The answer, therefore, at to whether the market forces in health provision can lead to optimal resource allocation and efficient solutions and optimization of social welfare depends largely on the subjective value judgments made by the researcher, his overall political and philosophical values and beliefs. It is also obvious that the answer that the society gives and the decisions it makes on issues of this type can be changed over time, as the institutional, political and economic framework in which the issues are raised, alters radically.

It seems however that recently the dominant view is that the competitive model can not work in the health sector. The special characteristics of the sector are many and inequality[20] is one of the major problems arising from the entry of competition in the health sector. The poor performance of the U.S. health care is attributed to reliance in market mechanisms (Woolhandler and Himmelstein, 2007:p. 1129), and so other nations should avoid emulating this bad example[21]. This is why U.S. President Barack Obama made clear his intention to adopt policies designed to control markets[22] from the first moment of assuming Office[23] .

For Europe, which under the European Social Model[24] is the only part of the world where social justice and competitiveness are treated as mutually achievable goals and not as mutually exclusive, the answer to the challenges can not be the unconditional surrender to market forces, but should be the strengthening of the active and dynamic welfare state, leading to a New Social Europe (Giddens, 2008; Rasmussen and Delors, 2007).

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20. Of all the forms of inequality, injustice in health care is the most shocking and inhumane" (Rev. Dr. Martin Luther King Jr., 25/5/1966, Second National Convention of the Medical Committee for Human Rights, Chicago).

21. Angell (2008) reaches a similar conclusion, arguing against efforts in Canada to privatize the health sector according to the U.S. paradigm.

22. "… without a watchful eye, the market can spin out of control", Barack Obama Inaugural Speech, (http://www.whitehouse.gov/blog/inaugural-address/).

23. As Epstein notes recently (25/9/2009) "...a year after he has not wavered one bit" (http://www.nejm.org/perspective-roundtable/health-care-reform-in-perspective/), and thus we recently (7/11/2009) had the pass of the bill on health care reform in the U.S. House of Representatives.

24. The European Social Model is essentially a political vision of a society that seeks progress and development without sacrificing any of its members, a society organized collectively against threats to the quality of life or life itself – such as sickness, unemployment, old age – a society which seeks anthropocentric ways for economic integration in the global economy.

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Nursing Action for the Climate Change: A Systemic Review

Theodosios Stavrianopoulos[1], Anna Chrysanthakopoulou[2], Giorgos Arvanitis[3]

1: RN, Bsc, Msc(c) , General Hospital of Pyrgos Ilia ,
2: RN, Bsc, General Hospital of Pyrgos Ilia ,
3: RN, Bsc, Regional University Hospital of Patra.

ABSTRACT

Background: Global climate change has had and will have considerable effects on human health.Nursing must become more centrally involved in mitigation, reducing the acidity and response efforts of the problem.
Aim: The presentation based on international literature review, of a framework for nursing action on climate change.
Data Sources: Method was used is to search electronic databases (MEDLINE, CINAHL) for a review of international literature until 2009 and became selection of books, articles and studies from libraries.
Results: Given the climate change, developed a working framework for serious professional thinking and action on community nursing. Like many other professions, so the nursing world should now raise the question of how it could contribute, and that could perhaps be better focused individual and collective efforts. The four main components of the framework for action are: the usual tactics, to maximize the skills, the right of priority sites and public grants.
Conclusions: The nursing should be linked closely with other professions and sectors in order to maximize national and international efforts to mitigate and combat climate change. The profession's response to climate change should be as varied as the sector itself, and from all countries.

Key Words: Climate change, nurses, nursing action, environment.

Introduction

No single policy, government, agency, industry or group of people is ever going to reverse global climate change, or even begin to address its considerable effects. Such is the enormity, scope and advanced stage of the emergency, only a concerted effort involving unified political action coupled with diverse responses from many peoples and sectors around the world, has any real hope of succeeding. (United Nations Environment Programme 2001)

Developing a working framework for future professional activity, (Lewis S. 2009) are four associated categories through which the international nursing could perhaps meet a) common tactics , b) maximizing specialties , c) Prioritizing places , d) public studies. (Figure one)

Results

1.1 Common tactics

All four of the above categories involve tactical thinking and action on climate change.

