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EJoHP 2(3)/2024

Contents

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Realizing the Right to Special Geriatric Care

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Abstract

The demographic trend of an aging population places increasing demands on healthcare systems worldwide, which necessitates adapting public health services to the needs of older adults. In Poland, current regulations lack provisions specifically tailored to the elderly. Recent legal reforms by public authorities represent an attempt to address this gap by establishing a network of entities providing special geriatric care. This article analyzes these regulatory frameworks and assesses the feasibility of their implementation.

Keywords: geriatric care, healthcare system, local government responsibilities

1. Introduction

The global trend of population aging is reshaping the landscape of healthcare. According to the World Health Organization, the number of individuals over 60 is projected to reach approximately 2.2 billion (World Health Organization, n.d.). As demographics shift, public administration, especially within healthcare, must adapt to these changing demands (Gorbatov, 2023). In Poland, the Constitution enshrines the right to healthcare for all citizens, as specified in Article 68, irrespective of their financial status (Konstytucja Rzeczpospolitej Polskiej z dnia 2 kwietnia 1997 r. [Constitution of the Republic of Poland, April 2, 1997], art. 68). This provision includes a particular commitment to elderly citizens, who, alongside children, pregnant women, and disabled individuals, are identified as priority groups. Poland's universal healthcare system, managed through the National Health Fund (NFZ), implements this constitutional guarantee.

The recently introduced Act on Special Geriatric Care (Ustawa o szczególnej opiece geriatrycznej z dnia 17 sierpnia 2023 [Act on Special Geriatric Care, August 17, 2023])

(hereafter referred to as "the Act"), which is central to this analysis, represents the first national legislation to mandate county-level governments to deliver a specific healthcare service. This legislative step is noteworthy, as it marks an unprecedented delegation of responsibility to local governments in the field of healthcare, alongside detailed specifications of these duties. The Act targets geriatric care for individuals over 75, a demographic with complex and often costly healthcare needs that also involve social, economic, and psychological considerations (Szwałkiewicz & Kaussen, 2006).

Additionally, the Act represents the first comprehensive attempt to define the government's role in addressing the needs of an aging population. By comparison, previous legislation, such as the Seniors Act, merely requires periodic monitoring and reporting on the status of older adults, but falls short of a comprehensive strategy (Ustawa z dnia 11 września 2014 r. o osobach starszych [Act on Older Persons, September 11, 2014]).

To better understand the significance of the Act, it is helpful to examine an excerpt from its justification: "The primary objective of this legislative initiative by the President of the Republic of Poland is to ensure special geriatric care for individuals over the age of 75, thereby promoting healthy aging. The proposed measures also lay the groundwork for transforming geriatric care toward a community-based model, in which medical services are accessible near the senior's place of residence" (Uzasadnienie do ustawy o szczególnej opiece geriatrycznej [Justification for the Act on Special Geriatric Care], June 13, 2023).

As indicated, the Act is widely viewed as a starting point and in its current form, it will most likely not reach full implementation. This cautious outlook is shared by public officials commenting on the bill draft.[1]

2. Normative Scope of the Act on Special Geriatric Care

The Act in question is a regulatory measure that defines the responsibilities of public authorities and healthcare providers in administering "special geriatric care." While the Act does not provide a direct definition of this term, its scope and the entitlements associated with it are thoroughly detailed in Polish law. The right to special geriatric care is part of the public health protection rights guaranteed by the Polish Constitution, which positions elderly individuals as a distinct and privileged group, meaning this right should be implemented with particular focus and priority. Comparable in significance is the right to long-term care, which holds distinct importance for senior citizens (Berezowski & Guzak, 2013). In line with the regulation, special geriatric care is

1 Deputy Minister of Health Wojciech Konieczny criticized the act as "ill-conceived and unrealistic," citing its disconnection from the actual conditions for implementation, such as the severe shortage of medical staff, which cannot be addressed in a short time. The minister also opposed dividing eligibility for statutory benefits into groups of those below and above 75 years of age. He noted numerous errors in the act, suggesting it requires radical changes, which may prove difficult due to the political power dynamics (Pietrzak, 2024).

to be provided through geriatric hospital wards, 75+ Centers (hereinafter referred to as Centers), and primary healthcare facilities. Particular attention is given to establishing geriatric wards at the appropriate tier of medical care, as well as to the planned number of beds and wards required to meet regional needs across all voivodeships, as outlined in Article 10. The timeframe for this task, along with establishing the Centers, is set at five years from the Act's enactment, per Article 55. The Act meticulously regulates the duties of the Centers, including the organizational structure of such units. It also assigns new mandatory responsibilities to county governments and, indirectly, to other local government bodies operating hospitals at the required level of medical service provision, to establish, expand, or adjust geriatric wards in line with these regulations.

3. Demographic and Legal Context for Implementing Special Geriatric Care

As highlighted in the legislative justification, individuals over 75 currently comprise more than 7% of the population in Poland (based on 2021 data) and are projected to make up approximately 11% within the next five years. This age bracket, often referred to as "advanced age," had previously not been recognized as a distinct demographic in healthcare legislation. Presently, the only entitlement specific to this age group is a care supplement paid out by ZUS (the Polish Social Insurance Institution) to those over 75, as part of their pension benefits. Eligibility for this supplement, as stipulated in Article 75, Section 1 of the Act on Pensions and Annuities from the Social Insurance Fund, is contingent upon reaching a certain age or having a certified disability status (Ustawa z dnia 17 grudnia 1998 r. o emeryturach i rentach z Funduszu Ubezpieczeń Społecznych [Act on Pensions and Annuities from the Social Insurance Fund, December 17, 1998]). The legislature has set 75 as the statistical threshold for "advanced age," while the WHO describes this period as "late old age."

While some may argue this threshold is arbitrary, as it excludes those who may need these services before reaching 75, the age criterion is consistent with widely recognized categorizations and is thus not uniquely subject to criticism. According to the WHO, the span from 75 to 90 years is considered to represent advanced age. This period of life poses heightened demands on special healthcare and support services. For example, outpatient consultations for individuals over 65 accounted for a full third of all consultations provided through Specialist Outpatient Care (AOS) in 2022, according to GUS data (Główny Urząd Statystyczny [Statistics Poland], 2022, p. 43). Similarly, over a third of consultations in Primary Healthcare (POZ) were also for this age group, which indicates that the demand for both specialist and basic medical services for people over 65 outpaces that of other population groups. Such findings make a strong case for age-based entitlements to healthcare services. However, it may be worth considering

the potential benefits of granting access to special geriatric care before the age of 75, depending on health status or specific care needs, especially as current legislation defines older adults as individuals aged 60 and over.

Unfortunately, efforts to ensure equal access to guaranteed healthcare services encounter numerous implementation hurdles due to limited availability of such services. These limitations arise not only from a low number of providers and limited funding in the National Health Fund (NFZ) budget but also from a critical shortage of medical staff. Additionally, the geographic concentration of healthcare facilities is uneven, which further complicates accessibility. The rising demand for healthcare services is spurred by a combination of greater health needs and advances in medical technology. According to a report from the Watch Health Care Foundation, the average waiting time for services reached 3.5 months in 2023—an alarmingly long delay given the often fragile health of older adults, who generally have limited ability to seek private, full-fee healthcare options. Waiting periods for specific services, such as physical therapy (average of 7 months) or orthopedics and musculoskeletal trauma care (8.3 months), are particularly troubling considering the acute needs of older adults in these fields (Jackowska, 2023). Expanding the range of available healthcare services is essential to accommodate the changing demographic structure and evolving public health needs. The urgency of this issue was brought to light during the COVID-19 pandemic, which exposed grave weaknesses in the preparedness of virtually all healthcare systems to handle similar crises that will almost certainly arise in the future (Bazyar, 2021).

4. Right to Special Geriatric Care

The right to special geriatric care grants access to publicly funded healthcare services as stipulated in Article 2 of the Act on Publicly Funded Healthcare Services (Ustawa z dnia 27 sierpnia 2004 r. o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych [Act on Publicly Funded Healthcare Services, August 27, 2004]) (hereafter, the Public Healthcare Services Act). Under this legislation, these services are available primarily to individuals covered by universal, mandatory, or voluntary health insurance. Additionally, under Article 5, point 36 of the Public Healthcare Services Act, special healthcare services are classified as special care.

Eligibility for special geriatric care is granted through a referral, as outlined in Article 36 of the Act. This referral must be issued by a licensed physician with authority under the health insurance scheme. Such providers include:

- primary care physicians,
- physicians offering specialist outpatient care in geriatrics, and
- physicians working in a geriatric ward or, in the absence of such a ward, another hospital unit.

The designated physicians, after conducting a preliminary geriatric assessment, refer eligible individuals to the appropriate local center based on their place of residence. The Act differentiates between two types of assessments in this context: preliminary and comprehensive. Primary care physicians are responsible for conducting the preliminary assessment, after which the patient is assigned to a suitable category on the VES-13[2] scale and referred to the center with this score. Other authorized physicians perform a comprehensive geriatric assessment before issuing a referral. Under Article 1, the Act grants individuals aged 75 and older distinct rights to special geriatric care. According to Article 3, this care includes:

- Preserving maximum functional capacity and independence,
- Providing healthcare services as defined in the Act,
- Conducting a full geriatric evaluation,
- Developing and implementing a personalized therapeutic plan,
- Offering medication reconciliation,
- Implementing preventive health measures and health promotion activities to reduce disability and dependence risks,
- Providing health education to patients and their caregivers, and
- Offering psychological support.

This statutory list is exhaustive, meaning it clearly defines the entitlements for seniors aged 75 and over, along with the corresponding obligations for healthcare providers delivering special geriatric care.

One notable provision is the right to a comprehensive geriatric assessment. The Act defines this assessment as a multidimensional and interdisciplinary diagnostic approach designed to identify health and caregiving issues, optimize treatment, facilitate healthcare planning, and improve both functional abilities and quality of life. This thorough definition underscores a progressive approach in establishing patient rights, as it guides patients and healthcare providers alike and prioritizes accurate and holistic diagnosis prior to initiating medical interventions.

The list outlined in Article 20, Section 2 of the Act specifies the services included within healthcare provisions, which encompass:

- Geriatric services provided by physicians and nurses,
- Physical therapy services provided by physiotherapists,
- Psychiatric support from psychologists,
- Nutritional counseling,

2 According to the dictionary of the Act, the VES-13 scale (*Vulnerable Elders Survey 13*) is a questionnaire-based assessment that includes self-evaluation of health status and daily activities, helping identify individuals at increased risk of significant deterioration in health and functional fitness.

- Occupational therapy, and
- Health education.

The comprehensive geriatric assessment forms the cornerstone for developing an individualized therapeutic plan, as mandated by Article 38 of the Act. This plan includes:

- Documentation of the patient's primary health and social issues,
- A clear outline of therapeutic goals,
- Specification of therapeutic methods,
- Identifying appropriate healthcare services,
- Determination of the patient's caregiving and support needs, and
- A timeline and schedule for implementing the personalized care plan.

The services guaranteed by the Act to eligible individuals go beyond the standard obligations of the healthcare system. Within the framework of the individualized care plan, which guides both therapeutic and support interventions, the assessment of care and support needs includes an evaluation by the relevant social welfare or social service center to ascertain eligibility for social assistance benefits or services. Furthermore, as stipulated in Article 40 of the Act, if the evaluation of health and living conditions reveals that a patient may require social services—such as general or special caregiving, or even placement in a residential care facility—the provider of geriatric care services is obligated to notify the relevant social welfare center or social service center of the need to evaluate these requirements.

Beyond coordinated healthcare services, patients in need of special geriatric care benefit from health education and psychological support at the Center. Health education, delivered by a health educator in a range of formats, is also available to caregivers of geriatric patients. Under Article 29 of the Act, the goal of health education is to raise awareness among patients and their caregivers concerning social and environmental factors that influence health. The program also includes evaluating the patient's capability to independently manage their health, monitor disease progression, mitigate its effects, develop coping strategies, increase physical activity, and encourage engagement in social life. Since outpatient geriatric care services are provided at the Center, transportation is necessary for patients to access these services. The provisions entitle them to daily transportation to and from the day-care facility. However, as per Article 24, Section 2 of the Act, this right to transportation is restricted to individuals attending the geriatric day-care center.

The right to access the day-care center is time-limited, as stipulated in Article 24, Section 4 of the Act, and allows for a maximum of 12 weeks within a 12-month period from the start date of geriatric day-care services. Individuals who cannot be transported to the day-care center due to their health conditions may receive services at home under Article 25. These home-based services are provided by a geriatric home care team. Although

the specifics of these home services are not explicitly defined, it is generally understood that they should mirror the offerings available at the geriatric day-care center. Naturally, due to the logistical challenges of delivering care at home and the need for medical staff to travel, the scope and intensity of these services may be significantly reduced.

An individualized care plan should account for the differences between day-care and home-based geriatric services. It is worth noting that the right to special geriatric care, whether provided at day-care centers or through home-based services, is consistent with the recommendations of the Polsenior 2 project. This project emphasizes the need to "expand the network of day-care facilities and ensure access (in terms of affordability and transportation) for older adults" as well as to "identify and swiftly reach individuals requiring support through improved coordination and information flow among social and healthcare services, in conjunction with local government entities" (Błędowski et al., 2022, p. 48).

In addition to receiving care at the Center, the right to special geriatric care may also be realized in a geriatric hospital unit. From the date of the Act's implementation, hospital-based geriatric services should concentrate on meeting the objectives specified in Article 3, Section 2 of the Act, particularly those addressing the right to special geriatric care. Given the phased process of establishing the network of Centers, implementing this component of the Act should be given priority. This strategy allows patients in geriatric hospital units to exercise their right to special geriatric care in a hospital setting. The establishment and operation of these Centers appear to be a well-conceived solution, akin to models adopted in other countries. For instance, in the United States, studies have demonstrated that community-based home care is not only more effective but also more cost-efficient than long-term institutional care, which remains one of the most common forms of support for older adults (Agency for Healthcare Research and Quality, 2012).

5. Entities Providing Geriatric Care Services

The Act in question not only introduced new entitlements within the public healthcare system but also established a new type of service provider: the Center. Under Article 17 of the Act, this entity can be a healthcare facility set up in accordance with the Healthcare Activity Act. Notably, the Act does not impose any specific organizational structure for the Center, which means that, in line with Article 4, Section 1 of the Healthcare Activity Act, the Center can be operated by an entrepreneur as defined by the Act on Freedom of Business Activity (Ustawa z dnia 2 lipca 2004 r. o swobodzie działalności gospodarczej [Act on Freedom of Business Activity, July 2, 2004) or by an independent public healthcare facility. Additionally, a district may choose to establish the Center within an existing healthcare entity.

The Act also permits districts to enter into agreements with neighboring districts, which would allow them to carry out special geriatric care tasks through an entity created or separated by the neighboring district. The Act does not prohibit the establishment of the Center within completely independent entities, such as regional hospitals or private healthcare providers offering paid services outside of the public health insurance system. However, the privatization of services has not been envisaged in the provisions of the Act.

