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## DO WE NEED ETHICS AND BIOETHICS IN CLINICAL MEDICINE?

### The science of medicine, the art of medicine and physician-patient relationship

Jozef Novotný<sup>1</sup>

#### ABSTRACT

A few (Many) thinkers have provided important insights into the physician-patient relationship. The practical use of medical knowledge (diagnosis, therapeutics, prognosis) is by no means accidental to modern science and theory more generally – and, it seems perfectly clear, to medicine as well to the very extent that it has allied itself with that science. Theory and power are integral to one another. The vision of theory and practice becomes inseparable in ways which the mere terms pure and applied science fail to convey. Effecting changes in nature as a means and as a result of knowing it are inextricably interlocked. Hence science is technological by its nature. At the same time, to the very extent that medicine's theory and practice is ordained to the diagnosis, therapeutic assessment, and prognosis of specific patients, it is a matter of practice as well. This *understanding of the close alliance between theory and practice – that practice informs and shapes theory – „is medicine's own creation and its original contribution.“*

The art of medicine and the science of medicine are not antagonistic but supplementary to each other. Good practice presupposes an understanding of the sciences which contribute to the structure of modern medicine, but it is obvious that sound professional training should include a much broader equipment. *The treatment of disease may be entirely impersonal; the care of a patient must be completely personal.* Thus, *the physician who attempts to take care of a patient while he neglects those factors which contribute to the emotional life of this patient is as unscientific as the investigator who neglects to control all the conditions which may affect his experiment.* The physician must always have a reasonably clear-cut indication for the administration of any drug. There are several important principles in the selection of drugs. First, the physician should employ drugs with which he is familiar, both in terms of beneficial effects and possible side effects or reactions. The physician should select a small number of agents to handle the various therapeutic problems, read about them, and use them primarily. Application of the scientific method to experimental therapeutics is exemplified by a well-designed and well-executed clinical trial.

The *sine qua non* of any clinical trial is its control. Selection of a proper control group is as critical to eventual utility of an experiment as the selection of the experimental group. There are several special considerations in the design of clinical trials if they are to be used to compare the relative effects of alternative therapies:

*1. specific outcome of therapy; 2. the accuracy of diagnosis and the severity of the disease; 3. the dosages of the drugs; 4. placebo effects; 5. compliance; 6. ethical considerations may be major determinants of the types of controls that can be used must be evaluated explicitly.*

*Now finally, we must not only study the factual basis of clinical diagnosis and treatment, but at the same time work toward an equally difficult goal: CULTIVATION OF A PROPER RELATIONSHIP WITH EACH OF OUR PATIENTS.*

#### Key words:

*Ethics – bioethics – clinical medicine – medical practice – disease – pharmacotherapeutics – placebo – outcome of therapy - compliance*

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## 1. INTRODUCTION

Medical knowledge and practice are continually changing. We live, therefore, in an atmosphere of doubt and uncertainty, and make our decisions and take our actions on the basis of probabilities. Advancement in knowledge of clinical medicine is now mainly accomplished by full-time clinical scientists in medical schools and research institutes throughout the world (51, 53, 54, 55, 67, 69, 75)

Disease do not always present themselves in pure culture, and indeed the perspective of the clinical scientist can sometimes be skewed. **Disease often tells its secret in a causal parenthesis** (51, 53, 54, 55, 67).

The practice of medicine combines both science and art. The role of science in medicine is clear. Science-based technology and deductive reasoning form the foundation for the solution to many clinical problems; the spectacular advances in genetics, biochemistry, and imaging techniques allow access to the innermost parts of the cell and the most remote recesses of the body. Highly advanced therapeutic maneuvers are increasingly a major part of medical practice. This combination of medical knowledge, intuition, and judgment defines the art of medicine, which is as necessary to the practice of medicine as is a sound scientific base. The practice of medicine in a managed care setting puts additional stress on the classic paradigm of the patient-physician

relationship (51, 53, 54, 55). The profession of medicine should be inherently linked to a career-long thirst for new knowledge that can be used for a good of the patient. The practice of medicine is dependent on the sum total of medical knowledge, which in turn is based on an unending chain of scientific discovery, clinical observation, analysis and interpretation. Physicians frequently confront ethical issues in clinical practice that are perplexing, time consuming, and emotionally draining. Experience, common sense, and simply being a good person do not guarantee that physicians can indentify or resolve ethical dilemmas. Knowledge about common ethical dilemmas is also essential. Physicians are expected to maintain mastery of their rapidly advancing fields (the science of medicine) while considering their patient's unique needs (the art of medicine) (51, 53-56).

## 2. THE ART OF MEDICINE AND THE SCIENCE OF MEDICINE

### 2.1. Introduction

Every student and practitioner of medicine should familiarize himself with *the classic essay on The Care of the Patient* by PEABODY: „The practice of medicine in its broadest sense includes the whole relationship of the physician with his patient. It is an **art**, based to an increasing extent on the medical sciences but comprising much that still remains outside the realm of any science. The art of medicine and the science of medicine are not antagonistic but

supplementary to each other. There is no more contradiction between the science and medicine and the art of medicine than between the science of aeronautics and the art of flying. Good practice presupposes an understanding of the sciences which contribute to the structure of modern medicine, but it is obvious that sound professional training should include a much broader equipment. The treatment of disease may be entirely impersonal; the care of a patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for an extraordinary large number of cases both diagnosis and treatment are directly dependent on it, and failure of the young physician to establish this relationship accounts for much of his ineffectiveness in the care of patients. What is spoken of as „clinical picture“ is not just a photograph of a man sick in bed; it is an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, sorrows, hopes, and fears. Thus, the physician who attempts to take care of a patient while he neglects those factors which contribute to the emotional life of this patient is as unscientific as the investigator who neglects to control all the conditions which may affect his experiment. The good physician knows his patients through and through and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed but the reward is to be found in that personal

bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in carrying for the patient“ (61).

## **2.2.the physician and the patient**

These beautifully expressed thoughts about the physician and his relationship to the patient are even more important to emphasize today than when they were written more than 75 years ago. Medicine has become, and will continue to become, much more a science, not less, so that the physician of tomorrow will have to be more a scientific, not less (51, 53-56). Nevertheless, the art of medicine remains, and the physician must continue to be wise and understanding with a deep respect for the patient as a human being. The secret of success in the care of the patient is still in carrying for the patient.

The physician must always have a reasonably clear-cut indication for the administration of any drug. This implies that he knows what is wrong with the patient and which drug is the most effective. There is little room in therapeutic technique for the shotgun approach to drug administration. The haphazard administration of a large number of drugs is more likely to harm the patient than to benefit him (51-56, 59). If the physician does not know what is going on, he is better advised to

follow a course of watchful waiting. There are certain exceptions, usually related to life-threatening diseases, which do not permit sufficient time to reach a final diagnosis. For example, the patient with findings suggesting septic meningitis is treated with several antibiotics while awaiting bacteriologic confirmation of the presumptive diagnosis (52, 53, 57). No drug should ever be given until the physician has determined whether or not the patient is sensitive to it. If a drug sensitive exists, the fact should be noted prominently. The careful physician also avoids drugs which might further complicate his patient's problems (51-56, 58, 59).

### **2.3. The selection of drugs**

There are several important principles in the selection of drugs. First, the physician should employ drugs with which he is familiar, both in terms of beneficial effects and possible side effects or reactions (53, 54, 55, 58, 59, 67).

The physician should select a small number of agents to handle the various therapeutic problems, read about them, and use them primarily. Over a period of time, he can develop a broad background of experience with a small number of drugs, rather than fragmentary knowledge of many drugs.

If a new preparation clearly provides a therapeutic effect which has not been obtainable with drugs already available, its use is indicated at an early date. On the other hand, if the drug appears to do no more than

older medications, it is good judgement to use the older preparations, which are likely to be both cheaper and safer. With most drugs, as experience accumulates, the therapeutic claims become more modest, and various kinds of toxicity, previously unsuspected, become manifest. One legitimate situation for using a new drug, however, is when older preparations have failed to produce the desired results in a given patient.

The physician must satisfy himself that a drug's claim of superiority to others already available are justified by the evidence at hand (51, 52, 53, 55-67).

### **2.4. Experimental medicine, therapeutics and bioethics**

Over a century ago Claude Bernard formalized criteria for gathering valid information in experimental medicine, but application of these criteria to therapeutics and to the process of making decisions about therapeutic has until recently, been slow and inconsistent. At a time when the diagnostic aspects of medicine had become scientifically sophisticated, therapeutic decisions were often on the basis of impressions and traditions. Historically, the absence of accurate data on the effects of drugs in man was in large part due to ethical standards of human experimentation. „Experimentation“ in human beings are precluded, and it was not generally conceded that every treatment by any physician was and should be designed and in some

sense recorded as an experiment (52, 53, 55, 56, 59 67).

Although there must always be ethical concern about experimentation in man, principles have been defined, and there are no longer ethical restraints on the gathering of either experimental or observational data on the efficacy and toxicity of drugs in adults. Therapeutics must now be dominated by objective evaluation of an adequate base of factual knowledge.

### **2.5. Scientific methods, experimental therapeutics and clinical trials**

Application of the scientific methods to experimental therapeutics is exemplified by a well-designed and well-executed clinical trial. To maximize the likelihood that useful information will result from the experiment, the objectives of the study must be defined, homogeneous populations of patients must be selected, appropriate control groups must be found, meaningful and sensitive indices of drug effects must be chosen for observations, and the observations must be converted into data and then into valid conclusions. A number of excellent, critical summaries of the scientific requirements for clinical trials have been published (6, 7, 8, 36, 51, 52).