However, the specific tactics that might be used by nurses on a frequent basis deserve dedicated attention. Three types of these tactics can be identified (Figure two).

One way in which nurses and other health professionals can influence positive change is by undertaking environmentally friendly activities. This activity could range from the actions of individuals, to the actions of entire nursing workplaces and workforces.(Neira M, Bertollini R et al 2008 , Frumklin H, McMichael AJ 2008) Another way that nurses might influence climate change, is by providing professional advice to patients and the public about activities that are healthy and environmentally-friendly, or by highlighting those activities likely to be detrimental to health and the environment. (Neira M, Bertollini R et al 2008 , Frumklin H, McMichael AJ 2008 , Canadian Nurses Association 2008 , McMichael 2008)

They might explain how consuming less animal produce is beneficial to cardiovascular health whilst, at an industry level it potentially reduces methane and carbon emissions in the production and transportation of such food.

Some argue that behavior modification (acting in an environmentally friendly way) is more effective at making society feel that it is making a significant contribution to combating climate change than actually effecting concrete change. As a result, irrespective of what individuals and

groups might do by their own accord, there is a need for governments to reduce carbon discharge directly through policy change and regulation. At the same time, they also need to facilitate a significant shift towards renewable energy to replace excessive consumption of oil, coal, and natural gas. (Lewis S. 2009)

With this in mind, a third tactic involves nurses and other health professionals working collectively to encourage policy change across institutional, national and international levels. (Canadian Nurses Association 2008 , McMichael 2008)

Nurses have always enjoyed recognition by officialdom and have held the attention,

support and respect of citizens, that makes them well placed to intervene in these ways. They possess power inside and outside the political process and, although it might not always seem the case, exercise more influence than many other sectors or groups.

Underpinning nurses participation in all three tactics outlined above are the perceived 'natural' and 'caring' features of the profession, and the personal connections and communications nurses have to individuals and their wellbeing. This makes them well placed to act as advocates and formulate strong arguments on health and the environment.

1.2 Maximizing specialties

The substantial and potentially calamitous problem of global climate change demands unified attention not only from health sectors and professions as wholes (Kein ME 2008) but also from all their internal specialties and fields. Each may tailor its responses to make a unique contribution through its core services. (Lewis S. 2009) In nursing, five types of specialty or sub-field can be identified (figure three).

Nursing's response to climate change must first reflect its specialization in, and contribution, to specific sectors of overall health systems whether these be primary health care, community health, public health, or others, nursing locates differently

in each, has different interpersonal interactions, power bases and can hence do different things. One could imagine, for example, school nurses discussing with children on environment and health.

Second, nursing has established specialist interests in specific client and demographic groups and possesses knowledge about their and their families specialist needs and circumstances. This expertise should be used to ensure that the circumstances of different groups are addressed and information is dispersed most widely.

A third division in nursing is based on distinct health conditions and types of medicine (for example palliative care, oncology, cardiology, intensive care).

Fourth, nursing is an incredibly diverse job category both in terms of breadth and levels of seniority. Whilst a head nurse specialist might educate ward staff on environmentally-friendly practice, a chief administrator/director, might adjust unit-level spending to address a particular environmental issue or might lead institutional scale environment initiatives and also be involved at the level of local government and planning.

In sum, nursing must closely link with other professions and sectors to maximize national and international mitigation and response efforts on climate change. Nursing however is far from a single uniform profession. The profession's response to climate change must be as diverse as the sector itself, and come from all quarters. (Kein ME 2008)

1.3 Prioritizing places

Climate-related health problems exist and impact differently around the globe. This is

critical geographical contexts which determine the nature of the professional response. (Lewis S. 2009, St Louis ME,Hess JJ 2008 , Hess JJ et al 2008)

Although it is understandable that nurses will naturally focus the majority of their

environmental efforts in their own countries, there is still a need to recognize that environmental change will be most aggressively felt in Southern Africa. (Lewis S. 2009) Greater elaboration on the complexity of the situation on this continent shows how one health problem roles into another.

Climate change in the future will intensify drought in Africa, reducing agricultural productivity there and causing famine. In addition to the direct health impacts of this on morbidity and mortality, a lack of food will exacerbate pre-existing health problems. For example, HIV/AIDS research tells us that that successful antiretroviral treatment depends on the consumption of nutritious food. (Anabwani G, Navario P 2005) People in these areas will therefore face even greater challenges and threats to their health.