The Center's area of operation is initially the district that established or separated it. This area can be expanded to include any district that has signed an agreement to transfer the statutory tasks. Given the scope of these responsibilities and the underestimated costs presented in the justification for the Act, it is anticipated that more districts will be willing to sign agreements to delegate tasks rather than directly assume them. Patient transport constitutes a significant cost, albeit one that is difficult to accurately estimate. As noted earlier, the services provided by the Center are ambulatory, which means that patients will require daily transportation to and from their homes. In larger districts, transportation costs could become particularly burdensome, especially since patients may live in various parts of the district. If tasks are transferred to a neighboring district, this cost could be further amplified by the need for transport across an even broader area.

The structure and organization of the Center are thoroughly outlined in Article 22 of the Act, which stipulates that the Center will consist of:

- A consultation clinic – providing specialist consultations and nursing services,
- A geriatric day care center – offering temporary, daytime care,
- A home geriatric care team – delivering healthcare services to patients who cannot receive them in an ambulatory setting due to their health condition,
- A team of geriatric care coordinators,
- A team of health educators, and
- An information and reception desk – offering information on the scope and rules of the services offered by the Center.

The Center, in its provision of healthcare services, is authorized to obtain health information about patients from other medical institutions as well as from social assistance organizations. The goal of this practice is to ensure comprehensive care for patients whose health is influenced by a range of factors, including their living conditions. Moreover, these individuals often require services from multiple healthcare facilities due to their complex health needs. However, these services are frequently provided independently of one another, without a holistic view of the elderly patient's overall health, and tend to focus solely on specific medical issues. In practice, the most demanding aspect of the Center's operations is likely to be managing the daily care facility. Coordinating individualized therapeutic plans for patients residing in different locations will be demanding. Additionally, the logistics of transporting eligible individuals from various parts of the district to the facility, and back, will be both complex and costly.

Article 24, Section 4 of the Act empowers the Minister of Health to establish regulations that define the operational framework and minimum scope of services provided by the geriatric day care center. These regulations are intended to guarantee proper support for patients and fulfil the objectives of special geriatric care. However, the decree has yet to be issued, and it is uncertain whether it will be, particularly in light of proposed amendments to the bill. According to the justification provided for the Act, the anticipated decree would specify a minimum set of services to be delivered by the center. These include daily care for patients, support and guidance for caregivers regarding the organization of care and treatment, meals on the days care services are provided, transportation of patients to and from the day care center, assistance from a geriatric care coordinator, and educational support from a health educator tailored to the needs of both the patients and their caregivers.

It is worth noting that, under to Article 51, Section 4 of the Social Assistance Act (Ustawa z dnia 12 marca 2014 r. o pomocy społecznej [Social Assistance Act, March 12, 2014]), it is currently possible to operate social assistance facilities for day care. These facilities can provide both general and specialist care services to individuals who, due to age, illness, or disability, require partial assistance to meet their essential daily needs. However, the scope of services provided by day care centers predominantly revolves around caregiving and catering to basic living needs.

In contrast, as specified in the discussed legislation, the activities of the Center are distinctly geared toward health protection. Given that the Center functions as a medical entity, it must adhere to the stipulations outlined in the Medical Activity Act. This entails obligations such as mandatory liability and medical event insurance (as detailed in Article 25 of the Medical Activity Act), compliance with general spatial, sanitary, and installation standards (as stated in Article 22 of the Medical Activity Act), and the requirement that health services be delivered solely by certified medical professionals who meet the qualifications set out in separate regulations (Article 17, Point 3 of the Medical Activity Act).

6. Center Personnel

The core team within the medical facility will consist of healthcare professionals, including doctors, nurses, physiotherapists, pharmacists, and dietitians. Health educators, whose qualifications are specifically defined by law, will also comprise medical staff. One of the most pressing staffing challenges will be recruiting geriatricians, whose expertise is indispensable to the Center's work. The legislative justification notes that the current number of practicing geriatricians in Poland is alarmingly low at only 562 (Uzasadnienie do ustawy o szczególnej opiece geriatrycznej [Justification for the Act on Special Geriatric Care], 2023). To meet healthcare system demands, the PolSenior 2 project recommends

that Poland should have 3,000 practicing geriatricians, with a projected need of approximately 4,500 in the near future (Błędowski et al., 2022).

It is worth noting that the Act establishes a new medical profession, namely that of a medical educator. According to Article 29 of the Act, the responsibilities of a medical educator include:

- Identifying educational needs,
- Planning the patient's health education,
- Raising patient awareness of social and environmental factors affecting health,
- Enhancing knowledge and skills related to navigating the healthcare system and understanding its functioning, and
- Evaluating the patient's independence in health monitoring and self-assessment, as well as their autonomy and engagement in physical and social activities.

Under Article 28 of the Act, a health educator must fulfill two main requirements: holding a higher education degree in medical or health sciences and completing training in health promotion and health education. The Act also stipulates that this training should expand and update professional knowledge and competencies in health promotion and health education, specifically tailored to the needs of geriatric patients. The curriculum for this mandatory training will be developed by the Medical Center for Postgraduate Education, in collaboration with experts who have substantial professional and academic experience in geriatrics. The final training program must receive approval from the Minister of Health.

Another position within the Center is that of the geriatric care coordinator. The educational requirements for this role are specified in Article 26 of the Act. The formal qualification includes holding a higher education degree in medical sciences or health sciences or completing postgraduate studies in fields such as gerontology, geriatrics, elder care, or geriatric care. According to Article 27 of the Act, the exclusive responsibilities of the coordinator include:

- Providing patients of the center and their caregivers with information on the organization of therapeutic procedures,
- Participating in the development of individualized care plans,
- Overseeing the implementation of these plans,
- Ensuring collaboration among entities and individuals involved in therapeutic procedures,
- Supporting center patients at all stages of therapeutic procedures, and
- Collaborating with entities providing medical services, social welfare units, and social service centers in matters related to the center's patients.

The clearly defined duties of the coordinator and the rigorous qualifications required for the role accentuate the importance of coordination in delivering special geriatric care.

It is reasonable to agree with the legislature's view that effective geriatric services must be planned and coordinated. Only through such a structured approach can the implementation of new service provisions achieve the desired outcomes. Elderly individuals often encounter barriers when trying to navigate and fully benefit from the public health system independently, which draws attention to the importance of the active role of the coordinator as mandated by the Act.

- After completing an individual plan, the coordinator should conduct a summary conversation to review its implementation.
- If a patient's needs that could be met by social welfare services are identified, the coordinator must, with the patient's consent, inform the Social Services Center about the necessity of assessing those needs.
- The coordinator should ensure that the patient receives an information card containing recommendations for post-therapy procedures upon the conclusion of the therapeutic plan.

Finally, it is important to discuss the qualifications and scope of competencies for the Center's Director—or, more accurately, the absence of specific regulations. The Act mentions the Director of the Center only briefly in Article 31, which sets forth their duty to provide information. This implies that the regulations from the Act on Medical Activity (Ustawa z dnia 15 kwietnia 2011 r. o działalności leczniczej [Act on Medical Activity, April 15, 2011] apply in this context. Article 46 of the Act specifies the requirements for the director of a medical entity that is not a business enterprise, which include:

- A higher education degree,
- Knowledge and experience that guarantee the proper execution of the director's duties,
- A minimum of five years of experience in a managerial position, or completion of postgraduate studies in management and at least three years of work experience, and
- No final conviction for an intentional criminal offense.

These requirements can be considered the minimum standard. The employing entity may establish additional criteria, such as familiarity with the field of geriatrics. Beyond the medical staff, the Center should also employ an occupational therapist and a psychologist. The Act does not regulate the competencies for these professions. However, Article 20 of the Act lists the range of health services provided by the Center, which includes psychiatric care services performed by psychologists and occupational therapy.

7. Competencies of Public Administration Authorities in Implementing Special Geriatric Care

Under Article 5 of the discussed Act, the responsibilities for implementing special geriatric care are directly assigned to the Minister of Health, the voivode, and the county government. The chief and most significant task of the voivode involves drafting the regional plan that governs the operation of special geriatric care facilities. As stipulated in Article 9 of the Act, the regional plan must include:

- The placement of hospital geriatric wards within the voivodeship and the determination of the minimum number of beds in these wards,
- The location and service areas of individual centers, and
- The collaboration between each hospital geriatric ward and no more than three centers within the voivodeship.

The goal of the regional plan is to strategically position geriatric wards to ensure adequate access to geriatric care for all eligible residents within the voivodeship. Hospital geriatric wards may be established in national-level hospitals or those classified as level II or III referral centers. In exceptional situations, wards can also be located in level I referral hospitals or other medical facilities that have contracts with the National Health Fund (NFZ). The mandated minimum for hospital geriatric wards is 50 beds per 100,000 residents aged 60 and older, as of December 31 of the preceding year.

It is noteworthy that, when determining the number of beds, the focus is on individuals aged 60 and above, as opposed to the age of 75 and older considered for Centers. For Centers, the population range used to establish their service area is between 6,000 and 12,000 county residents aged 75 and above. This implies that, under the provisions of the Act, counties with larger numbers of eligible residents should have more than one Center. If the population of eligible residents in a county falls below the minimum threshold of 6,000, Article 19 advises that the county should pursue an agreement with a neighboring county within the same voivodeship to transfer the responsibility for establishing a Center.

Nonetheless, it is difficult to unequivocally state that, in cases where the number of eligible individuals is insufficient, the obligation to create a Center becomes mandatory.

The procedure for developing a regional plan is meticulously outlined. According to Article 13 of the Act, once the voivode announces the commencement of work on the plan, counties have 60 days to submit their proposals for the organization of the Center. Should a county fail to present its proposal or fail to submit the required declaration from an operational healthcare entity confirming the establishment of the Center, the voivode, pursuant to Article 11, section 3, will designate its location within an existing healthcare facility in the county, provided the legal criteria for creating a Center are met. However, the Act does not specify what actions should be taken if no healthcare facility exists in the county or if such a facility is privately operated.

The voivode publishes the draft regional plan available in the Public Information Bulletin to solicit feedback from stakeholders, who are given 30 days to submit their opinions. Following the review of these opinions, the voivode finalizes the plan in collaboration with the National Health Fund, though the Act does not stipulate a specific timeframe for this stage. Ultimately, the approval of the regional plan is within the jurisdiction of the Minister of Health.

The voivode is also responsible for overseeing the Center's operations with regard to the organization and accessibility of healthcare services. This oversight is conducted in accordance with the regulations set forth in the Act on Medical Activities. Under Article 118, the voivode is granted the authority to:

- Inspect the Center's facilities,
- Observe procedures related to the provision of healthcare services,
- Review medical documentation,
- Evaluate compliance with the Center's organizational guidelines, and
- Evaluate the management of assets and public funds.

During inspections, authorized individuals, as specified in Article 122, section 2 of the Act on Medical Activity, have the right to enter the premises of healthcare facilities, review documentation, and request explanations from employees. Based on monitoring data, the voivode compiles an annual report detailing the organization and accessibility of services provided by regional centers, which is subsequently submitted to the National Health Council. This monitoring data and subsequent report can be used by the voivode to revise the regional plan, in compliance with Article 16 of the Act, to ensure the availability of special geriatric care services. If any deficiencies are identified, particularly in terms of gaps in access to geriatric care, the voivode is expected to take further corrective action to address and improve the situation. It is important to bear in mind that the voivode also exercises oversight over county governments. Article 77a of the County Government Act (Ustawa z dnia 5 czerwca 1998 r. o samorządzie powiatowym [Act on County Government, June 5, 1998]) empowers the voivode to request information and data related to the organization and functioning of the county, which is necessary for exercising their supervisory duties. This provision provides a sufficient legal basis for obtaining the required information from county authorities in connection with the implementation of tasks defined in the Act.

The county government, as a public administrative body, holds the primary duty of organizing access to special geriatric care services. The general legal framework for this is provided by Article 4, Section 1, point 2 of the County Government Act, which enumerates health promotion and protection among the county's obligations. This list also includes point 5a, which pertains to the county's role in senior policy, though Article 3f of the Act indicates that this typically involves the formation of senior councils. Furthermore, some competencies are regulated by the Act on Healthcare Services, but

these pertain to the county's obligation to facilitate equitable access to healthcare. As per Article 8 of the County Government Act, these tasks include implementing health prevention programs and other activities aimed at promoting, organizing, and initiating services in health promotion and health education.

As previously mentioned, the Act establishes mandatory duties related to the organization of healthcare entities tasked with providing special medical services. These newly imposed obligations place county governments in a unique position within the public administration structure for healthcare protection. Currently, Poland has 313 county hospitals, operating in nearly every county. Regrettably, reports from the Supreme Audit Office indicate that most of these hospitals are in debt (Najwyższa Izba Kontroli [Supreme Audit Office], (2023), a condition that has persisted since their transfer to county management on January 1, 1999, largely due to a lack of inadequate restructuring and the excessive number of facilities. These additional responsibilities could exacerbate financial difficulties, as insufficient funding for services or infrastructure may lead to further fiscal strain on the counties or the hospitals themselves if they are required to incorporate special geriatric care centers within their existing structures.

The key advisory body to the Minister of Health, established by the Act, is the National Council. The National Council's responsibilities include advising on geriatric care, proposing changes to geriatric care practices, reviewing regional plans, and evaluating the financing of geriatric services. The Council consists of 19 members appointed by the Minister of Health, chosen from public officials, patient advocacy groups, and national consultants. The Minister also appoints the chairperson of the Council. Although the Council's tasks are broadly defined, its influence on geriatric care could prove substantial. It seems prudent for the Council to begin recommending amendments to the Act to ensure effective implementation. Securing adequate funding for special geriatric services through the National Health Fund (NFZ) will also be a pivotal element of the Act's success. In this regard, the National Council should advocate for the most favorable valuation of services. Article 31a of the Act on Health Care Services grants the Minister of Health significant powers over rate setting, including the ability to approve and modify pricing rates. The role of the National Council in this process could be vital, as it can submit objections to the valuation of special geriatric care services and can influence the Minister, who holds the final approval. The first members of the National Council were officially appointed by the Minister of Health on March 1, 2024, under Article 51 of the Act.

8. Legal Framework for Financing Geriatric Care

The funding of special geriatric care services, as stipulated in Article 45 of the Act, follows the principles set out in the Act on Health Care Services. Unlike other healthcare providers, however, the NFZ enters into contracts for services with the Center based on its inclusion in the regional plan. Although the explanatory memorandum of the Act offers various financial details regarding infrastructure funding for the Centers, these are not legally binding. Nevertheless, they are vital for both recipients of care and entities responsible for organizing and delivering special geriatric services, as they help anticipate infrastructure funding needs.

Article 49 of the Act on the Medical Fund introduces amendments that expand the catalogue of fund allocations. Specifically, point 9 has been added, which provides for financing tasks such as the construction, modernization, reconstruction, or equipping of Centers. It is important to note that investment financing through the Medical Fund is awarded on a competitive basis. Consequently, counties must prepare and submit applications for funding once the Medical Fund announces a call for proposals. The minister for health is responsible for managing the application and evaluation process.