The *sine qua non* of any clinical trial is its control. Selection of a proper control group is as critical to eventual utility of an experiment

as the selection of the experimental group.

There are several special considerations in the design of clinical trials if they are to be used to compare the relative effects of alternative therapies:

1. Specific outcome of therapy that are clinically relevant and quantifiable must be measured.
2. The accuracy of diagnosis and the severity of the disease must be comparable in the groups being contrasted; otherwise, false-positive and false-negative errors may occur.
3. The dosages of the drugs must be chosen and individualized in a manner that allows relative efficacy to be compared at equivalent toxicities or allows relative toxicities to be compared at equivalent efficacies.
4. Placebo effects, which occur in a large percentage of patients, can confound many studies – particularly those that involve subjective responses; controls must take this into account.
5. Compliance to the experimental regimens should be assessed before subjects are assigned to experimental or control groups.
6. Ethical considerations may be major determinants of the types of controls that can be used must be evaluated explicitly. For example, in therapeutic trials that involve life-threatening diseases, the use of a placebo is unethical, and new treatments must be compared with „standard“ therapies (7, 36, 30).

### **2.6. Clinical diagnosis and the cultivation of a proper relationship with the patient**

The physician should be aware, that exciting advances in medicine sometimes create serious new problems. Our therapy makes use of powerful drugs, all of which can harm. Few hospital patients receive less than half a dozen different medications. In addition to intrinsic toxicity, these can interact with each other to produce unwanted effects. Knowing when to stop a certain treatment is as important as knowing when to bring it into use. One of the most important qualities needed by today's physician is ability to restrain curiosity. We should adhere to the rule that a potentially injurious diagnostic and therapeutic procedures should be carried out only when its possible benefit to that patient justified the risk. A test should never be done just for the sake of „thoroughness“...

Now finally, we must not only study the factual basis of clinical diagnosis and treatment, but at the same time work toward an equally difficult goal: *Cultivation of a proper relationship with each of our patients.*

Concluding our few remarks to *some ethical problems of pharmacotherapeutics* we would like to recall *a great ideas of Albert Schweitzer (51):*

*„These is no higher religion than human service. To work for the common good is the greatest creed.“*

### **3. DISCUSSION**

Since the beginnings of the Bioethics movement, a plurality of ethical theories have been used as a foundation for medical ethics. One approach just beginning to be examined is the grounding of medical ethics in a philosophy of the physician-patient encounter (63-66). On this view the phenomena of being ill, being healed and promising to heal are taken as the starting points for ethical reflection. An ethics based in the clinical encounter promises to be more closely related to the concrete experiences of doctor and patient than the application of pre-existing ethical theories (65, 62).

Medical ethics, the ethics of the physician as physician, has been the subject of systematic philosophical inquiry for only a quarter of a century (64). Before that, medical ethics was grounded in a set of moral precepts freely and unilaterally asserted and derived from Oath and Ethos of the ancient Hippocratic school. In recent years, philosophers have begun intensively to question these moral groundings and each of the precepts drawn from there (78). As a result, many today question whether any enduring moral foundation for medical ethics beyond societal or professional consensus is tenable.

To be sure, there have been proposals aplenty to substitute for, or replace, the traditional groundings. They vary with the particular philosophical stance one

takes as the analytical tool~ deontology~ consequentialism~ prima facie principlism~ Aristotelian or Thomistic virtue theories~ feminist, caring, narrative, or casuistic philosophies~ etc. (16). These theories and others have been applied intensively to medicine, clinical dilemmas, and professional conduct. The resulting moral diversity is simultaneously salubrious and confusing, but also philosophically interesting (6, 11, 2, 1, 3).

On the salubrious side is the opening of the previously protected sanctuary of physician-patient relationship to moral scrutiny (9, 5, 10, 13, 8). This was inevitable in an era of self-determination when medical ethics has become everybody's concern. How physicians conduct themselves in the face of the universal human experiences of illness and healing is of universal interest. Medical ethics cannot responsibly ignore the unprecedented scientific, societal, and political challenges posed in our times to the traditional accounts of physician-patient interrelationships (13, 16, 12, 15).

On the confusing side are the conflicting moral precepts, divergent answers to moral dilemmas and variant justifications so many different theories of ethics can generate. The fact of moral diversity and philosophical pluralism notwithstanding, can so many opposing views all be true? Or, must

we, as the post-modernists insist, give up any notion of a generalizable foundation for medical ethics and settle for what eventuates from the practices or social constructions of the moment? (18, 17, 16, 20, 24).

Few would argue for the traditional method of free moral custom found in professional codes. But not all would agree that there is no need for, or deny the possibility of, a durable philosophical foundation for medical ethics or the philosophy of medicine (62-66). For many the question remains: Now that the moral assertions of the past have been challenged, how do we deal with the fractured foundation? The questions posed by today's moral philosophers cannot be ignored. But there are too many perils in an easy acquiescence to coherence, social constructivist, or dialogical ethics to justify them as the only or the best answers (25, 32, 29, 22, 21, 23). In the long term, foundations cannot be avoided. However we designate it, some philosophical theory will be used to justify particular moral choices - even if that theory holds that no foundation is conceptually tenable (41, 26, 19, 37, 28, 45, 44). The central problematic is how to deal with the fragment of the fractured foundation. Can the insights of a quarter of a century of philosophical inquiry be assimilated without following that inquiry to its current deconstructionist conclusion? Beneath and beyond the skepticism of contemporary moral philosophy so far medical ethics is concerned,

there is an undeniable reality (25, 31). That reality is the encounter between one human person who is ill and seeks assistance and another person who freely professes to be able to heal. The patient's predicament and the professional's response to that predicament center in another reality – the intersection of the life-worlds of doctor and patient within which the acts of medicine take place. If we can understand something of this intersection, we can grasp more firmly the origins and essence of the moral encounter which makes medicine the special kind of human activity it is or should be (35, 31, 32, 36).

In the Life-world of doctor and patient, two persons encounter each other in a specific way distinct in part, though not wholly, from other types of personal relationship. The patient comes to the physician because he feels „sick“. He has detected some aberration in his body or psychic functioning that he considers „abnormal“, i.e., a deviation from his usual or expected functioning. Whatever that aberration may be – some symptom, some sign, some affective state – the person's perception of health, well-being or normality is put into question. The patient may for a time minimize, deny, or try to cope with, or treat, this new predicament but if it persists, worsens or causes anxiety, that predicament effects a change in the existential and experiential state of the sick person (61, 34, 43, 46, 60).

From a state of well-being, the person enters a state of illness

whether demonstrable disease is present or not. To be „sick“ is literally a statement of dis-ease – a loss of well being characterized by a constellation of changes in Life-world and lived body (61, 47, 49, 62). Anxiety about the meaning of the sign or symptom takes place of „ease“. What does this encounter mean? It is serious? Will it mean death, disability or inability to do what I want to do? Immediate and future plans are put on hold, or if pursued, they are approached warily and fearfully, with uncertainty that they will be fulfilled as anticipated. How the patient's life world will be reassembled is an open question neither patient nor physician can fully answer in the first stages of their encounter. The person altered by illness asks if he is the same person who became ill. He does not know if he will ever be again that person (48, 50, 38, 40, 39).

By „going to the doctor“ the patient is now dependent on the doctor's authoritative knowledge and his perception of the patient's experience of illness. Indeed, the patient invites the physician to enter his life-world, just as the physician offers to enter that world by his offer to heal. The life-worlds of doctor and patient inter-penetrate each other. Their relationship is conditioned henceforth by intersubjectivity. This is the moment of clinical encounter, the confrontation of one human person bearing the burden of illness seeking to be healed by another human person possessed of the knowledge and skill needed by the

sick person in search of healing. This is an encounter between the life-worlds of two persons who up to the moment of confrontation were strangers independent of each other. Now, they are intimately enmeshed with each other in the most intimate and special sorts of ways, some of which may make for a healing relationship and some for a harming one. How each of these perceptions is manifest in any particular person is a reflection of the uniqueness of that person. Yet this location can never be complete (72, 70, 68).

The patient's life-world is lived in intersection with the life-worlds of all who live in relationship with him. Family, friends, other clinicians also become enmeshed in the patient's world via the reality of sickness and disease. The meaning of illness to each person therefore will differ as it is interpreted in the infinity of variations possible in individual life-worlds. No two persons experience the predicament of illness exactly the same way. No life-world is exactly congruent with any other (73, 71). Nevertheless, there is a sense in which the alterations in life-worlds can be generalized, as a universal human experience. For even as there is uniqueness there is also commonality, since the life-world is a human creation and certain responses in that world are typified as „human“ responses (77, 74, 79).