Another crisis facing Africa is that of environmental refugees following drought and famine. There lies the potential for the movement of millions of people, particularly out of Southern Africa northwards. (McMichael 2008)

The health of these people will undoubtedly suffer further during their migration, and increase the incidence of disease. In the regions to which they move,their presence will increase pressure on already inadequate and under-funded health systems. (Lewis S. 2009) Migration however, is not exclusively a human activity.

More generally, beyond Africa, place needs to be recognized as a fundamental and important consideration. Issues arise for example as to how climate change impacts health differently in different neighborhoods, cities, towns, rural localities, natural regions and politically defined areas. A far greater geographical awareness must drive place-specific professional responses. (Hess JJ et al 2008 , Younger M et al 2008)

1.4 Public Studies

Nursing requires a dedicated field of research to support its environmental activity. In this endeavor, two issues come to the fore. The first regards scope of methods and perspectives. It is widely acknowledged that nurses need to base their decision- making on the best available published

evidence. Just as this is true for familiar clinical decisions and contexts, the same holds for decisions made in response to climate change. (Lewis S. 2009)

Whilst hard science can mount compelling arguments to prove the reality of climate change and how it might impact on health, one must also remember that beyond the scientific measurement and explanation of such phenomenon, climate change has deep social complexity meaning that it has social causes, effects and solutions. (Haines A 2008, Ebi KL, Semenza JC 2008)

The second issue regards the politics of research. Some social scientists have recently argued that their disciplines have become 'theory obsessed', ever more obscured from everyday life in the creation of specialized knowledge, and have thus allowed a gap to grow between inquiry and the big issues of the day. (Burawoy M 2005 , Murphy AB 2006)

Moreover, scholars also agree the quest for increasing depth and complexity of analysis has been paralleled by the emergence of an academic performance culture whereby the university has become a company with private sector management styles, and academics have become obsessed with and/or required to engage with corporate processes and procedures. This leaves little time for building activities and interests that would be perceived to lie outside' the formally assessed features of an academic job.

The original passion for social justice, economic equality, human rights sustainable development, political freedom or simply a better world, that drew us to sociology is channeled into the pursuit of academic credentials. Progress becomes a battery of disciplinary techniques, standardized courses, validated reading lists, bureaucratic rankings, intensive examinations, literature reviews, tailored dissertations, refereed publications, the all-mighty CV, the job search, the tenure file. (Burawoy M 2005)

In the face of these developments, researchers might join with political action or otherwise make their research more accessible to a wider audience. This might involve, for example, occasional changes to a simple and open writing style, the publication of research in a wider-range of venues including the internet and other popular media forms, and public talks, debates and dialogues.

Conclusions

Nursing might not have lost touch with public issues in the same way as some social sciences might have, it might learn from the public social science debate. In the face of climate change, it is time for nursing research to take a stand, to make and popularize strong convictions on the subject.

The nursing should be linked closely with other professions and sectors of act to maximize the national and international efforts for mitigation and combat climate change. The profession's response to climate change should be as varied as the sector, and come from all over the world.

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Table One : Four categories of nursing action on climate change (Lewis and Andrews, 2009)

Category	Further Explanation
Common Tactics	What nurses can do to influence public behavior and political action
Maximizing Specialties	The need for different nursing specialties to address specific climate issues
Prioritizing Places	The need to recognize differing circumstances and needs around the globe
Public Scholarship	The need to adjust the nature and focus of nursing research

Table Two: Types of common nursing tactics (Lewis and Andrews, 2009)

Tactic	Elaboration
Leading by example	Encouraging similar behavior
Giving Advice	At a practice and sector level
Political Action	From lobbying to direct action

Table Three : The different types of nursing specialties

Type of Specialty	Examples
Sector focused	primary health care, community nursing, public health nursing
Client focused	gerontology, pediatrics, mental health care
Body focused	palliative care, oncology, cardiology, intensive careJobs and roles
	nurse practitioners,clinical nurse specialists, educators , advanced practice nurses
Specialist empirical and theoretical interests	bio-ethics, policy creation, medical devises, risk, knowledge translation