The general financial implications of the Act for the financing of geriatric services, as outlined in its explanatory memorandum, are estimated at approximately 2.1 billion PLN, assuming that around 300 Centers will eventually be operational in Poland. This financing will be based on contracts with the National Health Fund (NFZ), as mentioned previously. This sum is identified in the memorandum as a target figure, and actual expenditures from the NFZ will depend on how many Centers are eventually established. Given the obligation stipulated in Article 55 to establish these Centers within five years of the Act's enactment, it is expected that most costs will arise towards the end of this period—provided there are no legislative changes delaying implementation.

The estimated costs outlined in the explanatory memorandum are largely attributed to staffing expenses. Monthly salary costs are projected at 172,000 PLN, which covers roughly 20 full-time positions. These figures, based on 2023 data, are preliminary and will likely be markedly outdated by the time the Centers become operational. Moreover, salary costs are anticipated to vary depending on the specific county hosting the Center. Regarding infrastructure, the estimated funding for the creation of approximately 300 Centers ranges from 735 million to 870 million PLN. These estimates are based on calculations of the resources needed to set up a Center. According to the memorandum, adapting an existing facility would cost around 500,000 PLN, reconstruction would require approximately 2 million PLN, and constructing a new facility from scratch is projected to cost 5 million PLN.

However, it appears, without going into detailed analysis, that these amounts may no longer be accurate. This conclusion can be drawn by comparing the estimates to current

market prices for commercial properties. The authors of the memorandum acknowledge that these figures are merely indicative and were derived from interviews with directors of institutions engaged in activities similar to those envisioned for the Centers.

Conclusions

The WHO has observed that the historic demographic transformation, which will see older adults become a substantial portion of the population, necessitates profound adjustments to social structures across virtually all areas of state governance. Foremost among these is healthcare, which significantly influences the well-being of older adults. Policymakers, when designing public policies for improving the situation of this demographic, must take into account its inherent diversity in terms of health conditions and socioeconomic statuses (Nieszporska, 2021). The growing demand for healthcare services calls for a comprehensive overhaul of the current healthcare system to ensure accessibility and equity.

The proposed Act represents a step in resolving these challenges. However, it must either be implemented as planned or revised and adapted before integration into Poland's healthcare system. Further actions are necessary, particularly the reorganization of long-term care services, which in their present state are ill-suited to the realities of this demographic change. The proposed creation of a network of county-level Centers is a promising solution, but its practical implementation may face obstacles, such as a shortage of qualified personnel and underestimated investment costs. Nevertheless, the idea is worth pursuing, albeit with refinements, as it responds to the pressing social and health needs of Poland's elderly population.

In the author's view, the success of the planned solutions hinges on constructive dialogue and effective collaboration with county governments, which will shoulder the responsibility of the Centers' organization. The costs associated with operating the new units must not be underestimated. Currently, hospital debt—especially at the county level—remains alarmingly high, exceeding 22 billion PLN (Fandrejewska, 2024). Without a realistic accounting of all anticipated expenses, the initiative risks becoming another failed attempt at reforming Poland's healthcare system.

Finally, it is essential to highlight the fragmented nature of the legal framework governing the healthcare rights of older individuals. This lack of cohesion undermines the ability to provide comprehensive healthcare security for an aging society. Moreover, the responsibilities of public authorities in this domain are poorly coordinated. As Maj points out, despite an extensive body of national, international, and EU regulations concerning older adults, the protection afforded to this group is inadequate. A cohesive reform effort is urgently required to establish clear and robust healthcare and welfare rights for older individuals.

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Nurses vs. Paramedics: Potential and Real-World Scenarios of Nurse-Paramedic Substitution in Professional Practice

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Abstract

The healthcare labor market is currently grappling with a widespread shortage of nurses across hospitals and other healthcare facilities. One potential strategy to alleviate this deficit involves substituting nurses with paramedics, although this practice is presently limited to certain hospital departments. This article seeks to examine this issue in-depth and to outline potential solutions based on insights gathered from detailed interviews.[1]

Keywords: nursing shortage, paramedics, healthcare workforce, hospital staffing solutions

Introduction

The healthcare services market is distinguished by unique characteristics, most notably its inherent instability, which influences both the demand for medical services and the availability of healthcare professionals. Hospitals employ a wide array of healthcare workers, each varying in educational backgrounds, professional responsibilities, and remuneration, influenced by broader labor market dynamics (Lenik, 2024, p. 123). Ensuring that all medical professionals meet the necessary qualification standards

1 The author also addressed the issue of the medical workforce shortage and potential strategies for its mitigation in her doctoral dissertation, titled *Determinants and Consequences of Employment Forms and Work Organization in the Context of Medical Workforce Shortages.*

is a fundamental concern, particularly given the strenuous psychological and social conditions they often face. These demanding environments necessitate advanced skills and competencies, such as affective neutrality and the ability to maintain professional objectivity under situational pressures (Faculty of Forensic & Legal Medicine, 2024; Hadida, Wacht, Livshiz Riven, Grinstein-Cohen, 2024). Such stringent requirements further limit staffing options, which intensifies the acute workforce shortages plaguing healthcare institutions (Kautscha, 2015, p. 91). Currently, the nursing profession is among the most affected by these deficits.

The primary objective of this paper is to shed light on the urgent need for innovative strategies to mitigate the nursing shortage in hospitals and other healthcare facilities. One viable solution involves substituting nurses with paramedics in certain roles. While this approach is currently limited to specific hospital departments, there are significant practical, ethical, and regulatory concerns about its feasibility and propriety. This study seeks to outline and elucidate these issues and considers potential solutions. The proposed approach is both feasible and grounded, rather than purely theoretical. Drawing extensively on data from in-depth interviews with healthcare professionals, the article explores the practicalities and implications of such a substitution strategy and offers a nuanced perspective on the challenges and opportunities involved in addressing the nursing shortage.

Legal and Professional Distinctions Between Nurses and Paramedics

The nursing profession, like other medical professions, is unique in its focus on protecting human health and life. Nurses, along with doctors, dentists, and midwives, belong to the esteemed category of professions of public trust, a status that arises not only from legal definitions but also from the high regard and deep trust society places in nurses. This recognition is both a source of pride and a considerable responsibility (Trzpiel, 2022, p. 14). In acknowledgment of these demands, legislators have established provisions in both general labor laws (e.g., the Labor Code) and specific regulations governing medical personnel, such as the Law on the Profession of Nursing and Midwifery. These provisions include the employer's obligation to facilitate the professional development of employees (Law of June 26, 1974) and the employees' obligation to continually update their knowledge and enhance their professional skills (Law of July 15, 2011).

In recent years, upgrading and expanding the qualifications of medical personnel has extended beyond the routine improvement of strictly job-related qualifications and competencies. It now encompasses the operation of state-of-the-art medical equipment, which is increasingly replacing older technologies in healthcare facilities, requiring personnel to adopt less invasive and more advanced methods for diagnosing and treating patients. Nurses and midwives, along with physicians, constitute the backbone

of essential healthcare services in healthcare facilities. As populations age and the prevalence of chronic and degenerative diseases increases, these professions—tasked with direct patient care and assistance in day-to-day functioning—are becoming increasingly critical. The roles of nurses and paramedics, in particular, extend far beyond basic care and the safeguarding of a patient's health and life, and cannot be regarded as merely supplementary or peripheral, as their work involves comprehensive patient management, and the delivery of advanced, holistic medical services (Piatkowski, 2010, p. 156).

The provisions governing the nursing profession are outlined in the Act on the Profession of Nursing and Midwifery (Law of July 15, 2011). To legally provide professional services, nurses must hold the required qualifications, verified through appropriate documentation: a diploma awarded upon completing a medical school with a specialization in nursing and a valid license to practice. The responsibilities of nurses include a wide range of services, including nursing care, preventive measures, diagnostics, therapeutic interventions, rehabilitation, and health promotion. The legal framework governing the paramedic profession is outlined in the Act on State Emergency Medical Services (Law of September 8, 2006). According to this legislation, to practice as a paramedic, an individual must hold a diploma verifying their professional title as a paramedic or confirming qualifications in the paramedic profession. The medical procedures that paramedics are authorized to perform are further specified in the Regulation of the Minister of Health on Emergency Medical Actions and Other Health Services (Regulation of June 22, 2023). These tasks include providing advanced first aid, securing individuals at accident scenes, assessing health conditions, and transporting patients in medical emergencies.

In March 2024, a decree issued by the Ministry of Health amended the regulation on emergency medical activities and additional health services that paramedics are permitted to provide (Decree of March 7, 2024). This amendment expanded paramedics' responsibilities, granting them new competencies such as collecting upper respiratory tract samples, performing antigen tests for viruses, conducting ultrasound examinations (subject to completing emergency ultrasound training), and administering a broader range of medications. Michal Kucap, a national expert in emergency medical services from the Polish Society of Paramedics, remarked: "We advocate for the continuous development of the paramedic profession, but it is equally important to assess the quality of this development" (Knorps-Tuszyńska, 2024). This statement underscores the expanding scope of paramedics' responsibilities, with further advancements likely to gain momentum.

Similarly, a new regulation issued by the Minister of Health took effect on June 15, 2024, broadening the professional competencies of nurses. Nurses now have access to an extended list of medications that they can prescribe and additional diagnostic tests that they can administer. For instance, nurses are now authorized to make decisions regarding flu and HPV testing and to prescribe emergency contraception (Szczepańska, 2024). The increasing responsibilities and expanded competencies of both nurses and

paramedics have raised concerns among other medical professionals, such as physicians and radiology technicians. These groups fear that tasks traditionally associated with their roles are being reassigned to other professions, potentially threatening their job security. Beyond the practical challenges of redefined roles, this issue has created a degree of unease that may impact the overall operational dynamics and workplace morale within medical institutions.

The potential substitution of nurses with paramedics in healthcare facilities has sparked significant controversy and debate in the media. Eight years ago, Lucyna Dargiewicz, the chairwoman of the All-Poland Trade Union of Nurses and Midwives, voiced concerns about a Ministry of Health draft regulation regarding paramedics' scope of practice. She argued that this regulation would allow paramedics to work across all healthcare facilities, including those without emergency departments, and essentially replace nurses. Dargiewicz also questioned whether paramedics taking over nurses' responsibilities (thereby displacing them from their jobs) would bear the same level of accountability for potential mistakes (Lurka, 2016).

In contrast, paramedics have expressed optimism about expanding their professional scope. Jakub Nelle, a paramedic from the District Ambulance Station in Krotoszyn, stated, "we are united by a common passion," and supported the draft regulation as a significant step forward for the paramedic community. He noted that it would enable paramedics to apply their expertise not only in emergency medical teams and hospital emergency departments, but also in hospital wards, clinics, and other healthcare settings where their qualifications could be valuable.

Two years later, the nursing self-government body issued a position paper in response to a draft amendment to the regulation on guaranteed inpatient services (Regulation of October 11, 2018). The statement demanded that paramedics be removed from the list of professions eligible for employment in hospital wards as auxiliary staff. The nursing representatives argued that paramedics lacked the necessary qualifications to provide "comprehensive, holistic care for hospitalized patients," as their training had been designed specifically for emergency medical services (Lurka, 2018). This stance outraged the Polish Association of Paramedics, whose leadership expressed surprise at what they described as a misunderstanding and dismissal of paramedics' competencies, knowledge, and skills honed through rigorous training and professional experience (Lurka, 2018).

The following year, tensions escalated further. The nursing self-governance body accused paramedic advocates of lobbying efforts aimed at discrediting the nursing profession. They also voiced opposition to the Health Minister's Regulation of June 27, 2019, which allowed paramedics to work in hospital wards beyond emergency departments (Bednarz, 2019). In a formal statement, the Supreme Council of Nurses and Midwives firmly declared: "The profession of nursing and the profession of paramedic are two distinct professions with different statuses and competencies as regulated by law. Treating these professions interchangeably is both a systemic and substantive error" (Bednarz, 2019).

It is undeniable that hospitals are grappling with a severe nursing shortage. To alleviate this, paramedics are often employed to assist in hospital wards, yet they cannot fully replace nurses due to the distinct scopes of duties and competencies associated with each profession. As Anna Staniuk, chairwoman of the All-Polish Trade Union of Nurses and Midwives of the Lower Silesia Region, explains, paramedics primarily serve as field responders, operate as an on-call service, and work in hospital emergency departments (Krajewska, 2022). The debate surrounding the potential replacement of nurses with paramedics continues to provoke a wide range of opinions. Many of these are rooted in mutual animosity and accusations between these two professional groups. This tension has fueled a palpable sense of antagonism and mistrust. However, what is the reality in hospitals where nurses and paramedics work side by side, in the same ward? How do these professionals view this contentious topic? What are their perspectives on finding a viable resolution to this issue, which is complex not only in practical terms, but also from formal and ethical standpoints?

To explore, analyze, and attempt to resolve these questions, the author sought the opinions of individuals directly involved in the healthcare profession and deeply invested in this matter. Through in-depth interviews,[2] a wealth of relevant insights and perspectives were gathered, shedding light on this multifaceted issue.

Nurses versus Paramedics: An Analytical Perspective Based on Survey Data

The author conducted in-depth interviews with six healthcare professionals employed in both public and private provincial hospitals. The characteristics of the respondents are detailed in Table 1, offering a snapshot of their demographics, professional roles, and employment conditions.

Table 1: Characteristics of Respondents

Gender	Age	Occupation, position	Education	Years of Experience	Form of employment
Male	23	Paramedic	University	1 year	Civil law contract
Male	47	Paramedic	University	21 years	Civil law contract
Male	54	Physician, department head	University	11 years	Civil law contract
Female	47	Physician, department head	University	15 years	Civil law contract
Female	56	Nurse	High School	9 years	Employment contract
Female	59	Nurse	University	38 years	Employment contract

2 In the in-depth interview survey, the author incorporated several questions from a similar survey conducted as part of the doctoral dissertation titled *Conditions and Consequences of Employment Forms and Work Organization in the Context of the Medical Workforce Shortage.*

During the in-depth interviews, the first question addressed whether the respondents were satisfied with the current standards and work scheduling system. Only physicians expressed dissatisfaction with their civil law contract employment, citing excessive working hours, including on-call duties, as reasons. One paramedic remarked, "The working time norms and systems and scheduling systems seem to be one of the perks of the profession, as they offer greater control over leisure time compared to other forms of employment. However, working 12- or 24-hour shifts can be exhausting." Another paramedic suggested that an ideal arrangement would combine the benefits of a standard employment contract paired with the flexibility to work 24-hour shifts. Conversely, one nurse preferred shift work as it allowed for higher earnings.

Respondents also shared their views on the organizational structure and workflow of their departments. While they generally assessed these parameters positively, they highlighted difficulties in collaborating with diagnostic facilities and other hospital departments, which, they noted, hinder patient care and prolong hospital stays—though this broader problem falls outside the scope of this article.