When we turn to the life-world of the physician, we begin with a very different perspective horizon. The physician is well and therefore

occupies a radically different world from the patient. Even if he is ill himself, he prescind, at least in part, from that illness when he acts a healer. He retains his freedom to act, limited by the science and ethics of medicine but not by his own disability. The disabled physician remains able to heal – sometimes even more sensitively than the non-handicapped. If he were disabled or ill to the point that he could not exercise his healing functions the physician would be disqualified as a healer. The physician's conduct is held within bounds by an ethical commitment that requires a certain suppression even of his legitimate self interest (80, 81, 83). The physician's life-world is constituted by all those things that derive from his private and personal life as they are transmuted by being a physician, as one committed to healing the sick. For every physician there is a unique mix of personal and cultural realities with the ethical, social and cultural meaning and requirements of being physician. How each physician balances these personal, professional and psycho-social modalities is just as unique as the patient's balance (80, 82). The physician differs from the patient in that the balance he has struck is not at issue as it is with the patient. In their shared world, he is not in the vulnerable, exploitable, dependent, relatively powerless state of the patient. He is the professional freely offering to „help“ the patient. It is true that he may be a „wounded healer“, but he is a healer nonetheless – even when his own vulnerability is part of his life-world

(78, 35, 76, 73). In making this profession, the physician also invites trust - in his knowledge, his competence and his character. The physician invites this trust and makes his promise of competence in the presence of another human person who is in the altered existential state we call sickness, with all the alternations of life-world. The patient is not just playing a „sick role“, he is now fashioning that role, creating it as he re-creates his whole life world. That person is vulnerable, dependent, anxious and eminently exploitable should the physician be a vicious and not a virtuous person. The patient, for his part, is forced to trust the physician even if he wishes not to do so. At least he must submit even if he does not trust - if he wishes to be healed by this doctor (11, 5, 26, 24).

The doctor and patient's life-worlds intersect in countless, complex ways, each of which may affect the success of the healing relationship. In an effective healing relationship these two different life-worlds must somehow interact positively around the common intention of healing which is the end or telos of their mutual clinical encounter (25, 28, 29). Both physician and patient expect healing to be the intentional focus of their encounter. Each share intentionality with reference to healing - the telos of the encounter. For both this means making the patient „whole“ again, repairing the damage to bodily or mental integrity, restoring the state of well-being or, if this is impossible, ameliorating the

impact of sickness and disease. This healing is the „act“ of medicine in which patient and physician come together. In a sense they heal together since the patient's cooperation with technically right and morally good clinical decision is essential. What is technically right derives from whatever there is of science and manual skill in medicine. What is morally good is a far more complex aim. It is the intersubjective apprehension of what is healing and what is harming to this patient that is crucial (62-65, 68). Then, knowing what medicine is, some statement can be made about the moral obligations of those who profess to practice it (35).

The telos of medicine is healing, and medicine qua medicine is that set of human activities that has as its end and purpose - both for doctor and patient- that act of healing, of „making whole again“. In the clinical encounter, the telos is a right and good healing action for this patient (61, 6, 14, 35). The doctor needs privileged access to the life-world of the patient, a truthful rendition of the impact of sickness, if he is to heal. In the same way, intellectual honesty, truthfulness, courage, suppression of self-interest, and compassion can be shown to be virtues entailed by the telos of medicine as well as by the interplay of life-worlds of doctor and patient (35, 31). These virtues are always understood implicitly and intersubjectively. Just how they are understood in a particular physician or patient encounter lies in the intersubjective world - patient and

doctor enter in the intimacy of their unique clinical encounter (35, 65, 43, 38, 36).

Thus, through the telos of medicine – the defining point of a philosophy of medicine – and the virtues entailed by that telos, a philosophy of medicine and an ethic of medicine are joined. Once apprehended, a philosophy and ethic of medicine can be grounded „internally“ – i.e., in recognition of the nature of medicine as it is revealed in its essential form in the phenomena of the clinical encounter. As suggested elsewhere, we can then also grounded the prima facie four principles of beneficence, justice, non-maleficence and autonomy in clinical realities, as well as the duties and obligations of both doctor and patient (60).

#### 4. CONCLUSION

Medicine is the most revolutionary of human technologies. It does not sculpt statues or paint paintings: it restructures man and man's life. In short, medicine is not merely a science, not merely a technology. Medicine is a singular art which has as its object man himself. Medicine

is the art of remaking man, nor in the image nature, but in his own image~ medicine operates with an implicit idea of what man should be. The more competent medicine becomes, the more powerful it is, the more able it is to remake man, the more necessary it consequently becomes to understand what medicine should do with its competence.

The relationship between patient and physician is unique in a number of ways, and is among the most intimate and certainly most delicate among persons (51). Because of its inherent inequality (of condition and awareness) and structural asymmetry (of power, knowledge, resources, legitimation), the relationship is especially fragile and exposed to constant dangers and temptations: manipulation and coercion, improper intimacies, and therapeutically compromising forms of remoteness, among others. Whatever else may be said about the interpretive disciplining of medical intelligence, therefore, it must surely include its being understood and practiced as a fundamentally moral discipline.

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#### REFERENCES

1. ARRAS, J. 1991. Getting Down to Cases: The Revival of Casuistry in Bioethics. *Journal of Medicine and Philosophy* 16: 29-51.
2. BAUMGARTEN, E. 1980. The concept of „competence“ in medical ethics. *Journal of Medical Ethics* 6: 180-184.
3. BAYERTZ, K. 2002. Warum moralisch sein? Ferdinand Schöningh, Paderborn, 285 pp.
4. BEAUCHAMP, T., L., CHILDRESS, J., L., 2000. *Principles of Biomedical Ethics*. 5<sup>th</sup> Ed., New York: Oxford University Press.
5. BEDELL, S. E. & DELBANCO, T. L. 1984. Choices about cardiopulmonary resuscitation in the hospital. *New England Journal of Medicine* 310: 1089-1092.

6. BEECHER, H. 1966. Ethics and clinical research. *New England Journal of Medicine* 274(24): 1354-1360.
7. BEESON, P.B., McDERMOTT, W., WYNGAARDEN, J.B., 1979. *Cecil TEXTBOOK OF MEDICINE*. Fifteenth Edition. W.B. Saunders Co., Philadelphia, pp. 2356 + i CXIX.
8. BENNER, P. 1997. A Dialogue between Virtue Ethics and Care Ethics. *Theoretical Medicine* 18: 47-61.
9. BERGLER, J. C. ET AL. 1980. Informed Consent: How much does the Patient understand? *Clinical Pharmacology and Therapeutics* 27(4): 435-440.
10. BIGGAR, N. 1989. A Case to Casuistry in the Church. *Modern Theology* 6: 29-51.
11. BOORSE, C. 1977. Health as a theoretical concept. *Philosophy of Science* 44: 542-573.
12. BOYLE, J. 1997. Just and Unjust Wars: Casuistry and the Boundaries of the Moral World. *Ethics and International Affairs* 11: 83-98.
13. BRODY, B.A. 1990. Quality of Scholarship in Bioethics. *Journal of Medicine and Philosophy* 15(2): 161-178.
14. BRODY, H. 1989. Transparency: Informed Consent in primary care. *The Hastings Center Report* 19: 5-9.
15. BRYAN, C. 2000. Promoting professionalism: a primer. *Journal of the South Carolina Medical Association* 96: 421-427.
16. CAPLAN, A. 1992. Does the philosophy of medicine exist? *Theoretical Medicine* 13(1): 67-77.
17. CARSE, A.L. 1991. „The Voice of Care“: Implications for Bioethical Education. *Journal of Medicine and Philosophy* 16: 5-28.
18. CASSELL, E. J. 1982. The nature of suffering and the goals of medicine. *New England Journal of Medicine* 306: 639-645.
19. CLOUSER, D. K. & GERT, B. 1990. „A Critique of Principlism“. *Journal of Medicine and Philosophy* 15: 219-236.
20. CLOUSER, D.K. 1995. Common Morality as an Alternative to Principlism. *Journal of the Kennedy Institute of Ethics* 5: 219-236.
21. CORLETT, J. A. 2001. Is There A Moral Duty to Die? *Health Care Anal.* 9(1): 41-63.
22. COUSINS, N. 1988. Intangibles in Medicine: An attempt at a balancing perspective. *Journal of the American Medical Association* 260(11), September 16: 1610-1612
23. DOLISTA, J. & VURM, V. 2004. *Vybrané kapitoly z biotiky (aspekt filozofický)*. 1. vydání . Jihoèeská univerzita v Èeských Budì jovicích. 70 pp.
24. DOLISTA, J. 2003. *Solidarita a pø ijetí odpovì dnosti za vlastní zdraví . KONTAKT, CZ, Universitas Bohemiae Meridionalis Budovicensis* 4: 249-251.
25. DRANE, J. F. 1985. The many faces of competency. *The Hastings Center Report* 15: 17-21.
26. DRANE, J. F. 1984. Competency to give informed consent. *Journal of the American Medical Association* 252: 925-927.
27. ELLSWORTH, A. J. ET AL. 2003. *Mosby's 2004 Medical Drug Reference*. C. V. Mosby, 1248 pp.
28. ENGELHARDT, H.T., JR. 1995. Towards a Christian Bioethics. *Christian Bioethics* 1: 1-10.
29. HAŠ KOVCOVÁ, H. 1997. *Lékaø ská etika*. 2. doplnì né a pø epracované vydání . Praha: Galén & Karolinum, 192 pp.
30. HARDMAN, J.G. ET AL. 2001. *Goodman & Gilman's The PHARMACOLOGICAL BASIS OF THERAPEUTICS*. 10<sup>th</sup> Edition. McGRAW-Hill Professional, 1825 pp.
31. HOLM, S. 1995. Not Just Autonomy – The Principles of American Biomedical Ethics. *Journal of Medical Ethics* 21: 332-338.