The Necessity of Change in Providing Nursing Care in Greece: Case Presentation (Implications in Basic Nursing Care)

Dr. Nikolaos A. Bakalis

RN, BSc, PgCert., PgDipl., MSc, PhD

Assistant Professor of Nursing, T.E.I. Patras

Dr. Georgia Theodorakopoulou

RN, BSc, PhD

Professor of Nursing, T.E.I. Patras

ABSTRACT

The benefit of nursing care is a multidimensional phenomenon with various reactions from the patients and from nurses as well. The interest in clinical practice of health-care scientists is increased, year by year, and this is appeared by the publications in the television and magazines.

Patient care is mainly nurses responsibility and never it was not as important as in our days. Public's expectations have been increased so that the patients and their families complain when the provision of health care is not good. Nursing, as a science, should follow the changes that taking place in health care in order to correspond to new challenges.

The paper describes the models of providing nursing care that are used today, analyzing team nursing as the "predominance" model that can be applied in Greece. The advantages of the model are reported and the plan of application is described. The roles of nursing staff are determined and the cost of the change is reported.

It is generally accepted that whichever model of providing nursing care we are using into practice, neither the objective of nursing care it changes but also not the quality of care to patients.

Key words: team nursing, providing care, plan

Introduction

For lots of years few attention was given in the growth of nursing practice in Greece. In most hospitals, due to lack of nursing staff, the nursing care is provided via the model "distribution of work". In that model, all nursing work is divided in activities and then distributed in one or more nurses (eg making beds, providing psychological support, giving medication, etc) (Salvage and Wright, 1995). Although there is a paucity of research in Greece regarding this model, it appears that patients and nursing staff find this model not satisfactory. Salvage and Wright (1995) describe the reasons that this model are not effective, first the care are divided in a number of actions that is connected with the medical diagnosis and second, nurses are described as individuals that cover mainly the individual care of patients.

However, subjects that emerge daily, for example, new expectations of nurses and patients, the need to provide holistic care to patients and continuing nursing education, give the impulse for changes in the nursing science. In other European Countries, for a example in Great Britain, in the of decade of 80's, the model distribution of work collapsed and nurses began to work models of clinical practice that the patient was the centre of nursing care, as team nursing, patient allocation and primary nursing.

Model distribution of work

Nurses, today, are found difficult to finish correctly their work. Basic nursing care such as psychological support and communication between nurses and patients, almost, do not exist. The main disadvantages of distribution of work model are two. First, it creates hierarchical work (Wilkinson, 1994). In other words, nursing care such as patients bath and feeding, are responsibilities to the assistant nurses or practical nurses, while work that is required scientific knowledge, is assigned in staff nurses. Thus, the basic nursing care which helps the nurse to develop personal relation with the patient and gives the possibility to observe the patient condition, it occurs rarely by staff nurses.

The second disadvantage is that nursing care becomes partial with minimal continuity of care (Wilkinson, 1994). Patient care is usually presented as a "line of works" and each aspect of needs is shared in different individual. The partial work is enhanced the creation of routine which has become so much strict, that also patients and nurses is occupied so much with the routine that forgets the basic needs (Waters, 1985). Consequently, patients are complained with regard to the care that is provided for them (Pearson, 1986). The publications in the press and in televisions certify the problems in patients care. It should be reported that the lack of nursing staff is the main factor that causes this situation.

It is true that if we increase the number of nurses, the situation probably will be better. But this is government responsibility and we cannot propose anything on this subject. What, however, we can make, is change nursing "status" by exploring the effectiveness of clinical nursing practice and promote innovations, that will improve patients care. As a result, new frames, models and protocols can be developed for the clinical practice.

It is generally acceptable that the models of clinical practise determine the nursing philosophy into practice (Fawcett, 1995). Thus, changing model of clinical practice is promoted new nursing philosophy. The fact that the societies change rapidly, forces the nursing science to follow these developments. Remaining constant in her philosophy, is removed by the social ambitions and thus it is isolated. This paper comes simply, to make the beginning of new innovation in nursing clinical practice, follow other colleagues.