The respondents expressed a positive view of the collaboration between nurses and paramedics. Paramedics emphasized the importance of nurturing good relationships and building mutual trust rather than focusing on differences. One physician remarked on his appreciation of working with paramedics, expressing regret that they cannot be employed in all hospital departments. Nurses similarly noted no significant issues in collaborating with paramedics, acknowledging that while their responsibilities differ, there are overlaps in certain duties. Importantly, all respondents confirmed that they adhere strictly to the responsibilities outlined by law for their respective roles. This is a crucial point, as each medical profession has a clearly defined set of duties established by legal frameworks, and is authorized to perform only those tasks within their scope of practice.

The respondents shared insightful perspectives on structural determinants influencing the operation of healthcare facilities, particularly regarding the benefits of employing both nurses and paramedics. Paramedics emphasized the importance of openness, communication, and dialogue between the two professional groups, along with the value of flexible employment options, opportunities for professional development, and a remuneration system based on professional competence rather than solely on seniority. They also stressed the value of improving qualifications, commitment to work, workplace identification, and contributing to the reputation of the hospital or treatment facility.

Some notable comments from physicians included:

"The breadth of training for paramedics is a positive aspect."

"Currently, paramedics can only be employed in specific departments. I hope this changes soon, given the growing shortage of nurses. … It is a positive step that both nurses and paramedics can choose between employment contracts or civil law contracts."

Nurses expressed similar views, raising issues such as the importance of upgrading qualifications, participating in courses and training, and having flexibility in employment forms. They noted that employment contracts provide job security and social protections, while self-employment offers higher earnings, flexible hours, and greater professional independence. However, they also voiced concerns about working hours often exceeding reasonable limits. The respondents also identified challenges and proposed changes to improve the system. They noted deficits in effective dialogue and insufficient competitiveness in the workplace. Many stressed the importance of recognizing employees who are loyal to a single workplace, contribute to its reputation, and represent it through their professional achievements.

Physicians pointed out the lack of opportunities for paramedics to work across all departments, limited pathways for paramedics to specialize, lower salaries for paramedics compared to nurses, and the rising average age of nurses. Nurses expressed concerns about the shrinking pool of nursing staff, the aging demographic of those still working, and the reliance on retirees to fill gaps. They also noted staffing issues in many hospitals and other medical facilities, with nurses and paramedics frequently working back-to-back shifts, leading to exhaustion. Both groups underscored the urgent need to increase financial resources and revise staffing policies to address the deepening nursing shortage.

Staffing shortages were a recurring theme among all respondents. Most agreed that shortages exist, although paramedics noted that the adequacy of staffing often depends on the workload during specific shifts. One paramedic raised concerns about the increasing administrative tasks imposed on medical staff that detract from their primary medical duties, while another remarked that staffing levels at his workplace were optimal and should be maintained to prepare for unforeseen emergencies, such as mass casualty events. One nurse acknowledged the staffing shortage across both professions but expressed a preference for prioritizing the hiring of more nurses rather than paramedics.

All respondents agreed on the need for formal and legal reforms to improve the current situation. However, when asked whether these legislative changes would genuinely benefit healthcare facilities and their staff, they provided mixed responses. One paramedic noted uncertainty, stating, "It remains to be seen how it will affect the paramedic profession." One nurse expressed optimism, acknowledging some positive outcomes, but other respondents disagreed, suggesting that the changes would not always be advantageous, pointing out that recent laws, such as the pay raise legislation, had created divisions among staff. This divergence in opinions shows that the introduced legal measures often fall short of meeting the expectations of their intended beneficiaries—medical personnel. Ambiguities in the laws frequently leave facility managers struggling to interpret them, which can potentially result in financial liabilities and misunderstandings between management, staff, and professional associations.

Regarding the collaboration and competition between nurses and paramedics, paramedics shared overwhelmingly positive feedback. One paramedic stated, "In the hospital

unit where I am employed, nurses and paramedics support each other." Another remarked that:

> "A lot depends on the employer. At my workplace, there is cooperation, and I am happy about that, but I know places where it's more of a rivalry between the two sides, sometimes fueled by higher-level institutions or representatives of these professional groups…. Healthy competition is beneficial as it improves individual performance and the functioning of units. Both professional groups bring unique experiences from their workplaces, would be valuable to utilize these through meetings or activity debriefings."

Doctors also confirmed that nurses and paramedics often cooperate and assist each other. Nurses, for their part, commented that there is cooperation, as both groups must fulfill their duties responsibly, although as one nurse noted: "In general, they cooperate with us, but when it comes to emergency procedures, there is some competition (such as during defibrillation or administering drugs during CPR)."

The respondents also discussed employment-related factors that could improve the efficiency of hospital services and promote the physical and mental well-being of nurses and paramedics. Paramedics emphasized concerns such as the imposition of additional duties, a lack of recognition for their efforts, and the absence of incentive bonuses or non-monetary rewards. They also suggested the importance of "increasing the visibility of what they do in the media." Doctors pointed to the need for higher salaries, opportunities for professional development funded by employers, and flexibility in choosing their working hours or shift patterns. Nurses similarly advocated for flexibility and higher wages:

> "It would be best if they could decide about their work themselves, but that's not possible. With so many people employed, someone has to be responsible for organizing the work. We should get higher salaries."

> "Increasing the number of employed medical personnel will lead to greater reliability in work and an improvement in the quality of medical services."

This range of responses underscores the need for comprehensive changes that address both structural and interpersonal dynamics:

> "Increasing the number of medical personnel employed will enhance reliability in operations and improve the quality of medical services provided."

During the interviews, respondents were asked how they envision the future operation of healthcare providers in Poland. One paramedic remarked, "It's not about quantity but quality," while a nurse commented that: "The functioning of hospitals will depend on the financial situation, the actual debt level, and the ability to secure funding from external sources, such as EU grants."

The discussion also touched on the potential replacement of nurses with paramedics in healthcare facilities. Paramedics noted that the two professions might increasingly alternate roles due to staffing shortages, noting that this practice is already being implemented in some facilities. One doctor linked this possibility to adjustments in paramedics' skill sets and professional responsibilities, while another stated, "Yes, absolutely. This is already happening in many hospitals." Among nurses, opinions were divided. One firmly opposed the idea, asserting, "No, I'm a nurse, and I'm against replacing nurses with paramedics or anyone else." In contrast, another nurse acknowledged the reality of nurse shortages and said, "In our hospital, this happens due to the shortage of nurses. I believe nurses and paramedics should collaborate and complement one another."

To delve deeper into the topic, the respondents were asked whether the responsibilities of nurses and paramedics should be altered—expanded or made comparable. Paramedics offered nuanced perspectives:

> "Given the evident shortage of nurses, both professions should have opportunities for self-directed learning, accompanied by increased salaries and a tiered system for personnel. This tiering could be based on experience and skills."

> "A lot depends on the workplace—whether it's a hospital or Emergency Medical Teams. The nursing profession has historically been structured around direct patient care, bedside responsibilities, executing doctors' orders, and developing and implementing care plans. The paramedic profession is relatively younger but requires workers to make independent decisions, often without consulting a doctor. Those choosing between these professions should ask themselves: Can I handle this? Some people prefer having decisions made for them, while others thrive on the 'front line,' relishing the opportunity to take on more responsibility."

Doctors, meanwhile, were firm in their stance, advocating for paramedics' responsibilities to be made comparable to those of nurses. They argued that this would enable paramedics to replace nurses on a broader scale across all hospital departments. Nurses, however, opposed the idea, offering arguments such as: "No. A nurse is a nurse, and a paramedic is a paramedic. And it should stay that way. If a paramedic wants to replace a nurse, then they should obtain nursing qualifications." Another said: "These are two separate professions, but I would expand paramedic education to include certain nursing tasks, and nursing education to cover standards in emergency medicine."

After conducting in-depth interviews, it became evident that perceptions regarding employment arrangements, work organization, and working time norms varied significantly among respondents, and depended on individual expectations and professional experiences. The respondents emphasized the importance of maintaining positive

relationships between employers and medical personnel, alongside offering flexible employment options, opportunities for professional development, and remuneration based on competencies, commitment, and workplace identification. The discussion also touched on employment-related factors that could enhance hospital service efficiency and improve the physical and improve the mental well-being of nurses and paramedics. Key issues included the imposition of additional duties, the absence of incentive systems, and the urgent need for increased staffing levels, higher salaries, and employer-funded professional development opportunities.

Surprisingly, in contrast to some of the earlier concerns and differing views cited in this article, the respondents uniformly described collaboration between nurses and paramedics as positive. However, when asked about the potential substitution of nurses with paramedics, significant disagreement emerged. The nurses strongly opposed the idea, whereas the doctors expressed hope that paramedics could be employed in all hospital departments to address the escalating shortage of nurses. The nurses themselves underscored the worsening deficit, pointing out that current workforce is aging and increasingly overburdened. They also highlighted the problem of medical personnel working across multiple facilities, a practice that jeopardizes both patient safety and staff well-being due to excessive workloads, long commutes, and exhaustion. A similar divide emerged regarding whether the scope of duties for nurses and paramedics should be expanded or aligned. Nurses were the only group to oppose such a change, insisting that the two professions are distinct and should remain so.

The in-depth interviews provided valuable insights into the dynamics of collaboration between nurses and paramedics and the contentious issue of replacing nurses with paramedics. As previously mentioned, the medical services sector has seen a steady decline in the number of practicing nurses year after year. While statistical data reveals an overall upward trend in the total number of nurses, a closer examination of detailed age-specific information uncovers a concerning pattern. The most significant increase in the number of nurses is observed among those aged 65 and older, as well as those aged 55–64—essentially the retirement-age demographic.

It is worth noting that nurses employed in specific settings, such as in psychiatric wards, surgical teams, or anesthesiology, are eligible for early retirement—five years before the standard retirement age—provided they meet statutory requirements (Law of December 19, 2008). However, the Central Statistical Office (GUS) does not collect data on the employment status of retired nurses, leaving uncertainty about how many nurses aged 55–64 remain active in the profession.

Table 2 provides a breakdown of nurses authorized to practice, categorized by age group and gender, for the years 2018, 2020, and 2022. Unfortunately, at the time of preparing this article, the CSO had not yet released data for 2023.

Table 2: Nurses Authorized to Practice by Age Group and Gender in 2018, 2020, and 2022 (Status as of December 31 of Each Year)

Year	Total	Nurses										
		Including women	Of which									
			Below 35		35 – 44		45 – 54		55 – 64		65 and over	
			Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
2018	295,464	288,799	26,874	1,931	41,363	2,114	96,522	1,698	85,761	794	38,279	128
2020	303,211	295,571	28,257	2,350	24,432	2,257	97,633	1,945	91,112	909	54,137	179
2022	313,213	304,365	31,036	2,424	24,529	2,604	86,590	2,366	92,649	1,123	69,562	330

Based on CSIOZ (2019); CeZ (2021, 2023).

It is crucial to note that the figures above represent nurses authorized to practice, which does not necessarily mean that all of them are actively practicing in the field.

Table 3 presents data on the number of nurses and paramedics employed in healthcare facilities over selected years, allowing for a comparative analysis.

Table 3: Nurses and Paramedics Employed in Healthcare Facilities (Status as of December 31 of Each Year)

Year	Nurses		Paramedics	
	Absolute number	Index per 10,000 population	Absolute number	Index per 10,000 population
2018	182,671	47.6	14,234	3.7
2020	181,625	47.5	15,006	3.9
2022	182,040	48.2	15,498	4.1

Based on CSIOZ (2019); CeZ (2021, 2023).

A comparison of the data in Table 2 and Table 3 reveals that the number of nurses employed in healthcare facilities is significantly lower than the total number of nurses authorized to practice. Over the analyzed period, the total number of nurses in healthcare facilities fluctuated slightly, with minor increases or decreases, mirrored by a consistent rate per 10,000 population. While the data undeniably show a slight rise in the number of nurses employed in healthcare facilities, the Central Statistical Office (CSO) does not provide an age breakdown for this group. However, if these data were proportionally aligned with the figures for nurses licensed to practice, it could be reasonably inferred—based on information from district chambers of nurses and midwives—that a significant proportion of nurses employed in healthcare facilities are over the age of 55. This reflects the aging workforce within the profession.

In contrast, the number of paramedics employed in healthcare facilities has demonstrated an upward trend, both in absolute terms and relative to the population (per 10,000). Although paramedics remain far fewer in number than nurses, their increasing presence highlights their potential role in alleviating the nurse shortage. Employing paramedics in certain hospital departments may provide a practical solution to mitigating staffing deficits in nursing.

Conclusion

A central tenet of contemporary human resource management is the notion that employers seeking to thrive in competitive markets, including the healthcare sector, must focus on attracting and retaining top talent (Pierścieniak, Grzebyk, 2014, p. 22). For nurses and paramedics alike, continuous professional development is not just an expectation but a necessity. The current state of the medical services market, combined with rapid advancements in technology, demands that medical personnel consistently update and expand their qualifications. Operating cutting-edge medical equipment and delivering high-quality care require considerable expertise, making the work of nurses and paramedics a specialty in its own right requiring substantial competencies (Curts, Ramsten, 2016, p. XII).

The persistent shortage of nurses in the medical services market, particularly in hospitals, has led to a search for solutions aimed at mitigating this issue. One proposed strategy is to replace nurses with paramedics in certain hospital departments. Deputy Health Minister Jerzy Szafranowicz has gone a step further, suggesting a broader rethinking of employment standards. He remarked: "Within the framework of the dialogue, we are also discussing employment norms for nurses, and whether to account for dependencies arising from the employment of paramedics, medical caregivers on the ward as well" (Mielcarek, 2024).

Analyses derived from both secondary literature and empirical findings through in-depth interviews reveal the necessity of medical professionals understanding the complexities of this issue. Additionally, the entities responsible for creating and regulating laws governing qualification requirements, duties, and competencies for paramedics must recognize the potential for paramedics to substitute for nurses in specific roles. This perspective was echoed by several respondents in the interviews, who highlighted paramedics' potential to help alleviate staffing shortages.

It is worth reiterating that both nurses and paramedics share a common mission: saving human health and lives. Therefore, professionals in both fields should place the patient and their overall well-being at the forefront of their efforts. The challenges posed by these staffing shortages will not resolve themselves over time, nor can they be dismissed as mere theoretical concerns. Instead, they demand proactive engagement

and innovative approaches. The realities of the healthcare sector, along with its inherent challenges, will continue to drive public awareness and policymaking efforts, creating opportunities to develop and implement practical, effective solutions to enact meaningful change in the healthcare system.