32. JANKOVSKÝ, J. 2003. Etika pro pomáhající cí profese. TRITON, Praha, 223 pp.
33. JONSEN, A.R. 1991. Casuistry as Methodology in Clinical Ethics. *Theoretical Medicine* 12: 299-302.
34. JONSEN, A.R. 1995. Casuistry: An Alternative or Complement to Principles. *Journal of the Kennedy Institute of Ethics* 5: 246-247.
35. KAPLAN, S. H., GREENFIELD, S. & WARE, J.E. 1989. Assessing the effects of physician – patient interaction on the outcomes of chronic disease. *Medical Care* 27: 110-127.
36. KASPER, L.D. ET AL. 2004. *Harrison's Principles of Internal Medicine*. 16<sup>th</sup> edition. McGraw-hill Professional, 2607 pp.
37. KEENAN, J. 1993. The Function of Double Effect. *Theological Studies* 54: 294-315.
38. KHUSHF, G. 1998. A radical rupture in the paradigm of modern medicine: conflicts of interest, fiduciary obligation, and scientific ideal. *Journal of Medicine and Philosophy* 23(1): 98-122.
39. KHUSHF, G. 2004. *Handbook of Bioethics: Talking Stock of the Field from Philosophical Perspectives*. Kluwer Academic Publisher, Dordrecht, 568 pp.
40. LAVORI, P.J., SUGARMAN, J., HAYS, M. & FEUSSNER, J. 1999. Improving informed consent in clinical trials: A duty to experiment. *Controlled Clinical Trials* 20: 187-193.
41. LEEB, D., BOWERS, D.G. & LYNCH, J. B. 1976. Observations on the myth of informed consent. *Plastic Reconstructive Surgery* 58: 280-282.
42. LITTLE, M. O. 1995. Seeing and Carrying: The Role of Affect in Feminist Moral Epistemology. *Hypatia* 10: 117-137.
43. LOEWY, E. H. 1997. *Developing Habits and Knowing What Habits to Develop. A Look at Virtue in Ethics*. Cambridge Quarterly of Healthcare Ethics 6: 347-355.
44. MACKEY, T. 2003. An Ethical Assessment of Anti-Aging Medicine. *J. Anti. Aging Med.* 6(3): 187-204.
45. MCNAMARA, K. 2001. The status of physicians in the 20<sup>th</sup> century. *Journal of the South Karolina Medical Association* 97: 522-525.
46. MCPHEE, S. J., LINGAPPA, W. R. & GANONG, W.F. 2002. *Pathophysiology of Disease*. 4<sup>th</sup> Edition. McGraw-Hill Medical, 760 pp.
47. MEISEL, A. 1988. A dignitary tort as a bridge between idea of informed consent and the law of informed consent. *Law, Medicine and Health Care* 16(3-4): 210-218.
48. MEISEL, A. & ROTH, L. H. 1981. What we do and do not know about informed consent. *Journal of the American Medical Association* 246(21): 2473-2477.
49. MEISEL, A. 1981. The „exceptions“ to informed consent. *Connecticut Medicine* 45: 27-32.
50. MORREIM, E. H. 1983. Three concepts of patient competence. *Theoretical Medicine* 4: 231-251.
51. NOVOTNÝ, J, 1997. Do we need Scientific, Technologic, Ethical and/or Humanistic Qualities of Today's Physician? *J. Health Man. Public Health* Vol. 2, No. 2: 34-44.
52. NOVOTNÝ, J. & NOVOTNÝ, M., 1999. Adverse drug reactions to antibiotics and major antibiotic drug interactions. *Gen. Physiol. Biophys.* 18, Focus Issue: 126-139.
53. NOVOTNÝ, J. & NOVOTNÝ, M.. 2000. Drug nephrotoxicity and its prevention. *BIOLOGIA Bratislava*, 55/Suppl. 8: 95-102.
54. NOVOTNÝ, J., 1998. Monitorovanie hladín liekov u onkologických pacientov. *Folia Universitatis Tyrnaviensis* Vol. 5, No.1: 53-57.

55. NOVOTNÝ, J., 1999. Nozokomiálne infekcie a antibiotiká, p. 47-81. In: Olejní k, J. a kol., Perioperačná starostlivosť. Bratislava: EBNER.
56. NOVOTNÝ, J., 1999. Pharmacoeconomics: principles, methods and application to pharmacotherapy. *J. Health Man. and Public Health* No. 4(1): 36-42.
57. NOVOTNÝ, J., 2001. Procalcitonin – an innovative diagnostic and prognostic parameter of septicaemia. *J. Anästhesie u. Intensivbehandlung* Nr.2: 73.
58. NOVOTNÝ, J., 2005. Toxikológia. In: Kováčik, G. et al. *Základy racionálnej klinicko-biochemickej diagnostiky*. Bratislava: PARTNERS, in press.
59. NOVOTNÝ, J., ŠTEĽO, J. & NOVOTNÝ, M. 1999. Rehabilitation of the tumour patients in neurosurgery. *J. Health Man. and Public Health* No. 3-4: 53-64.
60. NOVOTNÝ, M., NOVOTNÝ, J. & PØIBYL, H. 2005. Some ethical problems of pharmacotherapeutics. *Biologia*, Bratislava 60 (Suppl. 8): in press.
61. PEABODY, F. W. 1927. The Care of the Patient. *Journal of the American Medical Association* 88: 877-882.
62. PELLEGRINO, E. D. & THOMASMA, D. C. 2000. Dubious Premises – Evil Conclusions: Moral Reasoning and the Nuremberg Trials. *Cambridge Quarterly of Healthcare Ethics* 9: 261-274.
63. PELLEGRINO, E. D. 1979. Toward a reconstruction of medical morality: The primacy of the act of profession and the fact of illness. *Journal of Medicine and Philosophy* 4(1): 32-56.
64. PELLEGRINO, E. D. 1993. The metamorphosis of medical ethics: A 30-year retrospective. *Journal of the American Medical Association* 269(9): 1158-1163.
65. PELLEGRINO, E. D. 1995. Toward a Virtue – Based Normative Ethics for the Health Professions. *Journal of the Kennedy Institute of Ethics* 5(3): 253-277.
66. PELLEGRINO, E. D. 1998. What the philosophy of medicine is? *Theoretical Medicine and Bioethics* 19(6): 315-336.
67. PICKERING, G. W., 1977. Medicine at the crossroads: Learned profession or technological trade union? *Proc. Roy. Soc. Med.* 70:77.
68. RAFNSDOTTIR, G. L. & GUDMUNSDOTTIR, M. L. 2004. New Technology and Its Impact on Well Being. *WORK* 22(1): 31-39.
69. RENÖCKL, H., 2003. Vysoce výkonná medicína a křesťanská etika. *Kontakt* Vol. V.(2), p. 56-63.
70. ROWE, J. A. 2000. Accountability: A Fundamental Component of Nursing Practice. *British Journal of Nursing* 9: 549-552.
71. SCULLY, J. L., RIPPBERGER, C. & REHMANN-SCUTTER, C. 2004. Non-professionals' evaluation of gene therapy ethics. *Soc. Sci. Med.* 58(7): 1415-1425.
72. SHERLOCK, R. 1984. Competency to consent to medical care: Toward a general view. *General Hospital Psychiatry* 6: 71-76.
73. SCHLOTZHAUER, A. V. & LIANG, B. A. 2002. Definitions and Implications of Death. *Hematol. Oncol. Clin. North Am.* 16(6): 1397-1413.
74. SPINOZA, DE B. 2001. *ETIKA*. (Czech edition, translation by Karel Hubka, 1977), Dybbuk Publishing, 271 p.
75. STRAUSS, O., 1991. *Rekvieem za živých*. Bratislava: Slovenský spisovateľ 238 pp.
76. TOLLEFSEN, C. 2000. Embryos, Individuals and Persons: An Argument Against Embryo Creation and Research. *Journal of Applied Philosophy* 18: 65-78.
77. UHLMANN, R. F., PEARLMAN, R. A. & CAIN, K. C. 1988. Physicians and spouses predictions of elderly patients resuscitation preference. *Journal of Gerontology* 43: 115-121.

78. VEATCH, R. & MASON, C. 1987. Hippocratic vs. Judaeo-Christian Ethics: Principles and Conflict. *Journal of Religious Ethics* 15: 86-105.
79. VEATCH, R. M. 2001. Ruth Macklin: Against Relativism: Cultural Diversity and the Search for Ethical Universals in Medicine. *Theoretical Medicine* 21: 385-392.
80. WAITZKIN, H. 1984. Doctor-patient communication: Clinical implications of social scientific research. *Journal of American Medical Association* 252(17): 2441-2446.
81. WALLACE, L. M. 1986. Informed consent to elective surgery: The therapeutic value. *Social Science and Medicine* 22: 29-33.
82. WEAR, S. 1991. The Irreducibly Clinical Character of Bioethics. *The Journal of Medicine and Philosophy* 16: 53-70.
83. WELLIE, J. V. M. 1999. Towards an Ethics of Immediacy: A defence of a noncontractual foundation of the caregiver-patient relationship. *Medicine, Health Care and Philosophy* 2(1): 11-19.