In this paper, the model that benefits care, is team nursing. The particular model was preferred and not the others, because primary nursing is the entrusting of small number of patients in a nurse from admission to discharge (Pearson, 1988), while the model patiet allocation, is the way of nursing care which includes the entrusting of small number of patients in a nurse that however, changes daily (Pearson, 1988). As a result, both models need an appropriate number of nurses in order to work properly. In Greece, they are working about 36,000 nurses, that correspond 3,6 nurses in 1,000 residents (ESNE, 2004). In Greece, it appears that the lack of registered nurses leads to only one aim, "the job to be done". Keeping that in mind, it looks that the lack of nursing staff in Greece, does not permit the above models to be effective in clinical practice.

Proofs that support the change

Pearson (1992) describes team nursing as a system that benefits nursing care and is focused in idea of good team work. However, Butterworth and Faugier (1992) gave more explicit definition of team nursing. They propose that team nursing is the distribution of small number of nurses (team) in a group of patients, which is responsible for the patient care during hospitalisation. Researches have found that team nursing promotes high levels of nursing care (Wright 1990, Pearson 1992).

According to personal experiences in this model, nurses view patients as entity, designs and provide nursing care more personally. According to Lionis and Koutis (1995) viewing person as entity, it helps in the promotion of good communication and counselling abilities. Also, it helps nurses to develop close relations with the patients. When the communication is free, continuous and open, it creates an atmosphere of confidence and support. An example can be the pre-operation teaching. Giving information to patients with regard to their operation, what to wait for (before and after the operation) and giving support, hearing the questions and their concerns, the intensity and the stress can be decreased.

Besides, designing and providing patient care, nurses begin to move to more autonomous role (Pearson, 1992). The autonomy of nursing practice can be described by the power of nurses to make decisions regarding patient care and also when nurses feel responsible for their decisions. The main aim of clinical nurses is to develop their leadership abilities that can increase confidence and provide better quality of care (Gardner, 1991). In addition, the autonomy of nursing practice enhances nurses so as to behave to them with respect from other health sciences (medicine).

It is true that when nurses provide care in a holistic way, they learn their patients better, they avoid the routine of work and provide better care to patients. Also, this model gives the possibility to each member of the team to consult and discuss as a team any problems or difficulties that they occur (Fawcett, 1995). As a result, it offers possibility of tightening the relations between the staff.

Furthermore, team nursing promotes the humanitarian approach of nursing care which gives the opportunity to patients and relatives to participate in their care (Berry and Metcalf, 1986). This participation can be extended from the negotiation in the care plan up to the management of medication (educate patients and families).

In team nursing model, nursing staff is divided into two teams. Each team has a leader. It is the person who is in charge for planning and organisation of nursing care to patients. Each leader gives report to head of the department (sister), who manages and supervises the whole ward.

The sister is considered an important part in team nursing. It has been found that the sister can help in the support and growth of clinical practice (Butterworth and Faugier, 1992) and also provides protection to free and reliable clinical practice (Butterworth, 1995). In team nursing the sister has an important role to play such as to analyse situations, determine priorities, offer alternatives to patients, support staff nurses and provide innovations for effective nursing care.

When nurses have clear picture for the values and their visions, they will provide better quality of nursing care. In other words, what nurses believe for the patients, influence, finally, the way they work. It is true that the values guide clinical practice (Waters, 1985). Nurses need an environment to develop their abilities. The team should realise that the individual needs are team needs. They should trust each

other and according to Cole (1988) they are shared their problems and not only work as team but also think as a team. The conflicts do not help in the achievement of their needs. Each member of the team, should understand not only the roles of other members of the team but also to perceive these roles. With this way, nurses anticipate conflicts between the members and misunderstandings. Salvage and Wright (1995) propose that when the nursing team works well and support each other, the patients feel satisfied from the nursing care.

Plan Implementation

The pilot application of team nursing model requires the creation of long-term project and thus careful planning is needed in order to avoid conflicts and misunderstandings between the staff.