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Mentalization: An Overview of the Concept

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Abstract

The phenomenon of mentalization is currently widely discussed from various perspectives and approaches. This article is a short review of the creation and understanding of the concept from the perspective of various practices and needs and as a human ability that develops in early childhood. Mentalization is directly related to the theory of mind, which includes child and human development, and attachment theory, which provides the patterns for this ability. A person's dimension within the spectrum of mentalization indicates a broader or more limited perception of reality, of what is happening to them, and of what influences others' intentions. In other words, it involves how a person reads their situation and interprets what brought them to the point where they are and what intentions and reasons they attribute to the other person in a relationship. The dimensions of mentalization show in detail how its development in an individual affects various areas of observation and experience and, consequently, the individual's perceived well-being. By analyzing attachment styles in the development of mentalization, researchers can identify the influence and quality of mentalization in people with different attachment styles, indicating different scopes of mentalization. Naturally, the greatest quality is attributed to the secure attachment style. Mentalization as a function of traits presents a perspective on how different mental systems can coexist with each other, while simultaneously activating many styles and a range of thinking. Mentalization that develops incorrectly leads to psychopathology and most studies refer to borderline disorders. Finally, the article addresses the therapeutic aspect of psychotherapy and its impact on mentalization: its development, plasticity, and biological functions. This short introduction to the issue of mentalization, although it only approaches the entire depth of the topic, is a kind of inspiration to look at many aspects of mentalization and to explore them in the dimensions of human functioning mentioned in the literature.

Keywords: mentalization, theory of mind, attachment style

1. Introduction

Mentalization is a multidimensional, multi-level, and interdisciplinary concept, created at the border between many sciences, including philosophy, cognitive science, psychology, and psychoanalysis. The concept of mentalization first appeared in the 1970s and is currently one of the fastest developing and active areas of research in psychology, psychotherapy, and especially psychodynamic psychology. Fonagy and his team (Luyten et al., 2009) have been working for a decade on developing his concept of mentalization, starting with the genesis of mentalization and its impact on borderline personality disorders. Thus, he has created a broad substantive and empirical image of this disorder, and work is underway on the impact of mentalization, which shows the possibility and effectiveness of combining science and theory. He is currently working on expanding its application to other personality disorders, depression, addictions, and psychoses (Bateman & Fonagy, 2010; Soderstrom & Skarderud, 2009; Safier, 2003).

Mentalization is the ability to understand one's own behavior and other people's reactions to the world around one, thanks to states of mind as a category of interpreting what is happening inside oneself and what motivates others to act (Bateman & Fonagy, 2010). This function develops in the first five years of life. It takes place in the relationship between a child and their caregiver, paralleling the adoption and consolidation of internal attachment models. A trusting attachment relationship, through teaching the child to create mental representations of themselves and of other people as a response to regularly occurring experiences with the first attachment figure, ensures the proper development of the ability to mentalize. As the literature on the subject says, reduced mentalization ability significantly predicts the development of various types of psychopathology at every stage of a person's life (Cierpiałkowska & Górska, 2016b).

Mentalization is a continuous process, associated with a personality trait that is visible in various aspects of a person's behavior and arising spontaneously. In other words, mentalizing relates to empathy, interpersonal relationships, and most emotional and social skills (Allen et al., 2014). Without the ability to mentalize, many difficulties in social situations can arise. Thanks to mentalization, one can easily adapt to rigid thinking, without that built-in skill. All that is left can be lack of competency to exit or enter a needed variety of role models, insensitivity, and all kinds of complications in relationships. Poor mentalization makes it difficult to deal with various challenges during the normative problems. As we follow, mentalization can play a major role in the etiopathogenesis of personality disorders and can be significant to the prognosis. Developing mentalization skills is important for psychosocial well-being, building psychotherapeutic competence, and the whole process (Fonagy & Luyten, 2010). Mentalization plays an important role in developing a spectrum of scenarios regarding significant others in relationships. This description can highlight dysfunctional family dynamics.

Improving the process of mentalization in the family is related to reducing the weight of aggression and violence (Fonagy, 2006).

What makes mentalization difficult is anxiety, a fixation on depressive images and thoughts, and intense emotional experiences. The individual switches to reacting, which is positioned by unconscious patterns of behavior that are evolutionarily older. The higher the level of stress and emotion, the higher the chance that implicit mentalizing will overshadow. If, on the other hand, the experience gives a chance to the rational nature and one can reflect on the significant situation, one can have an optimal, flexible experience (mentalization) for both one's mental processes and others' behaviors, emotions, and thoughts (Jańczak, 2010). Mentalization is a unique ability that involves recognizing one's own and others' mental and emotional states, values, attitudes, and opinions (Jańczak, 2018).

2. From Theory of Mind to Mentalization

In the literature on the subject, there is a distinction between the concepts of mentalizing and theory of mind (Białecka-Pikul, 2012). These concepts are sometimes used interchangeably, but researchers also note that they are not synonymous (Sharp & Venta, 2012). It is suggested that mentalizing is a concept usually used in a clinical context, while the construct of theory of mind is encountered more often in research on child and human development. Research on mentalization directly relates the concept to attachment theory (Fonagy & Allison, 2012). Secure attachment relationships provide an adaptive learning environment where children can learn and develop mentalizing skills by having their experiences reflected back to them by important attachment figures.

The ability to mentalize refers to the processes of social cognition, especially the perception and recognition of the feelings, intentions, and other cognitive or affective states of oneself and others (Frith & Frith, 2003). Mentalization is an individual's ability to understand how mental processes affect the individual and others, how they proceed, and how they influence behavior. This can help the person anticipate the feelings, intentions, and actions of others that influence their reactions. Theory of mind, as we can see in the literature, omits the relational and emotional thread of understanding other people's behavior in order to distinguish between these two concepts (theory of mind and mentalization) (Fonagy et al., 2003). In research on theory of mind, understanding the mental states of another person ignores any personal emotional involvement in their history. This also applies to the regulatory effects of emotions under the influence of understanding the intentions of the other person and their feelings or desires (Górska & Marszał, 2014). Based on the distinction made by Baron-Cohen et al. (2003) between theory of mind and empathy, Fonagy points to two mechanisms of interpersonal interpretation: towards cognitive functions and towards emotions and affect

(Fonagy & Ghinai, 2008). Kernberg (2012b) points to the negative effects of the ability to empathize with difficulties in mentalization – he distinguishes between cognitive mentalization (without emotions) and affective mentalization (immersed in emotions which, as he says, manifest themselves in the cognitive-affective dimension of the description of mentalization) (Fonagy, 2013).

3. Dimensions of Mentalization

The different fields of mentalization, such as capability for self-reflection and understanding, the skill of noticing, understanding, and interpreting one's feelings, thoughts, and needs behind the action for an exact behavior or attitude. Next would be empathy, understood as the ability to see a situation from someone else's point of view and to recognize the reasons for the other person's way of thinking, feelings, and actions without losing one's own perspective. Recognizing mental simplicity is another dimension of mentalization; human feelings and interpretation of reality are complex and contradictory. Another dimension is adaptability, the ability to be flexible and adjust to a wide range of social situations, which comes with the skills of recognizing, predicting, and interpreting the actions of other people.

Conflict regulation is the next of many dimensions. It is understood as the relationship between mentalizing and the ability to find the best solution in a conflict which is directly proportional, since a person with a higher spectrum of mentalizing is more likely to be open to understanding rather than emotionally overreacting without looking for a solution. In the process of building up one's strength and a healthy, secure attachment in childhood, mentalizing plays a major role and serves as a foundation for healthy relationships later in one's life (Slade, 2005).

From a clinical perspective, intrapsychic representations – i.e., mentalizing in an emotional relationship with another, and specifically the difficult experiences of a person associated with it – affect emotional disorders (Allen et al., 2014). The structural basis of mentalization processes is intrapsychic representations. Patterns of intrapsychic representations related to the perception and experience of oneself can affect one's emotional reactions. They are activated during mentalization and impact the course of the entire mentalization process (Cierpiałkowska & Górska, 2016b).

Object relations theory assumes that personality is a system of positive and negative elements representing the self in relation to an object, which evolves from a period of symbiosis, separation, and individuation, the integration of both positive and negative aspects of the self and the object, and the development of more mature defense mechanisms, such as repression, sublimation, and suppression (Kernberg, 2012a). The degree of personality organization represents different degrees of integration (poorly integrated personality organization indicates psychotic, primary defense mechanisms

are predominant; borderline personality organization is relatively integrated, with more mature defense mechanisms; and neurotic personality organization indicates mature, fully integrated defense mechanisms). The levels of personality organization are shaped similarly to the elements that constitute it, the so-called representations of the self in relation to the object, the perception of the constancy of the self and of the object, and the accompanying defense or coping mechanisms (Cierpiałkowska, 2014). The representations of a child's attachment in the relationship with their mother, family members, and peers in childhood and subsequent stages of life create a certain structure (a system of representations), where a secure attachment style may predominate, but this does not at all mean that there are no representations of a non-secure attachment style and vice versa.

4. Attachment Style and Mentalization

According to Cierpiałkowska, there is a difference between people with a dominant secure attachment style and those with an insecure attachment style: the proportion of secure and insecure representations in the representational system differ.

We discuss mentalization from distal and proximal perspectives. The former is developmental and includes the processes of creating increasingly mature forms of mentalization during a child's development, in a certain sequence, and are the so-called new quality (Bouchard et al., 2008). The perspective of a child or adult describes their current state or capacity for mentalization as a result of having gone through stages of development. Proximal mentalization refers to the state of "here and now." This perspective refers to the way in which a person copes with situations arousing the emotions, assuming that the processes and structures involved in mentalization will develop, regardless of whether it is optimal or pathological (Cierpiałkowska & Górska, 2016a). Mentalization is the process of creating current, moment-specific perceptions of mental states and of analyzing and understanding mental states and behaviors. Current mental states can be induced internally and/or externally, are the result of one's own feelings or thoughts, and can be triggered by external elements, or commentary or criticism from another person (Bateman & Fonagy, 2010). Sometimes, mentalization is based mainly on information from the environment; at other times, mainly information stored in the mind is processed. In everyday life, we most often use both perspectives simultaneously, for example, when mentalization takes place in emotionally charged relationships. Certain traits are assigned to someone when information from both sources is integrated (Achim et al., 2013). Mature mentalization refers to various sources of inference and to the search for a conclusion in at least several options, whereas in personality disorders the interpretation takes place with reference to only one interpretative option: the dominant one, resulting from activated, most often split, representations.

The concept of mental states by Bouchard, Lecourse, and colleagues (Bouchard et al., 2008) also sheds light on the process of mentalization. The phenomenon of transformation into mental states refers to the representation of internal states, forms of emotional experiences (impulses that demand quick discharge), and more mature forms; these are called secondary representations.

At the same time, the process of mental states is joined by an element of modulation, reworking the representation. The aim here is to modulate the level of awareness of threatening mental elements; therefore, regulatory processes are often defensive towards what is represented (Bouchard & Lecours, 2008). A pathological lack of integrated emotion representations can stem from extremely intense emotions following a trauma or from avoiding emotional situations, for example, when a caregiver becomes aware that they may be the source of violence. This describes the combination of subsymbolic and symbolic disconnected experiences of the person (Bucci, 2011).

5. Mentalization and Mental Disorders

The knowledge and proper understanding of mentalization theory plays a major role in the biopsychosocial model, along with an understanding of mental disorders. As the literature shows, the differences in the ability to mentalize correlate with higher or lower incidence of certain mental disorders in a variety of different populations and groups (Sharp et al., 2009). Incorrectly developed mentalization in early childhood can be experienced as a trauma, abuse, or failure of the child. The early experiences are connected to the development of particular mental disorders later in life. From the growth of dysfunctional attachment styles, lack of mentalization and psychosocial tendency to certain mental disorders (borderline personality disorder). Researchers suggest that neurobiological factors – for example, structural and functional characteristics of the brain – are related to difficulties with mentalizing. Without this ability, the person may develop difficulties with social relationships, isolation, and conflicts, as well as mental disorders. Today, some studies highlight the relationship between diagnoses of schizophrenia, personality disorders, or eating disorders, for example, and their prediction and result understood as building mentalization skills.

Relationship between mentalization and the forecast of mental disorders, person capacity to mentalize can improve the understanding with the psychiatrist and psychotherapist, upgrade adherence and compliance and create the therapy process more effectively. Understanding one's own feelings and way of thinking is linked with better results of treatment. Mentalization boosts interpersonal contacts, which positively influence one's life. This is related to the stretching and support of the social system, the processing to the readaptation and resocialization. A limited ability to mentalize is associated with more frequent breakdowns and the appearance of some mental disorders (Choi-Kain & Gunderson, 2008).

6. Mentalization as a Function of Traits

According to Cierpiałkowska, is a basic property representing the integration of the personality organization of a given person that they have managed to achieve. In people with a lower level of personality organization and integration of internal representations, this basic property is initially weaker than in people with a higher level of personality organization. The discussed feature of a person with a given level of personality organization and structure of attachment representation is subject to various disturbances from stress and stimuli, activating representations that are important for a given person. As can be seen, for many different reasons mentalization is susceptible to disorganization; the ability is sometimes lost under certain conditions. It should be noted that sudden jumps from the state of mentalizing and reasoning about others based on external, non-mental premises are characteristic of borderline personality disorder (Fonagy & Bateman, 2014).

Contact between a person and the object of attachment stimulates internal operational models, from the perspective of images of the child–caregiver relationship that exist in them; thus, the person's ability to perceive the mental states of another as independent of their own feelings may be limited to some extent (Allen et al., 2008).

Mentalization difficulties are related to the threshold of arousal, which characterizes and distinguishes individual attachment styles. Threatening stimuli of the lowest intensity most quickly weaken the mentalization of people with an ambivalent-anxious attachment style. Mild stress will not weaken the ability to mentalize in people with an avoidant attachment style. Differences in people with a trusting attachment style will be visible only when the threat increases significantly (Fonagy & Bateman, 2014). Research and clinical observations indicate that the dynamics of mentalization depend on the analyzed content. Various situational factors, stimuli, and related interactions with intrapsychic properties can lead to disruptions and obstacles in the mentalization process. When we look at the dynamics of mentalization from the perspective of the internal organization of mentalization distinctions, we see that the intrapsychic world is heterogeneous, which means that different mental systems coexist, and that there are many modes with different levels of complexity (Fonagy & Bateman, 2014), styles, and ways of thinking. The organization of mentalization modes is similar to Klein's description (2007) of the schizoid-paranoid and depressive positions, where developmentally earlier systems of fears, defense mechanisms, and object relations are still potentially active.

7. Mentalization in Psychopathology

In psychopathology, primitive forms are dominant over reflective ones, whereas in a healthy individual it is the other way around, which additionally blocks the activation of primitive forms. Fonagy (Fonagy & Bateman, 2014) states that prementalization modes are based on concreteness (teleological) and are not subject to reality testing and or the imposition of a representational function of internal states (pretend mode or psychic equivalence) (Stawicka, 2008). In Bouchard et al.'s concept (2008) of mental states, primitive defense mechanisms used against mental representations predominate (Górska & Marszał, 2014), while according to Luquet (Bouchard et al., 2008), the size of primary mental representations, the degree of metaprimary thoughts, and the degree of metaconscious or intuitive thoughts fulfill this function. All of the above, as it results from the literature, concern the states partial or missing representations of affective experience.