**გვჭირდება თუ არა ეთიკა ბიოეთიკასა და  
კლინიკურ მედიცინაში?**

**მედიცინის მეცნიერება, ხელოვნება და ექიმი-პაციენტის ურთიერთობები**

**იოზეფ ნოვოტნი**

მრავალ მოაზროვნეს გამოთქმული აქვს საკუთარი მოსაზრება ექიმი-პაციენტის ურთიერთობების შესახებ. სამედიცინო ცოდნის (დიაგნოზი, მკურნალობა და პროგნოზი) პრაქტიკული გამოყენება არანაირად არ შეიძლება განვაცალკევოთ თანამედროვე მეცნიერებისა და თეორიის საფუძვლებისაგან. თეორიისა და პრაქტიკის ხედვა განუყოფელია ერთმანეთისაგან, რადგანაც მხოლოდ გამოყენებითი მეცნიერული მიდგომა ყოველთვის წარმატებული არ არის. ცვლილებები ბუნებაში და ცოდნაში ურთიერთგანუყოფელია. ამავე დროს, მედიცინის თეორია და პრაქტიკა უკავშირდება დიაგნოზს, მკურნალობას და პროგნოზს, რაც, რა თქმა უნდა, პრაქტიკული ასპექტებია. ამდენად, ძალიან მნიშვნელოვანია პრაქტიკისა და თეორიის ურთიერთდაკავშირების აუცილებლობა, რაც – “მედიცინის საფუძველი და მისი ორიგინალური წყლილია”.

## INFORMED CONSENT OF THE PATIENT IN THE CZECH REPUBLIC IN CONNECTION WITH THE CONVENTION ON HUMAN RIGHTS AND BIOMEDICINE

Jana Samková<sup>1</sup>

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### ABSTRACT

Dynamical development of science and development of protection of human rights in modern international agreements. The Czech Republic as a signatory of the Convention on Human Rights and Biomedicine with concentration on the right of informed approval of the patient with medical procedure.

### Key words

*human rights – international agreements – Convention on Human Rights and Biomedicine – Czech Republic and human rights – patient – informed consent*

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### 1. INTRODUCTION

The dynamical development taking place since the 20th century in the sphere of biology and medicine, both in the sphere of scientific research and in the sphere of medical practice, produces concerns in broad public of a lot of countries fearing that man will become only an object of scientific and medical operation without rights (2). More and more people feel real danger that new possibilities of manipulation with human being will lead to questioning or even denying human dignity (26).

As an antipole to these fears, international effort works on the field of elaboration of fundamental directives for legislations of member countries of Council of Europe that could become inspiration for further community of the world. One of such directives is the international document “Convention for

Protection of Human Rights and Dignity of Human Being in Connection to Application of Biology and Medicine”.

A part of the above mention Convention is the approval of the patient with medical procedure further to his information by the doctor and by health care staff; this approval is very lively discussed in broad professional and lay public at present.

One of the basic human rights is to observe the right of the patient to decide about his/her own fate during providing health care (5).

Execution of any procedure is conditioned by consent of the patient who must be informed properly and clearly of the essence of the procedure, its consequences and risks in advance. Conditions of execution of procedures in different situations are defined when the

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patient is not capable or not able to decide freely. Special attention is dedicated to the protection of mentally sick persons, to emergency requiring urgent solutions and to wishes expressed previously (27).

## **2. HUMAN RIGHTS THE BASIC NEEDS OF MODERN PERSON**

### **2.1. Need of law**

The need of law and its systematic fulfillment should reflect, fulfill and satisfy basic needs of modern person. The law becomes a need we become aware of, recognizing and respecting it in other people as well. We see the need of law clearly in social context of integration of the individual in the life of the society. It can be said generally that where rights of one person end, rights of other person begin (3).

### **2.2. Human rights**

Human rights can be generally defined as such rights that are inseparable from our environment and without that we could not live as human beings. They allow us to develop and to use fully our human qualities, our intellect, our abilities and our mind and to satisfy our spiritual and other needs. They are based on the increasing demand of mankind to lead life in which basic dignity and value of each human being obtain respect and protection (8).

The best known means and tools of implementation of human rights are democracy, tolerance and

international understanding. The aim of their effect is a world of law and peace, that has not existed in modern history of the Earth but that represents a positive life perspective for its inhabitants (7).

### **2.3. International documents on human rights**

International documents on human rights are a widespread way, and today we can state that they are, at the same time, a well-trying way to declare the will of protection of rights and liberties of man over the scope of individual countries and communities (28).

Human rights and liberties are protected by a series of international documents elaborated by different international organizations, as the United Nations Organization, Council of Europe, European Union and others (6). The development of these declarations fulfills gradually the concepts of equality and represents the humanist sense of modern democracy (9).

International agreements in general, and in the sphere of human rights in particular, should serve to create the necessary commitments for member states. In this sense, we can distinguish two categories of commitments. Ones can be characterized as absolute and immediately realizable, others as relative and gradual (13, 14).

In the conventions, an essential non-discriminatory article is declared,

establishing unequivocally that no reason can and may lead to discrimination of the individual in implementing rights and liberties. These are for example skin color, race, sex, religion, property, political or other beliefs, national or social origin or other status.

This provision has an extraordinary significance for each convention or for the whole code (29). But it must be understood that the duty of non-discrimination has also its limits and that it cannot be applied absolutely. The distinguishing line between just and unjust discrimination must therefore be objective, it must have a rationally justifiable aim and it must be reasonable and ensure adequacy between the applied means and aims that should be reached (5).

#### **2.4. Convention for Protection of Human Rights and Dignity of Human Being in Connection to Application of Biology and Medicine**

The Convention on Human Rights and Biomedicine ranks among historically youngest international documents elaborated by the Council of Europe.

As the introduction to the Convention on Human Rights and Biomedicine states, in international context the Convention on Human Rights and Biomedicine and its amendment protocols are not alone. The reminiscences of brutal abuse of medical sciences in inhuman experiments on people during World

War II, carried out under the motto of "pure Nordic race", provoked urgent need of international protection for the future and stressed the effort to prevent manipulation with people for the purposes of development of medicine. The first step was the Nurnberg Codices from 1947 and Helsinki Declaration of the World Medical Association in 1964. The conclusions of the conferences held in Tokyo 1975 and Manila 1980 confirmed that man is not and cannot be object of science and health care, but that he has himself the right to decide about his fate, including the right to refuse medical care and to decide of dignified dying (Копейна нбврh smlouvy, 2001).

In connection with the development of science that knows no limits, eminent need has arisen, the need to unify the existent standards and views in this sphere of law on international field. This need has lead the countries to the persuasion that it is necessary to concentrate on this sphere of human rights in the scope of the Council of Europe. In 1991, the Committee of Experts for Bioethics was established and entrusted by the Committee of Ministers to elaborate, in cooperation with the Committee for Human Rights and the European Committee for Public Health of the Council of Europe, a general convention defining general standards for protection of biomedical sciences (36).

The aim of the Convention is to guarantee untouchability of his

rights and basic liberties to each individual and to guarantee him dignity and peculiarity without making impossible the progress in science and research (17). So the Convention is the first legally binding international tool reflecting the present development in the sphere of biology and medicine. But it expresses, at the same time, the need to use this progress exclusively to the benefit of man, both of present and of future generations. The convention concretizes some general principles contained in the European Convention for Protection of Human Rights and Basic Liberties, as liberty to decide of own fate and body and right to protection of privacy and integrity. The principles and rules contained in the Convention concern not only individuals, but also the benefit of society and mankind as a whole, but protection of interests and welfare of the individual are considered as superior over the interests of society and science. The signatory countries commit themselves to integrate these principles and rules into their legal order. But the states are not prevented from providing higher protection of rights in the scope of their jurisdiction than it is established by the Convention (MZ UR, 2000).

The Convention was opened to signature on April 4<sup>th</sup>, 1997 in the Spanish Oviedo (after this, it is also called the Oviedo Convention); the Czech Republic signed it on June 24<sup>th</sup>, 1998. The Convention entered in force after ratification by five

member states of the Council of Europe on December 1<sup>st</sup>, 1999. Any member state of the Council of Europe, non-member state that took part in the preparatory work (Japan, Canada, Vatican, the USA), but also the European Union can join the convention. The Convention is subjected to ratification, acceptance or approval. The depository of the Convention is the Secretary General of the Council of Europe (MZ UR, 2000).

## **2.5. Information of the patient and informed consent**

The information of the patient belongs to his basic rights. The doctors and the nursing staff sometimes do not consider the patient as a partner but as an object about that they decide by themselves and that does not need information. This approach often leads to useless disagreements between the patient and the nursing staff and sometimes even to complaints and negotiations of expert commissions (4).

Therefore strong stress should be put on improvement of the communication between the patients and the health care staff and on improvement of the information of the patient. A condition of accreditation of a medical institution is the introduction of the system of information of the patient and his family as well (32).

From the point of view of time development, particularly since the beginning of the Nineties, we have

been registering substantially increased stress on the autonomy of the patient in his decision taking about his own health, about the care or non-care for it and on creation of the necessary conditions (34).

In the Czech Republic, it can also be estimated from the medical-legal practice that the doctors get more legal problems, complaints, claims and lawsuits from insufficient communication with the patient and his family than from professionally incorrect procedure. Therefore, we consider appropriate communication of the doctor with the patient and his relatives as efficient prevention of legal problems that the doctor can face in executing his profession (Mach, 2004). Thus it is important to give attention to due enlightenment. When the patient has to express approval to therapeutic or examinational procedure, it is indispensable for him to know its essence (10).

Legal standards of the Czech Republic impose the doctor, besides the duty to instruct the patient, a conditioned duty to instruct also his family members about the character of his illness in an appropriate way. The answer to the question why the instruction of the family members is conditioned can be found in the Bill of Basic Rights and Liberties and in the provisions of the Civil Code regulating the personality protection. The provision of the § 11 of the Civil Code establishes, besides other personality rights, also the right to

privacy. Thus when the patient does not wish his family members to be informed of his health condition, this wish - expressed will - of him must be respected (12).