Table 1: Plan and implementation of team nursing modelî

PLAN
I) Recognition for education before the application
2) Introduce the model to nurses
3) Description of nurses role
4) Analysis of nurses role
5) Introduce the model to patients
6) The ward implements the model
7) Evaluate the situation and change (if necessary) the plans of application

IMPLEMENTATION
I) 3 months. It is important the individual that will develop the model to know it very well
2) 3 weeks.
The Ist week, leaflets will be given to nurses
2nd + 3rd week, the vision of nursing practice will become explicit
3) I month. Four meetings will take place
Ist + 2nd: Discussion and questions from the previous meeting.
3rd + 4th: Description of roles.
4) 2 months. Six meetings will take place
Ist + 2nd: Conclusions from the proposed roles. Discussion and questions.
3rd + 4th: Analysis of roles. Shaping the teams. Examples will be given to staff.
5th + 6th: Criticism of meetings.
5) 2 weeks. Information leaflets will be given to patients/relatives. If the patients have questions, the staff will give the required clarifications.
6) 2 - 3 months.
7) I month. Six meetings will take place.
Ist + 2nd: Research (questionnaires will be given to patients in order to evaluate the model).
3rd + 4th: The staff will evaluate the model. The teams will discuss the positive and negative issues of the model.
5th + 6th: The teams will discuss and evaluate the problems that occurred and alternatives will be proposed.

Roles

In team nursing, all nurses have a role. It is important to describe the proposed roles in order to be explicit about the contribution of each member of the team. More precisely, the sister is the coordinator of all activities and communication. She is the person in-charge for the provision of nursing care, the orientation of new staff and teaching students. In order to achieve the duties successfully, she should have clinical experience and academic qualifications (postgraduate degrees) (Butterworth, 1995). Thus, it will support (clinically) the nurses, she will be the person in-charge for the teaching of clinical educational courses and will function as a researcher.

Nurses will be responsible for patient care. Nursing staff will be divided in 2 teams. Each team will have a leader that will be determined by the sister (usually the most experience nurse). Each team will be constituted from 2-3 nurses (depends on the number of beds) and will care for about 10 patients. The team leader of the team will be responsible to divide, applied and evaluate the nursing care (Salvage and Wright, 1995).

Students will be distributed in each team under the supervision of the sister. Depends on the study level, they will work with the other members of the team or will undertake some patients independently. Thus, the students will not be `a pair of hands' helping the staff, but will be members of the team and they will have a role to fulfill. According to Butterworth and Faugier (1992) the way that a department is organised and how nurses are working are the most important factors for the learning environment of student nurses.

Design

Although the design is very often considered important, is ignored by the nursing science. In order to fully understand the proposed model of clinical practice, regularly meetings should take place. Physiotherapists, the sister and the medical professor of the department meet each week and the medical professor will provide medical directives (Watets, 1985). At these meetings, issues such as effectiveness, efficiency, impartiality and acceptance of the model will be discussed.

The design for the model of clinical nursing practice can also be achieved through patients. Patient satisfaction is one way to measure quality of nursing care (Baker and Whitfield, 2002). Questionnaire will be given to patients in order to estimate clinical nursing practice. Thus, analyzing the results of the questionnaire the teams can determine whether the patients are satisfied with the nursing care and how well the model is working.

Cost

The word ´innovation' determines the change. It is true that changing something, will cost something, and the model of team nursing is not an exception. The categories that include cost are reported below:

a) Equipment: photocopy machine. The fact that each nursing sector has the above equipment, the cost is annihilated. **b)** Education and training: staff information and patients orientation. Through information leaflets the staff and the patients/relatives will be informed for the new model. The leaflet will be constructed in collaboration with academic (nursing) staff. With regard to the production of leaflet, it can produce via photocopy and therefore the cost is annihilated. Questionnaire will be used (in collaboration with academic colleagues) and the production of these will become via photocopy. The analysis and presentation of results will become in collaboration with the academic staff. Conferences will take place in the hospital. Books and magazines with regard to new model should be bought (2,000 Euros). **g)** General expenses: a blackboard will be bought (200 Euros) which all patients will be entered, the teams (the teams are divided in blue and red teams) and the nursing staff that is working in each shift.

According to Fawcett (1995) the long term plans should include the economic resources that are needed and the resources that are available. We presented the resources that are needed for the application of team nursing model. The question is, what resources are available? As we are mentioned before, the cost of application is about 2,200 Euros. It is important to report that from this money, only the 200 Euros are essential for the pilot implementation of the model. The remainder money (2,000 Euros) includes material which will be useful when the model is applied completely into practice. For the pilot implementation, 200 Euros, is needed. The sister will negotiate with the economic department of the hospital.