Mature mentalization is the result of the integration of personality organization and various conditions, including the level of stress. The integration of mental structures means optimal stability and sufficient coherence of their contents, as well as contradictory partial representations that generate ambivalent qualities – to be embedded in the psyche – coexisting with the others in a kind of "concordance of opposites." At the level of individual representations, it is possible to create a certain conflict, while meta-rules allow these conflicting qualities to coexist, which can neutralize each other, resulting in a weakening of the extremes (Kernberg, 2012a). Integration, as indicated in the literature, combines opposing qualities and levels of represented experience within a representation: sensory-motor representation can be combined with symbolic or verbal representation, building a common representation of emotional experience (Bucci, 2002). The effect of this may be sensory experiences that we can take as a manifestation of fear and that can then become a starting point for recognizing our own experiences in relation to another person.

As Cierpiałkowska (Cierpiałkowska & Górska, 2016) states, the degree of integration of internal representations is defined as relative, because even in a highly integrated structure, we see atoms of the representation system that are sometimes dissociated or split off. Therefore, highly and less organized structures are mutually different in terms of the proportion of integrated and non-integrated particles. In a situation of stress or high emotional arousal, non-integrated parts may also be activated in people demonstrating a higher level of personality organization, which will manifest itself as a periodic disruption through a weakening of the ability to mentalize, where despite the ability for reflective mentalization, a given individual mentalizes worse than their general potential. In personality structures with a lower level of organization, due to the low level of integration and the predominant insecure attachment style, there is a more clearly generalized deficit or a generally visible reduction in the ability to mentalize.

Fonagy (2010) refers to the alien self found in narcissistic personality disorder, seeing it in relation to the false self-construct described by Winnicot (as cited in Fonagy, 2006). Internalized and collected in the alien self are elements that are terrifying to the person, as well as some concerning their sense of value and referring to idealization, and others that may be a split structure due to a caregiver's improper reflection of the child's emotions. A split structure occurs in the personality structure in any form as a result of temporary exclusions in the reflection of parents; the empty space in the mind of non-traumatized people is then filled with self-narrative thanks to mentalization (Fonagy, 2006). When there are traumatic experiences and repeated neglect in mirroring, the discrepancy between the mirrored content and experience becomes large, which makes it impossible to fill this gap, while the means of achieving apparent integrity is the externalization of the persecutory parts. In Fonagy's description of the alien self, the part that has been dissociated is deprived of its "internal relationality;" it remains a representation of the emotional state of the caregiver recognized as part of the self. As it turns out, the aforementioned representation does not contain an understanding of the relationship between the object and the self, or vice versa. The thread of internal relationality discussed above is a point of conflict between Kernberg's theory and Fonagy's theory.

8. Referring to Attachment Theory

The concept of intrapsychic structure splitting, which refers to the cut-off between internal operational models, was published by Howell (2005). As Bowlby (1988) points out, operational models sometimes remain in conflict, potentially interacting with each other in a defensive manner, while in a case of extremely problematic attachment, even several separate internal operational models are created. Intrapsychically, a selected complex of operational models may be available to consciousness, one containing representations of an idealized attachment object and a rejected "bad" child, while another set of internal operational models contains disappointing elements of the parent, which the child has been influenced by but has simultaneously erased from their consciousness. This dissociation between internal operational models resulting from traumatic experiences provokes dissociative experiences characteristic of disorganized attachment (Howell, 2005).

The tendency to see another person in many different roles and situations, questioning the permanent assignment of one role to them, and the ability to seek a different perspective while involved in a relationship are examples of selected possible phenomenological descriptions of proper and flexible mentalization about the other person. It should be emphasized, however, that this is already an advanced ability and although it is achieved more or less during a person's development, it is also often lost in moments of regression,

appearing in the form of subjective and distorted reasoning. A developmental and key point in current mechanisms of mentalization is the ability to decenter, conceptualized differently in different theories but collectively described as the ability to transcend one's own subjectivity and perspective.

The development of mentalization is therefore seen in terms of a transition, from a lack of mentalization towards recognizing the internal states and emotional states of others based on the subjective world of the person recognizing, to a more effective recognition of someone's mind, combined with self-distance and going beyond one's own projection. An important point of mentalization in the sense of inferring another person's state of mind is hypermentalization, understood as a form of mentalization based on early forms of projection (Sharp et al., 2011). It is related to the basic issue of mentalization in the interpersonal sense, the accuracy and contextual justification of inferences about the intrapsychic world of others. Assigning another person intentions, emotions, or a way of thinking, recognizing that they have their own internal world, is already a developmental achievement, but its accuracy is not guaranteed. Excessive mentalization, unprotected by reality testing in situations where relational scenarios resulting from internal representations dominate the realistic recognition of the other person's intentions, may prove to be pathological as a mentalization deficit. Hypermentalization is a pathological form of mentalization. Although it refers to others' having intentions, it is at the same time projective abuse: it is a contextually incorrect attribution to another of intentions that belong to the intrapsychic world of the one who hypermentalizes someone.

9. Mentalization and Psychotherapy

"Mentalizing may be a precondition to increase openness to new social experiences" (Markowitz et al., 2019). Contemporary psychoanalytic concepts explain the process of transition from projectivity to mentalization "from a distance" by taking into account concepts drawn from the areas of object relations and intersubjectivity. Object relations refer to the differentiation of the self from the object and another object from the other person. In both approaches, they refer to the separation phase: individuation and its consequences for the development of mentalization in relation to the states of others. On the other hand, the intersubjective theory undertakes a reinterpretation, trying to establish the dependencies of the object relations theory with the relational theory of mind. Proponents of the object relations theory, including Mahler et al. (1975) and Kernberg (1996), see the process of transition from projectivity to reality testing and assigning importance to the process of differentiating the representation of the self from the representation of the object. This process of differentiation begins in the first stage of the separation-individuation phase and extends through the differentiation stage

in order to reach the ability to individuate through repeated experiences of differentiation and refusion while maintaining dependence. Before the separation stage of the symbiosis phase, a self-object dyad is formed, which Mahler calls a symbiotic orbit, one with a common boundary. After the formation of symbiosis, one moves on to the phase of the differentiation process; in the self, one observes the emergence of desires that differ from those of the object. This is the beginning of the path of internal separation forrepresentations.

Mature differentiation helps reduce the tension between the sense of one's own subjectivity and connection with others. Differentiation provides a sense of connection, contact with others, and – thanks to the sense of enmeshment and fusion – it allows for autonomy and independence, without a sense of isolation and alienation (Lapsley & Stey, 2010). The differentiation process creates the foundations for autonomy while maintaining connections, which has major consequences in the area of self–object representation – this in turn affects mentalization. The state of mind resulting from separation-individuation allows one to see objects as independent, with individual desires, and also to maintain subtle reality testing in social aspects (Caligor & Clarkin, 2013), i.e., correcting one's own projections by taking into account the perspective of others.

Many experimental and clinical studies have reported connections between personality disorders and specific mentalization disorders. Borderline personality disorder, or as Kernberg (1996) calls it, borderline personality organization disorder, stands in the foreground of these studies. In the context of treating such disorders, mentalization-based therapy has proven to be effective. It is treated as a separate therapeutic modality, as well as a specific therapeutic attitude used in therapeutic approaches (Fonagy et al., 2010). It is currently assumed that various therapeutic modalities, especially psychodynamic and cognitive, must take into account the degree of mentalization capacity, especially in patients with personality disorders. It is recognized that difficulties regulating emotions and relationships with others, especially in personality disorders, stem from an inability to mentalize in various social situations. Assuming that difficulties in mentalization come from internal operational models of attachment, we must assume that the general direction of treatment is to stimulate the patient's attachment and motivate them to engage in therapy while working together on their mentalization skills. Arousing the patient's curiosity to see how their own and others' mental states proceed, motivating them to take action, and explaining people's behavior are probably some of the most important tasks of Fonagy's therapy (2010).

As we follow the literature on the subject, we come to the realization that mentalization is a multilevel process based on many factors which can be organized into three main categories: biological aspects entailing the brain structures, the medial prefrontal cortex, and the temporoparietal lobe. Many different methods are applied to show the mechanisms of those approaches, such as functional magnetic resonance imaging,

which presents particular neuronal activity as a key role on the way to mentalization (McAdams, 2018). There is also a hypothesis that the neurotransmitters in this process are oxytocin, serotonin, and dopamine (Slade, 2005). The different penetrance of multiple genes with various levels of expression are responsible for mentalization as a continuum in a specific order.

The level of parental mentalization forms secure attachments in primal relationships and the child's future ability to create deep, meaningful connections with other people (Bretherton, 2011). The promising way for young children who are experiencing a normative crisis, and afterwards through different situational and personal problems, is also connected to their level of mentalization (Fonagy et al., 2002).

Different cultures attach various meanings to the act of mentalizing and conditioning, or stop its development (Luyten et al., 2009). The mechanism by which childhood emotional trauma correlates with a high risk of psychopathology in adulthood is not yet fully understood. Several authors point out that poor mentalizing skills lead to a transdiagnostic risk for psychopathology (Fonagy & Campbell, 2016).

The ability to understand and recognize one's mental interpretation of the world is related to the social realization of the person. This operation is related to better coping with specific difficult situations and can change for better relationships. The variety of situations at work and school can influence one's communication style with other people later in life. The understanding and management of one's emotions and behavior refers to the integrated and adaptive handling of the individual's present abilities in a spectrum of context, with the person's more successful adaptation, which we can call psychological flexibility (Bateman & Fonagy, 2016). Mentalization is the main aspect of human personality. It is associated with more successfully dealing with biopsychosocial difficulties during adolescence and later in life. We can connect that with better emotional regulation. The overall authentic image, including experiences, thoughts, behavior, etc., build the convection with others, empathize, take responsibility in creating one's life, and fully express personal creative potential in social functioning.

With different psychotherapy techniques, the psychotherapist's skill to mentalize is allied with the effect of therapeutic outcomes: the development of the ability to better recognize oneself in terms of another person's thoughts, emotions, and needs, to understand and name them, and to create sufficient boundaries to encourage them. This process is helpful in resolving the internal conflict between clients/patients and therapists (Bateman & Fonagy, 2016). Exercising mentalization skills helps conversations between the client/patient and the therapist become more effective and, subsequently, to move beyond therapy into the social reality of the person's life. In this way, they can address their thoughts and feelings toward others more precisely and comprehensively. The experience of different psychological traumas throughout a person's life can lead to difficulties in mentalization, which influences an individual's ability to overcome

the difficult times of what has happened before and can cost the defragmentation of the self. For this reason, restoring the client's/patient's power to mentalize significantly aids in crisis resolution and brings about positive psychological participation. The skill to mentalize can improve to more adequately recognize and interpret reference and reactions in psychotherapy (Allen et al., 2008). The process of mentalization helps to a large extent in figuring out other people's motivation and the aims behind their behavior, which is important to initiate changes in the client/patient. Taking responsibility for one's own life leads to better coping and adjusting to new ways of reacting (Morin, 2006). "While there is still much research needed to empirically understand and define the role of mentalization in the psychotherapy process, the results of this systematic review have at least one implication for practice: the patient's mentalizing capacity matters, and the psychotherapeutic treatment should (also) be adapted to this" (Lüdemann et al., 2021).

10. Conclusion

"As much as mentalizing can promote mental health and rewarding interactions, its instability can equally result in vulnerability for mental illness and social isolation" (Choi-Kain, 2022). The conclusion which follows from the information presented above could be summarized as the development of mentalization in an individual, family system, and the personal society being able to bring about some positive outcomes, such as developing the ability to observe, to communicate one's state of mind, emotions, and needs to another, and to create healthy boundaries; the skills to satisfy others, respect oneself and others' rules and boundaries; the ability to relate to others' knowledge, distinction, and separation without creating a fear of separation, compulsion, or presumption; and taking obligations for ourselves and others whom we enter into relationships with. Moreover, the holistic understanding of clients/patients and their psychological distress, building psychotherapeutic competence while empathically conducting psychotherapy, throughout the whole psychotherapeutic process, can lead to successful growth from psychotherapy and a post-therapy positive effect.

The construct of mentalization has developed into a complex concept over years of theoretical and practical research and analysis. On the other hand, there is a focus on people's external, physical, and observable characteristics or reactions. Internal states are sometimes considered to be internalization of the outside environment (Fonagy et al., 2007). The division into external and internal characteristics refers to mentalization being applied to the self and others. Mentalization directed at the self or an object is defined as a dimension, the basis of which is seen as the neuroanatomical and developmental basis of both processes. As shown by research (Fonagy & Luyten, 2009), the same regions of the brain are responsible for identifying emotions

and thoughts about oneself and others. In some personality disorders, an incorrect distinction between self and object or irregularities in the degree to which one's identity is integrated are observed. The literature indicates two independent neuroanatomical systems, by which one differentiates oneself from others (Fonagy & Luyten, 2009). In the course of evolution, an automatic, hidden mechanism has developed, which helps one to understand another person more easily.

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Analysis of Health Attitudes Among Poles in the Context of Selected Epidemiological Threats

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Abstract

Infectious diseases remain one of the most pressing challenges to public health in Poland, as illustrated by the crises of the HIV/AIDS epidemic and the COVID-19 pandemic. Considering cultural, social, and political influences, this study investigates the health attitudes of Poles toward these epidemiological threats. While research confirms that health has become the highest priority for Poles, apprehensions about cancer continue to overshadow fears of infectious diseases such as HIV and COVID-19. Paradoxically, despite relatively low levels of anxiety about infections, there is a troubling gap in voluntary HIV testing and a tepid response to COVID-19 and other vaccination campaigns. An examination of these health attitudes exposes barriers to persuading the public to embrace preventive behaviors and reconsider their health-related choices. In the aftermath of the COVID-19 pandemic, which has illuminated systemic vulnerabilities in public health infrastructure, there is a growing need for intensified educational campaigns aimed at enhancing health awareness and rebuilding trust in immunization. These findings reinforce the key importance of multifaceted health strategies that address not only medical, but also psychological and educational angles to effectively confront future health crises.

Keywords: health attitudes, infectious diseases, COVID-19, HIV, health education

Introduction

Infectious diseases represent a pervasive and multifaceted threat to individuals and society as a whole. Recent studies underscore notable issues such as fear, social support mechanisms, and the efficacy of preventive measures in mitigating the impacts of these diseases. Epidemics like the HIV/AIDS crisis and the COVID-19 pandemic—experienced within just one generation—have not only placed immense pressure on healthcare systems, but have also reshaped psychosocial patterns within communities. Over time, these outbreaks have profoundly influenced various facets of social life and altered medical standards. To fully grasp the ramifications of these phenomena, we must consider non-health-related contexts, including cultural norms, beliefs, and political circumstances, as these factors shape health attitudes and behaviors, especially in response to future infectious disease threats.