Under appropriate way of instruction we certainly imagine particularly its understandability, notably for a lay, choice of place and time of presentation (e.g. not during walking on the passageway of the institution), regard to emotional perception of the patient, his psychological disposition, definiteness of the data without mere allusions leading to speculations and different interpretation, necessary dose of patience of the instructor even in case of negative reaction of the patient etc. It depends on the skill and experience of the doctor to sense correctly all the circumstances and to proceed according to them. When he does not hit the target, it usually does not constitute his legal responsibility, but rather ethical one. The Ethical Codex of the Czech Medical Chamber stresses in the provision of the § 3 art. 4 the duty of the doctor to inform the patient responsibly and to instruct him, which means respect of the above mentioned principles.

According to the Convention on Human Rights and Biomedicine, each country must head to ensure fair access to health care in due quality to everybody. Any procedure must be carried out in accordance to the law and to professional standards. The methods must be in conformity with the

present development of knowledge, while observing the adequacy between the aim and the tools used (17).

Central place in the Convention is occupied by the principle of informed approval that implements liberty of decision taking and protection of benefit of each individual. Execution of any procedure is conditioned by consent of the patient who must be informed properly and clearly of the essence of the procedure, its consequences and risks in advance. Conditions of execution of procedures in different situations are defined when the patient is not capable or not able to decide freely. Special attention is dedicated to the protection of mentally sick persons, to emergency requiring urgent solutions and to wishes expressed previously (20).

No human being can be forced to undergo any procedure concerning his/her person without giving his/her consent to it (13). So, respect of the patient's wish is guaranteed. A responsible professional medical worker should give the patient optimal range of objective information about the procedure he is going to carry out, including possible consequences and alternatives. He is not allowed to pressure on the patient in any way. The patient should know all substantial facts concerning the procedure (18, 19). The information must contain the purpose, character and consequences of the procedure,

related risks - not only risks connected with the type of the intended procedure, but also individual risks according to each patient, as age, concurrence of other illnesses, civilization risks, e.g. overweight, smoking etc. All above mentioned attributes must be fulfilled for the validity of the consent. Besides, they must be communicated to the patient in such a form in that he is able to understand them (30).

The consent can be expressed or implied. Expressed consent can have written or oral form and depends particularly on the character of the procedure. Implied approval occurs when routine medical procedures are concerned (31).

Explicit, concrete consent occurs for example in case of participation at a research or consent to take a part of human body, organ or tissue for transplantation purposes (33).

The informed consent can be withdrawn any time and this decision must be respected. Nevertheless, this principle does not apply strictly in all cases. For example in case of withdrawal of consent to a procedure during its course, that would endanger the patient's life or health condition, the doctor is bound to complete the procedure (18).

The international document deals specially with protection of persons who, by their mental disability or

minority, cannot give consent, concretizing such cases in its articles 6 and 26 and defining emergencies in which the right to approval is limited (6). In Europe, different legal systems exist. In some countries, the ability of the patient to give informed consent is verified with each individual procedure, in some countries, the protection of the disabled is given by the law of legal disability according to which the person is declared disabled for one or more types of legal acts that can include consent (6). The Convention on Human Rights and Biomedicine lets it on internal national legal rules to carry out the informed consent in accordance to the law, while observing maximal possible protection of the patient and respecting protection of basic human rights and preventing discrimination.

For this reason, the document states a list of criteria when an adult person can be considered as a person incapable to give consent, according to internal national law. These are mental disorders, illnesses or coma, injuries and other urgent situations. Persons with mental disorders represent exception from the general rule of informed consent of adult persons because their ability to decide about the suggested treatment of mental disorder is limited just by the mental disorder. Under certain concrete conditions, they can be subject to treatment without their consent. The conditions consist of: presence and observability of mental disorder, the

procedure is related to treatment of mental disorder; when it is not related to it, it must be a procedure during treatment of serious somatic illnesses or cases (apendicitis, medicine overdose). Another condition is that without presence of treatment, the health would be probably seriously damaged, and that the measures established by the law for protection of these persons, e.g. protection by a judicial organ, must be observed (1).

In minor persons, the procedure can be carried out only with the informed consent of a parent, legal representative, person in authority or another organ determined by law. The opinion of the minors should be taken into consideration, its significance increases with the age of the child and his/her maturity level (6). This leads to the idea that the consent of the minor should be indispensable or at least sufficient for certain procedures. Member states must ensure that the child who is able to create his/her own opinions is guaranteed the right to express these opinions freely in all issues concerning him/her, while the opinions of the child are attached importance according to age and maturity of the child (6). In spite of that, even in persons unable to give informed consent, maximal possible information of the patient about the intended procedure is recommended (Mach, 2004).

In emergencies, e.g. patient in coma, procedures that cannot be postponed and are executed for direct benefit of

the patient, conflict of two duties can occur - i.e. to provide medical care and at the same time to ask patient's consent. The Convention on Human Rights and Biomedicine gives the doctor the right to act in these situations without waiting for patient's consent (Mach, 2004).

The document takes into consideration even previously expressed wishes, particularly in cases where the patient gives his/her consent in advance, according to the supposed development of the illness, as e.g. progressive dementia. These previously expressed wishes must be respected, although the doctor should have the possibility to check whether the wish concerns the present situation and goes on being valid, for example in connection to the development of scientific knowledge about the given procedure (6).

## **2.6. Convention on Human Rights and Biomedicine in the Czech Republic**

In the name of the Czech Republic, the Convention for Protection of Human Rights and Dignity of Human Being in Connection with Application of Biology and Medicine was signed in Strasbourg on June 24th, 1998.

In the Czech Republic, the legal force is declared by the Law No. 96/2001 of the Code and the Czech Republic is its contractual party at present. Thus the commitments following from it concern fully the Czech health service. It was granted the status of agreements of basic human rights and liberties according to the art. 10

of the Constitution of the Czech Republic, superior over common laws. Now, it is guaranteed preference over common laws; anybody who detects actual contradiction of the rules of this agreement and the Czech laws and sublaw rules of health system or those related to health system should give preference to the rules from these agreements, depriving so the internal national rules of effect. However, the contradiction of the agreements and the Czech law can be only apparent: the Czech law can establish a stricter, higher standard, that is evidently not prevented from applying by anything (16).

The circle of professional workers who can be concerned by the Convention on Human Rights and Biomedicine in their profession is wide. In addition to doctors and health care workers, these are judges, benches, policemen, teachers, scientists and students. Institutions and businesses, particularly health care institutions, schools, scientific institutes, health insurance funds and common insurance companies cannot be omitted either. Anybody can be a patient. Health care is funded predominantly from public sources. Thus the point of view of the taxpayer cannot be omitted either (27).

It is gratifying that the Czech Republic ranks among the member states of the Council of Europe that have accepted this Convention, expressing so their determination to fulfill it. By ratification and declaration, the commitments and provisions of the Convention became

a part of our legal order, and in dependence on their normative character can constitute subjective rights of individuals as well (27).

## **2.7. How the Czech Republic fulfills the provisions of the Convention on Human Rights and Biomedicine, Chapter II. Consent, with its valid legal standards**

### *2.7.1. Used methods and techniques*

Consents and secondary data analysis was used to obtain relevant and valid data (11).

### *2.7.2. Results*

It was found out by the data analysis that the Czech Republic provides through the Constitution of the Czech Republic, its Article No. 10, that "Ratified and declared international agreements on human rights and basic liberties the Czech Republic is bound with are immediately binding and have priority before law" (Constitution, law No. 1/1993 Code). The consent of three-fifth majority of all deputies and of three-fifth majority of present senators is necessary to pass a constitutional law and to approve an international agreement according to article No. 10 (Art. 39 Par. 4 of the Constitution of the Czech Republic, 6) (25). The president of the republic stipulates and ratifies international agreements according to letter b; he can delegate stipulation of international agreements to the government or, with its consent, to its individual members (Art. 63 Par. 1 of the Constitution of the Czech Republic, 5).

Another legal resource is the communication of adoption of the Convention for Protection of Human Rights and Dignity of Human Being in Connection to Application of Biology and Medicine: Convention on Human Rights and Biomedicine (Communication of Foreign Office No. 96/2001 Code).

The Charter of Basic Rights and Liberties, the Resolution of the Czech National Council No. 2/1993 Code of declaration of the Charter of Basic Rights and Liberties as a part of constitutional order of the Czech Republic mentions in Article 6 that everybody has the right to life. Human life deserves protection already before birth and nobody may be deprived of life, further in Article 8 that personal liberty is guaranteed. The law stipulates in which cases a person can be taken or held in institution health care without his or her consent. Such action must be communicated to the court within 24 hours and the court decides about this placement within 7 days. Women, adolescents and handicapped persons have right to increased health protection in work and to special work conditions (Art. 29). Article 31 stipulates that everybody has the right to health protection. The citizens have, on the base of public insurance, the right to unpaid health care and to health devices under conditions stipulated by the law (Charter of Basic Rights and Liberties, 5).