Conclusion

The paper describes the team nursing model and presents a plan to implement the model into clinical practice. We wish this model to be applied and work properly in order to make important contribution in nursing clinical practice. Consequently, developing the nursing practice will involve improvements in nursing education, research and administration (Wright, 1990).

We also believe that the application of team nursing model will have positive results not only to nurses and nursing science, but also in the quality of patients care. More precisely, team nursing is focused:

-in the recognition and application of nursing as a therapeutic act
-in the growth of autonomous role for nurses
-in better patients treatment and prevention (holistic care)
-better collaboration of nursing staff (the team has the same aims, values and visions)
-in the creation of new roles for nurses
-better cooperation between nursing staff and patients/relatives

The time is suitable for nursing in our country, `to break the shell' and to become open and positive with regard to the dreams and achievements. The aim of nursing science is, through innovations, to provide the best nursing care to patients.

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THE EPITOME OF USEFUL INFORMATION

INCORPORATION OF THE HELLENIC REGULATORY BODY OF NURSES

The Hellenic Regulatory Body of Nurses was constituted by the law 3252/2004 as a form of a Public Body and functions as the official professional body representing the nurses. The enrolment of all nurses is compulsory as is done in corresponding chambers overseeing other professions and functions as a regulatory body and the official counselor of the state (Pan-Hellenic Medical Association, Legal Association of Athens, Technical Chamber of Greece etc.)

MAIN GOALS OF HRBN

In an effort to make the reasons that all nurses should be subscribed to HRBN clear, shown below are the basic goals as presented by the law 3252/2004 and these should be implemented by HRBN:

- The promotion and development of nursing as an independent and autonomous science and art.
- The research, analysis and study of nursing matters and the formulation and submission of scientifically documented studies of the various nursing problems in the country.
- The construction of proposals on nursing matters.
- The continuous training and educating of nursing staff and the materialization and utilization of training programmes.
- The participation in materializing programmes which are funded by the European Union or other international organizations.
- The editing of certificates which are necessary for obtaining a license to practice the nursing profession.
- The evaluation of the nursing care provided.
- The representation of our country at international organizations regarding the nursing department.
- The publication of a journal, an informative bulletin, text books and leaflets so as to inform its members and the public.
- The study of Medicaid matters and the organization of scientific congresses that are independent or in cooperation with other bodies.
- The creation of an ethics committee for the nursing profession.
- The definition and cost assessment of nursing activities.
- The protection and enhancement of the level of health of the Greek population.

MEMBERS OF HRBN

It is compulsory for members of HRBN to be nurses, in other words they should be graduates of the following:

a) University level nursing schools
b) Technical level nursing schools
c) Former higher school for nursing, visiting nurses belonging to the ministry of health, welfare and social security
d) Former nursing school "KATEE"
e) Foreign nursing schools with degrees that are accepted as equivalent to the corresponding Greek schools
f) Military supreme nursing schools

STRUCTURE OF HRBN

HRBN is composed of a central administration, which is located in Athens, and seven peripheral sections, one in each health district of the country.

CENTRAL ADMINISTRATION

The central administration is made up of a 15 member executive council and has its central office in Athens. The address is 47 Vasilisis Sofias Avenue p.c. 10676, tel: 210 3648044-048 and fax: 2103617859 and 210 3648049. HRBN's website is www.enne.gr and email: info@enne.gr .

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7. 7th P.S. Crete: 116 Menelaou Parlama St., Irakleio p.c. 73105 tel: 2810 310366, 2810 311684 and fax: 2810 310014

MEMBER REGISTRATION AND SUBSCRIPTION

All nurses are obliged to apply for registration at the nearest peripheral section. The application form requires a certified copy of the nurse's degree and official identification, two coloured photographs, the receipt from the bank statement for the amount of 65 ?, a simple copy of the license to practice the nursing profession and other titles that the applicant might have are optional (postgraduate degrees, certificates for foreign languages, social activities etc.).

All nurses are obliged to renew their subscription annually, in person or by post (not by fax) till the end of February, by handing in the appropriate statement to the nearest peripheral section. The statement should be handed in simultaneously with the annual subscription fee, which has been assigned to the amount of 45 ? by the law 3252/2004.