The COVID-19 pandemic is a stark reminder of the enduring danger posed by infectious diseases to both public health and social stability. Not long ago, many believed that infectious diseases had been largely relegated to history and that dangerous viruses were under control. This misplaced optimism redirected focus toward lifestyle diseases, prompting concentrated efforts to reverse alarming trends in cancer, cardiovascular conditions, and diabetes. However, infectious diseases remain a leading cause of morbidity and mortality on a global scale and continue to rank among the most intractable and formidable public health threats worldwide.

The recognition that infectious diseases pose not only a significant threat to individual health but also to global economies and security is widely shared among business leaders, policymakers, and scientists. The "Global Risks Report 2023," unveiled during the World Economic Forum in Davos, identified infectious diseases as one of the paramount global challenges, alongside threats such as terrorism, economic downturns, and the deployment of weapons of mass destruction (World Economic Forum, 2023). The report further emphasizes that the economic fallout from pandemics—exacerbated by disparities in vaccination rates and access to healthcare, as well as widening educational gaps, continue to present substantial obstacles, potentially steering the world onto increasingly divergent developmental paths.

In light of mounting global concerns, particularly amid the COVID-19 pandemic, analyzing public health attitudes has become a vital area of research. Studies on public awareness and health behaviors in specific populations provide valuable insights into the health status of societies and serve as a guide for healthcare policymakers, institutions, media outlets, and NGOs conducting educational outreach and awareness campaigns. In times of severe health crises, the challenge often lies not only in persuading individuals to adopt specific health-positive behaviors, but also in understanding patients' attitudes and motivations, which is key to crafting credible messaging and coherent communication strategies. This issue is particularly pressing in an era of declining trust

in scientific paradigms, when comprehending the determinants of health behaviors is indispensable for safeguarding the well-being of millions worldwide.

This study examines the evolving health attitudes and anxieties of individuals and sheds light on the complex psychosocial dynamics that have unfolded during two of the most significant recent epidemics: HIV/AIDS and COVID-19. It synthesizes findings from selected socio-medical studies that analyze health attitudes, knowledge, and health-promoting behaviors in response to infectious diseases.

Socio-Historical Context

The recurring waves of infectious diseases, often manifesting as epidemics, have profoundly shaped human civilization. Poland, much like other nations, has endured cycles of devastating epidemics throughout its history, leaving an indelible mark on society. Over the centuries, Poles have faced major outbreaks of diseases such as the Black Death, cholera, influenza, and tuberculosis. The pervasive fear of these diseases was so deeply rooted that its echoes are still found in language, rituals, and religious hymns meant to ward off illness.

The earliest documented accounts of infectious diseases in Poland date back to the 11th century. As chronicler Jan Długosz vividly described the era: "Hunger, pestilence, and plague reigned terribly at that time not only in Poland but throughout nearly the entire world" (Mecherzyński, 1869). Despite these accounts, historians and virologists remain divided on whether the initial wave of the plague definitively reached Polish territories. Nonetheless, it is certain that the regular outbreaks of the plague began in 1348, when the so-called *mortal plague* reportedly decimated around one quarter of the population, according to contemporary records. Subsequent waves of plague continued to ravage Polish lands over the ensuing centuries, with the last documented cases appearing in the 18th century (Chylińska et al., 2008).

Frequent wars on Polish soil undoubtedly facilitated the spread of infectious diseases, but another major factor was Poland's position as a crossroads for major trade routes, which enabled wide-ranging contact with people from diverse regions, thus inadvertently catalyzing the transmission of diseases. One example is syphilis, which appeared in Poland as early as 1495, merely two years after it was "brought" to Europe from the Americas by Christopher Columbus (Koleta-Koronowska, 2010). In the 19th century, Poland also experienced high morbidity rates due to cholera, and its epidemics posing a persistent threat until the mid-20th century, when advances in medicine gradually introduced more effective diagnostic tools, immunization techniques, and treatment options for various infectious diseases. The last major epidemic in Poland—and one of Europe's final outbreaks of smallpox—occurred locally in Wrocław in 1963. Thanks to the swift response of medical

professionals and the collaboration of multiple institutions, the epidemic was quickly contained. Poland's response exemplified one of the crowning achievements of modern medicine: the eradication of smallpox through vaccination campaigns.

In contrast, a more contemporary yet paradoxically overlooked issue is the ongoing HIV epidemic, which has persisted in Poland for over three decades since the virus first appeared in the country in 1985. Political events of the era, including martial law and communist rule, markedly impacted social attitudes toward this infectious disease. While Poland's relative isolation from global transmission sources spared it from the catastrophic first wave of the HIV/AIDS epidemic, political agendas often led to misinformation and ineffective prevention strategies, which often targeted random individuals rather than at-risk populations.

The history of infectious diseases in Poland offers valuable lessons on the complex interplay between society and public health, which are crucial for understanding how societies adapt to shifting epidemiological conditions and for developing effective health strategies to deal with contemporary healthcare issues. Epidemics of infectious diseases have consistently posed formidable obstacles for Polish society, bringing not only physical suffering but also social and economic losses.

Public Health Attitudes and Concerns About Infectious Diseases

In Polish society, health consistently occupies the apex of life priorities. According to a 2019 CBOS survey, more than 55% of respondents identified maintaining good health as a paramount life value, second only to family happiness, which was prioritized by 80% of participants (CBOS, 2019). This valuation of health was reinforced during the COVID-19 pandemic, with 47% of respondents in 2020 identifying health as their most important value, surpassing family, which ranked second (CBOS, 2020).

However, not all illnesses elicit the same level of concern within the population. For years, cancer and strokes have been the most feared conditions among Poles. This trend is corroborated by the 2021 *Polish Risk Map* study conducted by Deloitte and the Polish Insurance Chamber (PIU), in which an overwhelming 81% of respondents identified cancer as their greatest fear (PIU, 2021). Ironically, this widespread anxiety sometimes hinders preventive behaviors, such as routine screening, which leads to delayed diagnoses and diminished prospects for successful treatment. The same study also illuminated pervasive fears about long-term impairments, including brain damage resulting in a vegetative state (76%) and loss of physical independence (80%), which ranked sixth among the most apprehended health issues.

A comparative study carried out in February 2020, before the COVID-19 pandemic, and repeated in February 2021, amidst the pandemic, sheds light on how the pandemic

and its socioeconomic repercussions—such as lockdowns and widespread job or income losses—intensified certain fears among Poles. The findings show that three key fears remained unchanged across age, gender, and location: the death of a loved one, insufficient financial resources to treat a serious illness, and the severe illness of a close family member. Out of 40 fears analyzed, concerns related to health and access to medical care dominated the top ten risks most frequently cited by respondents. Interestingly, in the second wave of the study, respondents spontaneously mentioned the pandemic itself as an independent risk factor, albeit only 13% of respondents considered it their greatest fear. Concerns about serious illnesses affecting loved ones grew by 4 percentage points, while worries over limited access to healthcare increased by 5 percentage points (PIU, 2021).

However, these health-related fears have not translated into more proactive healthcare practices. According to research conducted by the IQS Institute (IQS Institute, 2023), nearly 40% of Poles visit a doctor only once every six months or less, and the pandemic did not lead to any significant increase in the frequency of medical consultations. Additionally, Eurostat data show that 40% of Poles forego preventive health screenings, a figure that places Poland among the countries with the highest rates of missed screenings in Europe (EU Report, 2021).

Poles Exhibit the Lowest Levels of Concern About Infectious Diseases

For years, infectious diseases have consistently been regarded as low-priority health concerns by Polish society, as evidenced by the limited participation in preventive vaccination programs. This lack of concern extends to diseases labeled as "taboo," such as sexually transmitted infections (STIs), which not only carry a heavy social stigma but also trigger psychological denial mechanisms, often associated with public reluctance to acknowledge their risks.

This trend is further substantiated by the study *Poles and Health: Perceptions and Practices*, conducted on a representative sample of the Polish population (Sobierajski, 2023). The study compiled contemporary data on health-related fears, attitudes toward healthcare, vaccination, and preventive screening. Results show that apprehensions about infectious diseases remain relatively low: only 13% of respondents expressed significant fear of contracting HIV or developing AIDS, 7% of COVID-19, and 6% of the flu.

This lack of concern may partly reflect the success of public health campaigns and preventive measures implemented by Polish healthcare authorities. However, it is also likely influenced by the unexpected impact of the COVID-19 pandemic, which, instead of reinforcing pro-vaccination attitudes, fueled the growth of anti-vaccination movements. The widespread debate over vaccine safety and efficacy has amplified public skepticism, forming a substantial barrier to the effectiveness of ongoing vaccination programs.

Concurrent research also points to a deeper issue: a lack of health awareness regarding infectious diseases, particularly in terms of preventive care. Alarmingly, a significant proportion of the population fails to undergo regular health screenings, which underscores a broader gap in health literacy. These findings emphasize the need for improved health education, more accessible public awareness campaigns, and enhanced online resources. Investments in these areas are vital to elevating health literacy and building a proactive approach to healthcare in Polish society.

Polish Attitudes Toward HIV

The HIV epidemic presents an intriguing sociological phenomenon in contemporary Poland. A new generation—those born in the 1990s and 2000s—has emerged among populations at risk of infection. This group has not experienced the fear and uncertainty that characterized the early years of the epidemic. By the time they came of age, antiretroviral therapies had rendered HIV a manageable condition, and the topic had largely disappeared from headlines, surfacing only in occasional reports around World AIDS Day on December 1.

However, recent data reveals a troubling trend: Poland experienced a nearly 90% surge in HIV infections last year, recording an unprecedented 2,380 new cases (National AIDS Center Bulletin, 2023). Despite this alarming increase, only 13% of respondents in a recent study expressed concern about contracting HIV. This lack of awareness mirrors the general lack of awareness about sexually transmitted infections (STIs), as evidenced by the extremely low testing rate—only 10% of Polish adults have ever been tested for HIV (Sobierajski, 2023).

Further data is provided by a 2020 study conducted by ARC Rynek i Opinia for the National AIDS Center. Although over two thirds of respondents reported taking conscious steps to reduce their risk of HIV infection, many demonstrated insufficient knowledge of transmission routes. Misconceptions were widespread: around 40% of participants incorrectly identified childbirth, breastfeeding, or pregnancy as potential sources of HIV transmission. Additionally, uncertainty surrounded other modes of transmission, such as medical procedures in hospitals. Alarmingly, 10% of respondents believed that casual contact, such as handshakes or cheek kisses, posed a risk. Although one in three respondents acknowledged that HIV could affect anyone, many dismissed the relevance of the issue to their own lives, citing a perceived lack of personal exposure.

Only 20% of respondents had ever been tested for HIV, and awareness of testing procedures and protocols varied widely. For example, while 82% knew that blood tests are required to detect the virus, many were unsure about the appropriate age for testing, the timing after potential exposure for accurate results, or where such tests could be accessed. Only half of the respondents stated that they knew where someone seeking an HIV test could go (ARC Rynek i Opinia, 2020).

Changing Health Attitudes and Concerns Amid the COVID-19 Pandemic

As it presented numerous challenges for healthcare systems and policymakers, the COVID-19 pandemic has profoundly reshaped health attitudes and perceptions of health risks in contemporary Polish society. The socioeconomic repercussions of the pandemic caused by the SARS-CoV-2 virus are anticipated to persist for years, affecting not only public health but also social and economic stability. These experiences have become a part of the cultural legacy and created a new collective awareness.

The first year of the pandemic saw notable changes in health attitudes among Poles. The 2020 study *The Impact of the COVID-19 Pandemic on the Emotions, Behaviors, and Attitudes of Poles* (Hamer et al., 2020), conducted by psychologists from SWPS University, the Institute of Psychology of the Polish Academy of Sciences, and Indiana University of Pennsylvania, provides an insightful analysis. Researchers surveyed participants at four intervals, asking about their fears related to various aspects of the pandemic, and tracked fluctuations in responses across these periods.

The study revealed that fears related to the pandemic were most intense during its early stages, peaking in April, and declining through May and June.

- Healthcare system capacity: In March, 74% of respondents expressed fears about hospital overcrowding and the inability of the healthcare system to manage the crisis. This concern peaked at 79% in April, dropped to 56% by May and June, and climbed again to 64% in December.
- Illness of loved ones: Fears regarding a loved one falling ill stood at 72% in March, rose to 75% in April, decreased to 60% in May and June, and slightly increased to 61% in December.
- Access to medical care: By May and June, 65% of respondents expressed concerns about difficulties accessing non-pandemic-related medical care. This figure increased to 69% in December.
- Neglected health issues: Fear of other health problems being overlooked due to the focus on COVID-19 was first reported in May and June, with 64% of respondents expressing such fears. By December, this figure had risen to 68%.
- Ventilator availability: Notably, December marked the first time when concerns about the potential unavailability of ventilators for loved ones were surveyed, with 54% of respondents expressing fears regarding this possibility.

Demographic analysis revealed key differences in pandemic-related health attitudes and fears based on gender and age. Women consistently reported higher levels of concern than men across all survey periods. Older respondents (aged 55 and above) also exhibited greater levels of worry compared to younger participants, possibly due to pre-existing

health conditions. This suggests that life experiences and heightened vulnerability may influence respondents' perception of epidemiological threats.

The researchers attribute the declining fears surrounding the pandemic to the so-called "adaptation phase," a process in which individuals acclimate to a persistent stressful situation that remains unchanged despite their efforts to mitigate it. Additionally, the authors suggest that the decrease in concerns may stem from the use of denial as a coping mechanism, wherein individuals downplay the perceived threat to manage their stress.

While the COVID-19 pandemic has caused global shifts and heightened public health awareness, and infectious diseases have emerged as a major global concern over the past three years, viruses like COVID-19 and influenza remain relatively low on the list of health concerns for Poles. Only 7% of respondents reported significant fear of contracting SARS-CoV-2, and even fewer (6%) expressed concern about the flu (Sobierajski, 2023). This low level of fear aligns with existing observations about Polish attitudes toward vaccinations and the growing resistance to immunization (Raciborski et al., 2022). Poland remains one of the European countries with the lowest vaccination rates for COVID-19 and influenza (Raciborski et al., 2022; European Centre for Disease Prevention and Control).

Conclusions

The findings on health attitudes and the diminishing concerns about the pandemic closely mirror the vaccination decisions of Poles and the rising prevalence of vaccine hesitancy (Raciborski et al., 2022). Poland ranks among the European countries with the lowest COVID-19 and influenza vaccination rates (European Centre for Disease Prevention and Control). According to the European Centre for Disease Prevention and Control, 60% of the Polish population has completed the primary vaccination series, compared to 73.1% in EU/EFTA countries. However, as time has passed since the onset of the pandemic, interest in vaccination has markedly declined. For instance, only 33.1% of Poles have received the first booster dose, in contrast to 54.8% of the EU/EFTA population. The numbers are even lower for the second booster dose, with just 7.7% of Poles vaccinated, compared to 14.3% across EU/EFTA countries.