In the sphere of informed consent of the patient, there is particularly the Law of the Health of the Nation, No. 20/1966 Code as amended,

principally the § 23 Instruction and consent of the patient that stipulates that the doctor must instruct the patient or his family members in an appropriate way about the character of the disease and about the necessary interventions so that they could become active collaborators in providing preventive medical care. Examination and treatment are carried out with the patient's consent or when this consent can be supposed. When the patient refuses the necessary care despite of the appropriate explanation, the doctor requests a written declaration (reverse) about it. When the urgent execution of medical intervention is indispensable to save life or health of a child or a person divested of legal capacity and when the parents or the guardian refuse consent, the doctor has the right to decide about the execution of the intervention. This provision concerns children who cannot judge the indispensability of such intervention with regard to their intellectual maturity. Without patient's consent, examinations and treatments can be carried out, and when it is necessary with regard to the character of the disease, the patient can be taken in institution care, when the problem is in diseases stipulated by a special directive, in which compulsory therapy can be imposed, when the person displaying signs of mental disease or intoxication endangers himself or his environment or when it is not possible, with regard to the health condition of the patient, to request his consent and when urgent interventions necessary to protection of life or health are in question, or when the patient is a disease carrier. The § 24 states that when the patient

is taken in institution care without his written consent because of reasons stated in § 23 Par. 4, the health care institution must communicate this to the court in whose district it is seated within 24 hours. The hospitalization is not communicated when the patient declared his consent to institutional care additionally, within 24 hours (law No. 20/1966 Code, as amended).

For the implementation of the right of the citizen I quote the Civil Code, particularly the § 11 Right to protection of life and health and privacy, § 415 and subsequent, particularly § 444 and subsequent, of responsibility for personal injury (law No. 40/1964 Code in wording of law No. 509/1991 Code). From the sphere of criminal law, the Criminal Law and states of facts concerning life and health (§ 219 murder, §§ 221-224 personal injury, § 215 mistreatment of persons in charge, § 189 dissemination of infectious disease, § 207 non-providing help) (law No. 140/1961 Code as amended). Least but not last, the Civil Court Order, §§ 191a to 191g - rules of hospitalization without patient's consent and regulation of the so called detention proceedings (law No. 99/1963 Code as amended).

### 2.7.3. Discussion

We found out by consents analysis and analysis of secondary resources that the Convention on Human Rights and Biomedicine was adopted into the legal order of the Czech Republic according to the Art. 10 of the Constitution of the Czech Republic. I agree with the statement of Křížepelka (1999) who points out in

his exposition that the Convention on Human Rights and Biomedicine is superior to common laws. Now it has guaranteed priority over common laws; whoever discovers a factual contradiction of the rules of this convention with Czech laws and sublaw rules of health care or those related to health care should prefer the rules of this convention, deprive so the national rules of effectiveness. Nevertheless, the contradiction of the conventions and the Czech law can be only seeming: Czech law can stipulate a stricter, higher standard, the use of which is of course not impeded by anything.

Regardless of the adopted international convention, the legal scope of the informed approval of the patient with curative or diagnostic intervention is generally recorded already in the Charter of Basic Rights and Liberties and further elaborated in detail in the Law of the health of the nation as amended and in other laws of the Czech Republic.

It could be generally stated, in conformity with the authors stated in the first part of the article, that in the sphere of consent of the patients with the intervention, the Czech Republic meets the conditions of the Convention on Human Rights and Biomedicine binding for its member states. At the same time, it is a proof that since the Nineties of last century, the stress put on autonomy of the patient in his decision taking related to his own health, to the care or non-care for it and on the creation of the necessary conditions for it has been increasing. We agree with the author Κο•ουλεκ (2003) on this finding.

As well as the author Jahodřiově (2003), we did not find any mention in our legal order of the right of the patient to be non-informed about his health condition during the data analysis. The Convention on Human Rights and Biomedicine gives an unequivocal solution for the case when the doctor does not provide the patient with information about his health condition. It is possible in case that the patient does not wish to be informed. The cases when information is not provided to the patient in his interest must be stipulated by law according to the Convention.

A certain possibility to non-inform the patient is given in the present valid legal order by the § 23 of the Law of the health of the nation where it is stated that the doctor must inform the patient in an appropriate way. We suppose that at present, the concept "appropriate" includes also the doctor's respects towards the patient refusing the information of his health care.

We think that it can be expected at the same time that in the future, the right to non-information of the patient about his health condition, stipulated by the Convention, will be taken over into Czech rules as well. In the meantime it is included in the draft bill of health care.

### 3. CONCLUSION

The aim of the article was to map the issue from the theoretical point of view, dealing with the informed consent of the patient with curative or diagnostic intervention in conformity with the adoption of the

Convention of Human Rights and Biomedicine by the Czech Republic.

We maintain the position that when the Czech Republic has established the objective to integrate itself in the European Union with honour, which is a relevant and general question

exceeding the scope of the problem discussed here, then it is necessary that the citizen gets exact, complete, undistorted and addressed information, not only about his health condition and not only in the sphere of health care.

#### REFERENCES

- BURIÁNEK, J. Hospitalizace v psychiatrické léčebně proti vůli pacienta. *Česká lékařská komora*, update: 1.2.2004 (cit. 6.2.2004) <http://www.lkcr.cz/detail.php?id=235>
- DOSTÁLOVÁ, R. podle ABC Teaching Human Rights, Využívání lidských právů m. In *Rozumí me lidským právům m?*, Praha, Evropské informační středisko Univerzity Karlovy, CZ, 1994, p.140
- DUNOVSKÝ, J. et al. Sociální pediatrie vybrané kapitoly. Praha, Grada Publishing, CZ, 1999, p. 279
- FISCHEROVÁ, F. - SOVOVÁ, E. - MLÝNSKÁ, M. Informační práce pro pacienty. In *Zdravotnictví v České republice*, Praha, Bibliographia Medica Eechoslovaca, roč. 5, č. 1-2/2000, CZ, p. 3
- FLEGL, V. Ústavní a mezinárodní ochrana lidských práv. Praha, Nakladatelství C.H.Beck, CZ, 1997, p. 289
- FLEGL, V. Významné mezinárodní dokumenty k ochraně lidských práv. Praha, Nakladatelství C.H.Beck, CZ, 1998, p.325
- HAVELKOVÁ, H. Demokracie pro muže a pro ženy (Filosofická reflexe). In *Ženy a jeho práva I. Lidská práva, ženy a společnost*, Praha, Evropské středisko UNESCO pro výchovu k lidským právům, CZ, 1992, p.96
- HEJČEK, K. Sociální aspekty lidských práv. *České Budějovice, Jihočeská univerzita v Českých Budějovicích, Zdravotní sociální fakulta, teze přednášek Akademický rok 2002/2003*, CZ, 2002, p. 26
- HÝBNEROVÁ, S. Mezinárodní ochrana lidských práv. In *Rozumí me lidským právům m?*, Praha, Evropské informační středisko Univerzity Karlovy, CZ, 1994, p.140
- JAHOUŠEK, R. Souhlas nemocného s léčebným výkonem. In *Zdravotnické právo v praxi*, Praha, SOLEN 2003, 1/2003, roč.1.CZ, p.3
- KOZLOVÁ, L. Nějaké základní problémy sociologického výzkumu. In *Kontakt Zdravotní sociální fakulta Jihočeské univerzity v Českých Budějovicích*, České Budějovice, roč.2000, č.1, CZ p. 4.
- KOŽOUŠEK, J. Poučení pacienta lékařem. In *Zdravotnické právo v praxi*, Praha, SOLEN 2003, 1/2003, roč.1.CZ, p.3
- KRAMÁČEK, V. - CHODURA, V. - KAHOUN, V. Nesouhlas pacienta s hospitalizací i souběhu somatické a duševní choroby. In *Kontakt, České Budějovice: ZSF JU*, roč.1.,1999, č. 3, CZ, p.3
- KROUPOVÁ, A. Úvod do výchovy k lidským právům m. In *Rozumí me lidským právům m?*, Praha Evropské informační středisko Univerzity Karlovy, 1994, CZ, p.140
- KROUPOVÁ, A. Výchova k občanství pro 21.století : Úmluva o právech dítěte. In *Rozumí me lidským právům m?*, Praha, Evropské informační středisko Univerzity Karlovy, 1994, CZ, p. 140
- KOPELKA, F. Česká republika a Úmluva Rady Evropy o Bioetice. In *Časopis pro právní vědu a praxi*, Praha, 1999, roč. 7, č.1, CZ, p. 8
- KOPELKA, F. Evropský standard lidských práv a zdravotnictví. In