All nurses who register or renew their subscription to HRBN are given a Nursing Identity Card.

LICENSE TO PRACTICE THE NURSING PROFESSION

The license to practice the nursing profession can be administered at the local prefecture by presenting the necessary documents and certification of registration at their HRBN peripheral section. When receiving the license to practice it is compulsory to present a copy to the peripheral section to which they belong.

According to the law 3252/2004, whoever practices the nursing profession without a license to practice will be prosecuted according to the article 458 of the Greek penal code.

Any individual of the peripheral council or the board of directors can file a complaint for illegal practice of the nursing profession and thereafter must notify the judiciary authorities.

In the case of a temporary disciplinary sentence or final disqualification from HRBN the license to practice is automatically suspended.

ADMINISTRATIVE BODIES

HRBN is administered by the assembly of representatives and the executive council. The peripheral sections are administered by the general assembly and the peripheral council.

HRBN'S INTERNATIONAL REPRESENTATION

HRBN is a member of FEPI and has one of the seven positions on the board of directors. England, Italy, Spain, Ireland, Poland, Croatia, Romania and Portugal participate in this European federation. France, Cyprus and Belgium are under consideration for participation. For more information the website is www.fepi.org.

SELECTION AND SERVICE OF ADMINISTRATIVE BODIES

HRBN's board of directors is elected by the assembly of representatives. The representatives are elected separately for each peripheral section by the members of the department's General Assembly. The peripheral councils are elected in a similar way by the members of the peripheral department's General Assembly.

These elections take place every 3 years and Nurses that take part are members in good standing (subscription payed).

DISCIPLINARY CHECK

The members of HRBN are initially submitted to a disciplinary check by the peripheral section, which also functions as a disciplinary council. The secondary disciplinary check, as well as the disciplinary check of the members of the board and the peripheral councils is executed by the supreme disciplinary council, whose president is the supreme court judge.

SCIENTIFIC JOURNAL

HRBN created the "Hellenic Journal of Nursing Science" in 2008 which is its official journal. It is a multidimensional journal with an editorial committee which aims at the promotion of the nursing science in Greece.

The "Hellenic Journal of the Nursing Science" is a reliable, modern, quarterly scientific journal which is published in Greek and English and is available in electronic and print-

ed form. A nominal fee is offered to all interested researchers, university teaching staff, students and the entire nursing community in general as well as the tertiary university and technical level schools (Greek or foreign).
Simultaneously it offers young scientists easy access to knowledge and the chance for nursing to progress, as well as a scientific step for the nurses who work in the academic area and the clinical area to publish their work and undergo some constructive criticism. The journal publishes research studies, reviews, original dissertations and book reviews.
The papers that are published, are credited in a manner that is regulated and certified by the Greek legislation according to international standards.

INFORMATIVE JOURNAL

HRBN created a monthly informative journal in 2008 "Rhythm of Health – Ρυθμός της Υγείας", aiming at promoting and demonstrating each nurse as a unified psychosomatic and professional personality.
The nurses in Greece have the need to solve primary issues that concern their profession as well as the need to express themselves, to communicate, to enjoy themselves and to demonstrate the diverse aspects of their social purpose.
"Rhythm of Health - Ρυθμός της Υγείας" aims at uniting the voice of all nurses in the country and becoming an immediate and dependable form of communication, giving a chance to all voices of the professional community to be heard.

GOALS FOR THE FUTURE

With the collaboration of all its members HRBN aims at materializing and completing some important projects that are requested by the nursing community, some of which have already started being carried out:

- The definition and cost assessment of nursing activities.
- The creation of an open line of communication so as to record and solve the nursing problems.
- The enhancement of international relations between Greek nurses and organizations, for and international institutes.
- The creation of an electronic digital library which can be used free of charge by members of HRBN and to which the whole country will have access.
- Will offer specific training and postgraduate courses.
- The organizing of scientific congresses and day meetings with formal accreditation.
- The formation of specific project committees such as a training committee, a documentation committee, a foreign affairs committee and an informative committee.
- The creation of a network of experts on nursing issues and the provision of legal advice.
- The creation and function of specialization programmes.
- The certification of nursing specialties and nursing adequacy.

CONTACTS

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