The relatively low level of concern about COVID-19 in Poland may partly be attributed to public health campaigns and preventative efforts undertaken by healthcare authorities. However, another significant factor is the unintended consequence of the pandemic itself. Initially expected to strengthen pro-vaccination attitudes, the pandemic instead contributed to the growing popularity of anti-vaccination movements. Moreover, the widespread debate surrounding the safety and efficacy of COVID-19 vaccines has amplified skepticism and uncertainty, posing substantial challenges to the success of vaccination programs.

This growing mistrust is further compounded by the evolving narrative surrounding the pandemic. Early hopes that COVID-19 vaccination campaigns would promote collective health awareness have given way to a landscape dominated by doubt and misinformation. Discussions about vaccine risks and benefits have often been polarizing, thus eroding confidence in healthcare initiatives and potentially undermining the effectiveness of current and future vaccination efforts.

Conclusions and Recommendations for the Healthcare System

The analysis of survey data on health concerns among Poles reveals a clear connection between limited awareness of the health consequences of certain diseases—particularly infectious diseases—and corresponding health behaviors and attitudes. The low percentage of individuals who recognize the health risks associated with infectious diseases underscores the urgent need for a comprehensive approach to health education and the promotion of preventive measures. Addressing these gaps is crucial to tailoring healthcare services and prevention programs to the actual needs of the population.

Health education is a cornerstone for mitigating disease-related fears and promoting proactive health behaviors. Providing knowledge about prevention, early detection, and available support resources can significantly reduce societal stress and anxiety. More importantly, such education can lead to higher rates of regular preventive screenings, which are essential for improving overall public health outcomes.

The findings also underscore the pressing need for strategic educational and informational campaigns to rebuild trust in vaccinations and to raise public awareness about their health benefits. Strengthening confidence in vaccines is pivotal for improving immunization rates and achieving the population immunity necessary to effectively combat infectious diseases.

In light of these findings, the healthcare system should strive to adopt a holistic approach that considers not only medical factors, but also the social and economic dimensions of health.

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Issues in Implementing the Polish Association of Suicidology Volunteer Programs

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Abstract

Volunteers, carrying out their work without pay and of their own accord under constantly changing societal conditions, serve as a bridge between individuals in a suicidal crisis and professionals providing expert support. The concept of volunteering to help people in a suicidal crisis has existed and developed for several decades in Western European countries.

The aim of this article is to discuss the issues of volunteer work for the Polish Association of Suicidology. These challenges cannot be fully understood without considering the issue of motivation in volunteer work. The implementation of volunteer work for the Polish Association of Suicidology requires the development of many procedures designed to encourage volunteers to achieve the goals.

Keywords: volunteering, prevention of suicidal behavior, Polish Association of Suicidology

Introduction

Volunteering, a word derived from the Latin term *voluntarius* and meaning a willingness to act, is an important element of modern society. Its current form gained prominence through the efforts of Pierre Cérésole, who in 1920 established the *Service Civil Volontaire* – a pacifistic response to the destruction of the First World War (Bogdańska, 2011). Volunteer work covers a range of efforts aiming to help those in need.

One particularly important topic is supporting those who find themselves in a suicidal crisis. The key is establishing communication between a person thinking about taking their own life and individuals who can offer professional help (psychologists, psychotherapists, psychiatrists, and suicidologists). It is equally important for people who may

know someone experiencing a suicidal crisis to know how to react in such situations, and perhaps also take specific actions to guide their loved one to the care of professionals. The idea of volunteering resonates with individuals who possess the appropriate sensitivity, as well as the desire and ability to help people in a suicidal crisis. This includes extending support to people who have been affected by a suicide (Czabański, 2016).

In Poland, volunteer work is regulated by the Act of April 24, 2003 on Public Benefit and Volunteer Work, which specifies the rules governing volunteers' activities. Any adult may become a volunteer, except in situations where age restrictions are in place, such as in care and educational facilities. Volunteering entails a wide range of activities for the benefit of non-governmental organizations, public administration bodies, and individuals and its importance in Poland is steadily increasing. According to the above-mentioned Act, a volunteer is defined as a natural person who, of their own accord and without pay, performs the services specified in Art. 2(3) of the Act (Journal of Laws of 2024, item 1491).

A key element is understanding the motivations that drive individuals to engage in volunteer work, a topic which requires further exploration.

Motivation in Volunteer Work

When examining volunteer work, the main focus is often on analyzing the motivations that impel a person to take on such roles. From a psychological perspective, motivation for volunteerism is connected with the concepts of altruism, helping, and prosocial behavior (Kroplewski et al., 2015).

The literature on the subject of volunteering distinguishes between internal and external sources of motivation (Kroplewski et al., 2015). Internal motivation stems from the personal needs of the individual, such as fulfilling their values, experiencing personal growth, or reinforcing a positive self-image. In turn, external motivation arises from the social environment, including the opinions of others or social recognition (Grabowski, 2014). Psychologically speaking, motivation may also be categorized as either egoistic or altruistic. Egoistic motivation entails the satisfaction of one's needs, e.g., improving one's well-being, whereas altruistic motivation is focused on the needs of others. These two forms of motivation often complement each other, creating a multifaceted picture of a volunteer's motivation.

Volunteers derive energy from their work and from the opportunity to take on a new social role, test their abilities, and engage with others (Załuska & Boczoń, 1998).

In modern societies, people with mental disorders are still approached with reserve. This raises questions about the motives that guide volunteers who choose to work with people in a mental crisis (Hallet et al., 2012). Authors have identified two main motives: giving and getting. The former reflects a desire to help out of a sense of social

responsibility, while the latter pertains to personal benefits, such as learning or developing skills or gaining a sense of belonging (Zadrożna, 2021).

The theory of human resources management suggests that motivation to work is based primarily on financial rewards, which limits its application to volunteers. However, elements of Maslow's hierarchy of needs – such as the need for recognition, respect, or self-fulfillment – and Alderfer's theory of needs – belonging and development – can be applied to volunteering (Piechota, 2014).

The above leads to an apparent contradiction: although volunteering is defined as a selfless activity, it can also be motivated by self-serving benefits. This phenomenon has been observed by other researchers, who have identified personal benefits as significant motivators of prosocial behavior (Esmond & Dunlop, 2004). Cialdini (as cited in Basińska & Nowak, 2010), on the other hand, distinguished the key motives for such actions: improving one's social position, gaining approval, managing one's self-image, and dealing with emotions.

It seems that the issues of motivation for volunteering are essential for implementing volunteer initiatives for the Polish Association of Suicidology.

Volunteer Work for the Prevention of Suicidal Behavior at the Polish Association of Suicidology

Volunteers complement the professional care providers. As Brunon Hołyst explains, "volunteers reach people in need of help who are unable to contact a professional clinician or are reluctant to seek one. Volunteers bridge the gap between receiving professional care and no care at all" (Hołyst, 2024).

A volunteering plan was developed according to the assumption that suicide prevention efforts involving specialists and experts should be supplemented with the work of volunteers – people who are close to those at risk of suicide (Czabański & Pryba, 2022). The idea was based on the belief that any sensitive person, after the relevant preparation, can act to save people in a suicidal crisis. Examples of such actions would be referring someone in a suicidal crisis to an institution for professional help or providing appropriate support to people bereaved by a suicide (Czabański, 2016). The starting point for this concept is volunteers acting as a bridge between people at risk of suicide and professionals working in the field (psychologists, psychotherapists, psychiatrists, and suicidologists).

Indeed, this type of volunteering typically involves pastors and lay people working in Caritas, but other people may also participate in it: employees of Social Welfare Centers (social workers), school employees (teachers and pedagogues), graduates of Postgraduate Suicidology Studies (Warsaw Management University), and – after proper preparation – students of pedagogy, psychology, sociology, social work, public health, emergency medical services, medicine, nursing, social dialogue, and counseling.

The goal of the project is to establish a support network for people in a suicidal crisis and the loved ones of people who have committed suicide, as well as to disseminate knowledge, especially among adolescents, about supporting peers and helping them in the event of a suicidal crisis.

The beneficiaries of this initiative are

1. people at risk of suicide
2. loved ones of those who have died by suicide
3. adolescents, who can direct their at-risk peers to psychologists, psychotherapists, psychiatrists, and suicidologists.

The duties of PTS volunteers include

- supporting people in finding professional assistance for a suicidal crisis
- helping those affected by suicide with everyday tasks (i.e., shopping, cooking, caring for children, handling administrative matters, and accessing healthcare)
- facilitating the assessment of financial needs and the receipt of financial assistance (e.g., if the breadwinner in the family has taken their own life)
- reaching out to young people with information on how to help a peer in a suicidal crisis
- mobilizing a support network (extended family, neighbors, and friends)
- providing information on the available forms of psychological, psychiatric, social, legal, and medical support (addresses of institutions and organizations, contact information of specialists, and phone numbers of helplines)
- creating and running a support webpage (under the patronage of the Polish Association of Suicidology):
  a) informative/promotional tasks (providing people in crisis with information about the volunteer initiative and the terms for applying for help)
  b) knowledge base (offering resources for volunteers and people in crisis on how to cope with crises)
- participating in social campaigns, such as "Life is Worth Talking About" [*Życie warte jest rozmowy*] (www.zwjr.pl)
- assisting in the organization of open lectures and conferences on preventing suicidal behavior
- reporting on one's efforts to the designated person within a given branch of the Polish Association of Suicidology, with data regarding how many cases were taken up, how many people received help, what kind of help it was, and any problems or proposals for further training.

More information can be found in the Regulations for Volunteering at PTS. The most important factor, however, is a desire to help those in a suicidal crisis. How can such people be reached?

1. The first path, which offers an opportunity to mobilize social capital within individual local communities, is through parish communities of various denominations: a parish priest at a parish branch of Caritas, and then a trained volunteer from Caritas.
2. The second path is through the police force, who file reports with the Municipal (City) Office. They inform OPS, MOPS or MOPR, who in turn inform volunteers.
3. By reaching out to adolescents in secondary schools and grades 7 and 8 of elementary schools, the idea of helping peers in a suicidal crisis can be popularized and those who are at risk can be identified.

Tasks at various stages of the project include

- developing the Regulations for Volunteering at the Polish Association of Suicidology
- conducting phased recruitment of volunteers (interviews to verify the candidates' motivation and suitability before referring them for training)
- appointing a team of experts from the Polish Association of Suicidology to provide support and consult in suicidal crises (especially for difficult cases)
- providing safety measures and supervisory support for volunteers
- developing a training framework and materials for volunteers (Guide for Volunteers Helping People in a Suicidal Crisis).

The main problem in organizing PTS' volunteering activities involve coordinating activities and developing document templates: the regulations for PTS volunteers, contracts, certificates for completing PTS volunteer training, ID badges, etc. Other challenges related to volunteering at the Polish Association of Suicidology deserve separate treatment. Additionally, the issue of onboarding candidates for volunteer roles within the Polish Association of Suicidology also merits focused attention.

Other Challenges in Preparing Candidates for Volunteer Work with the Polish Association of Suicidology

The challenges of getting started as a volunteer result from the nature of the work, which can lead to an excessive emotional burden and contribute to a sense of helplessness. It appears that some of the people applying to become volunteers of the Polish Association of Suicidology are unable to assess their strengths against their intentions and the demands of working with people in a suicidal crisis. Many people initially express a willingness to volunteer but conclude (even before working directly with people in a suicidal crisis) that they lack the necessary skills. Moreover, many cannot imagine the actual work necessary for

people at risk of suicide. As a result, a significant number of candidates for PTS volunteers ultimately decide not to complete the final training, which is a prerequisite for taking up volunteer work. Observations from the last two years seem to confirm this.

Another problem hindering the development of the PTS volunteer program is the complicated process of finding candidates who meet the specific criteria needed for volunteer work. Volunteers should be empathetic, selfless, committed, creative, ready for action, honest, discreet, responsible, and law-abiding. They should also be open, sensitive, selfless, professional, strongly motivated to help others, tolerant, and able to cooperate with others (Limański & Drabik, 2007). The selection of volunteers prioritizes these character traits over their formal qualifications alone (Scott & Armson, 2000). However, such a wide list of expectations may intimidate some potential volunteers and discourage them from pursuing the role further. These problems are also compounded by constantly communicating with and being around people in a suicidal crisis. Education and regular training are strategies that can combat compassion fatigue and prevent volunteers from resigning (Kinzel & Armson, 2000). Meanwhile, many volunteers complain about time constraints and express a willingness to continuously improve their qualifications.

As Brunon Hołyst states, a volunteer focuses on the person and not the problem. They must listen in an active, empathetic, and non-judgmental way. However, they should be able to assess the risk of suicide in those seeking help (Hołyst, 2024).

It is also worth noting that volunteer work involves stressful situations. Volunteers trained in suicide prevention must also develop their coping skills in difficult situations so as to avoid secondary traumatic stress during their work (Kinzel & Nanson, 2000). Experience from other countries shows that 77% of volunteers have experienced adverse effects from working on a crisis hotline and that it has affected their mental health and well-being (Willems et al., 2020). There are studies describing professional burnout among crisis hotline volunteers (Cyr & Dowrick, 1991; Roche & Ogden, 2017). A high level of stress and professional burnout often occur when a volunteer becomes emotionally involved in the problems of another person (Ogińska-Bulik, 2006; Kozak, 2009). This may result in what is known as the "empathy trap" (Bogdańska, 2011), a condition in which the effort of compassion is compounded by a high level of stress. This can occur when volunteers are faced with another person's pain or the experience of death (Szymankiewicz, 2013). All of these cases can potentially occur during the work of volunteers of the Polish Association of Suicidology or others who may repeatedly face the deaths of those they assist (Stawiarska, 2011). An awareness of the exhausting nature of this work and the risk of long-term professional burnout (Szymankiewicz, 2013) can discourage some people from fully committing to volunteer activities for people in a suicidal crisis.

During the recruitment process, it is important to suggest to undecided candidates, or those who are uncertain about their communication skills, alternative tasks which will not bring them into contact with people in a suicidal crisis. Such candidates can perform various other tasks, such as helping to organize webinars, scientific conferences, and lectures

on the topic of preventing suicidal behavior. They can also take part in short presentations for broader youth groups, not only for people currently struggling with suicidal crises.

At times, volunteers may encounter people with severe mental disorders, addictions, behavioral issues, or aggression. Under such circumstances, they may feel unable to meet the expectations of the people they are helping. For these reasons and others, it is necessary to ensure the safety of the volunteers. The Polish Association of Suicidology should therefore provide its volunteers with access to experts who can offer substantive assistance, depending on their needs, when they face crisis situations.

Conclusions

The concept of volunteering to help individuals in a suicidal crisis is relatively new in Poland, but this initiative is necessary. Every year, hundreds of thousands of people in Poland experience suicidal crises and require preventive intervention. It seems that these efforts should be carried out not only by professionals – doctors, psychiatrists, psychotherapists, psychologists, educators, employees of crisis assistance centers, helpline operators, and suicidologists – but also by people with the appropriate skills to redirect people at risk of suicide toward specialists. This is a significant task, but one that can be addressed with properly trained volunteers.

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