- Zdravotnictví a právo, Praha, ORAC, s.r.o., roè. 2002, CZ, p. 4
18. KØEPELKA,F. Etické komise ve svìtì a v Èesku pohledem právníka. In Zdravotnictví a právo, Praha, ORAC, s.r.o., roè.2001, è.1, CZ, p. 4
  19. KØEPELKA,F. Informovaný souhlas v klinickém hodnocení léèiv ve vnitrostátní i mezinárodní perspektivì .In Zdravotnictví a právo, Praha, ORAC, s.r.o., roè. 2001, è.8, CZ, p. 4
  20. KØEPELKA,F. Informovaný souhlas èlovìka pøi zdravotnickém výzkumu. In Zdravotnické právo v praxi, Konice, Solen, roè.2003, è.1, CZ, p. 3
  21. KØEPELKA,F. Právo a etika ve zdravotnictví a biomedicínském výzkumu. In Universitas Revue MU v Brnì , Brno, Masarykova univerzita v Brnì , roè. 2001, è.1, CZ, p.5
  22. MACH,J. Komunikace lékaøe a pacienta s infaustní prognózou – má lékaø právo na „milosrdnou lež ? Èeská lékaøská komora, update: 1.2.2004 (cit. 6.2.2004) <http://www.lkcr.cz/detail.php?id=250>
  23. MACH,J. Komunikace lékaøe se zákonnými zástupci nezletilého pacienta. Èeská lékaøská komora, update: 1.2.2004 (cit. 6.2.2004) <http://www.lkcr.cz/detail.php?id=242>
  24. MACH,J. Náležitá komunikace s pacientem – ùèinná prevence právních problémù . Èeská lékaøská komora, update: 1.2.2004 (cit. 6.2.2004) <http://www.lkcr.cz/detail.php?id=256>
  25. PLAVCOVÁ, M. Ústava Èeské republiky a lidská práva. In Rozumí me lidským právùm? Praha, Evropské informaèní støedisko Univerzity Karlovy, 1994,CZ, p. 140
  26. RELICHOVÁ,J. Úvod do genetiky, Lidský genom. Vìdìní, možnosti, souvislosti, Brno, Sborník k interdisciplinární konferenci v Brnì 2000, CZ, p. 210
  27. SAMKOVÁ,J. Interpretace sdìlení o pøijetí Úmluvy na ochranu lidských práv a dùstojnosti lidské bytosti v souvislosti s aplikací biologie a medicíny: Úmluva o lidských právech a biomedicínì . roèníková práce, vedoucí práce: Velemínský, M., Èeské Budìjovice, Jihoèeská univerzita v Èeských Budìjovicích, Zdravotní sociální fakulta, 2002, CZ, p. 37
  28. SAVICKÝ,I. Lidská Práva a lidská odpovědnost. In Rozumí me lidským právùm?, Praha, Evropské informaèní støedisko Univerzity Karlovy, 1994,CZ, p. 140
  29. SAVICKÝ,I. Lidská práva – práva mužù a žen? In Èlovìk a jeho práva I. Lidská práva, ženy a spoleènost, Praha, Evropské støedisko UNESCO pro výchovu k lidským právùm, 1992, CZ, p. 96
  30. SIGMUNDOVÁ,M. – TELEC,I. Nìkolik poznámek k ochranì osobnosti ve zdravotnictví . In Zdravotnictví a právo, Praha, roè. 2003, è. 6, CZ, p. 6
  31. SOVOVÁ,E. – MLÝNSKÁ,M. – FISCHEROVÁ,F. Jak zlepšit informovanost pacienta. In Zdravotnictví v Èeské republice, Praha, Bibliographia Medica Èechoslovaca, roè. 5, è. 1-2/2000,CZ, p. 3
  32. VELEMÍNSKÝ,M. & coll. Klinická propedeutika pro studující ZSFJU.Èeské Budìjovice, ZSFJU Èeské Budìjovice, 2003, CZ, p. 110
  33. VESELSKÁ,R. – KURE,J. Lidský genom – vèdìní, možnosti, souvislosti.Brno, Sborník k interdisciplinární konferenci, Brno 2.-3.listopadu 2000, CZ, p. 210
  34. VURM,V. Vybrané kapitoly ze sociální holékaøství pro studující ZSFJU. Èeské Budìjovice, ZSFJU 2000, CZ, p. 108
  35. Akèní plán Rady Evropy na posílení demokratické stability V Evropì , , In FLEGL,V. Významné mezinárodní dokumenty k ochranì lidských práv, Praha, Nakladatelství C.H.Beck v Praze roku 1998, CZ, p. 325
  36. Aktuální otázky ochrany lidských práv v Èeské republice. Praha, Èeský helsinský výbor, 2002, CZ, p. 98
  37. Evropská úmluva o lidských právech a základních svobodách, In FLEGL,V. Významné mezinárodní dokumenty k ochranì lidských práv, Praha, Nakladatelství C.H.Beck v Praze roku 1998, CZ, p. 325
  38. Helsinská deklarace svìtové lékaøské asociace, v platném revidovaném znìní ,.

- update 1.2.2004 (cit. 6.2.2004) <http://www.pzv.law.muni.cz/pzv-predpis-hd.htm>
39. Charta Organizace spojených národů a Statut Mezinárodního soudního dvora, Část první. Cíle a zásady Spojených národů v oblasti lidských práv a mezinárodní smluvní právo. In FLEGL, V. Významné mezinárodní dokumenty k ochraně lidských práv. Praha, Nakladatelství C.H.Beck v Praze roku 1998, CZ, p. 325
  40. Konečný návrh vysvětlující zprávy k Úmluvě na ochranu lidských práv a důstojnosti lidské bytosti v souvislosti s aplikací biologie a medicíny. Štrasburk, dne 16. prosince 1996, 580. schůze náměstků ministrů, <http://www.mzcr.cz/utvary/mez/zprava.asp>
  41. Listina základních práv a svobod. usnesení předsednictva Evropského parlamentu ze dne 16. prosince 1992 č. 2/1992 Sb. In FLEGL, V. Ústavní a mezinárodní ochrana lidských práv, Praha, Nakladatelství C.H.Beck, 1997, CZ, p. 289
  42. Mezinárodní pakt o hospodářských, sociálních a kulturních právech. In FLEGL, V. Významné mezinárodní dokumenty k ochraně lidských práv. Praha, Nakladatelství C.H.Beck v Praze roku 1998, CZ, p. 325
  43. Mezinárodní pakt o občanských a politických právech. In FLEGL, V. Významné mezinárodní dokumenty k ochraně lidských práv. Praha, Nakladatelství C.H.Beck v Praze roku 1998, CZ, p. 325
  44. Opěnění protokolů k mezinárodnímu paktu o občanských a politických právech. In FLEGL, V. Významné mezinárodní dokumenty k ochraně lidských práv. Praha, Nakladatelství C.H.Beck v Praze roku 1998, CZ, p. 325
  45. Průvodce občanskou Evropskou unií. Praha, Distribuční středisko Ministerstva zahraničních vztahů s Evropskou unií, Edice Průvodce EU, Praha, 2003, CZ, p. 60
  46. Úmluva na ochranu lidských práv a důstojnosti lidské bytosti v souvislosti s aplikací biologie a medicíny. Praha, Ministerstvo zdravotnictví, 2000, CZ, p. 72
  47. Úmluva o právech dítěte. In FLEGL, V. Významné mezinárodní dokumenty k ochraně lidských práv. Praha, Nakladatelství C.H.Beck v Praze roku 1998, CZ, p. 325
  48. Ústava České republiky, ústavní zákon Evropského parlamentu ze dne 16. prosince 1992. In FLEGL, V. Ústavní a mezinárodní ochrana lidských práv. Praha, Nakladatelství C.H.Beck, 1997, CZ, p. 325
  49. Všeobecná deklarace lidských práv, Část druhá. Mezinárodní charta lidských práv. In FLEGL, V. Významné mezinárodní dokumenty k ochraně lidských práv. Praha, Nakladatelství C.H.Beck v Praze roku 1998, CZ, p. 325
  50. Zákon č. 20/1966 Sb. ze dne 17. března 1966 o péči o zdraví lidu v platném znění. ASPI Publishing, citace 6.2.200. <http://www.pzv.law.muni.cz/pzv-predpis-zpzl.htm>

**პაციენტის ინფორმირებული თანხმობა ჩეხეთის რესპუბლიკაში ადამიანის უფლებებისა და ბიომედიცინის კონვენციასთან დაკავშირებით**

**იანა სამკოვა**

მეცნიერებისა და ადამიანთა უფლებების დაცვის დინამიური განვითარება თანამედროვე საერთაშორისო შეთანხმებებში. ჩეხეთის რესპუბლიკამ ხელი მოაწერა ადამიანთა უფლებების და ბიომედიცინის სფეროში საერთაშორისო კონვენციას, რომელიც კონცენტრირებულია პაციენტის უფლებებზე სამედიცინო პროცედურასთან დაკავშირებით ინფორმირებული თანხმობის გამოსახვის შესახებ.

## CONNECTING IS THE KEY TO SUCCESS

Markéta Dundálková<sup>1</sup>

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### ABSTRACT

Inclusion Europe, the Association for Help to the Mentally Handicapped in the Czech Republic (*Sdružení pro pomoc mentálně postiženým ČR, SPMP*) is a non-governmental volunteer organisation for parents, relatives, self-advocates and other people. SPMP has one common purpose: to help people with intellectual disability, including persons with complex dependency needs. The association supports all activities concerning the improvement of living conditions and the enforcement of equal opportunities of people with intellectual disability. With this intention the association informs and educates the general public. SPMP started its activities with its establishment in 1969. The organisational structure is based on regional committees of the association who provide a major part of its activities. The association consists of about 70 local branches. It runs schools, workshops, homes and several clubs and edits as well a central journal and several local bulletins.

### Key words:

*human rights – mentally handicapped persons - intellectual disability*

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### 1. INTRODUCTION

**The European Association of Societies of Persons with Intellectual Disability and their Families.** Inclusion Europe is a non-profit organisation defending the rights and interests of people with intellectual disability, their families and their organisations in the European Union and other European countries. It is committed to fight for the human rights of people with intellectual disability and is especially concerned with the human rights situation in the countries of Central and Eastern Europe. Inclusion Europe coordinates a wide range of activities in many European

countries, including conferences, working groups, projects and other exchange on relevant topics. It provides responses to political initiatives at European level as well as expertise in areas of relevance to people with intellectual disability. Inclusion Europe advises the European Commission and members of the European Parliament on disability issues and works closely with other European organisations.

**Awareness raising** (UN Standard Rule 1) highlights the low awareness of the general public and the professionals like, doctors, teachers and social workers about the life of persons with intellectual disability (15, 20, 27, 31, 37, 43). The quality of life of persons with intellectual

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disability is to a great extent influenced by the attitudes and values shared by society in general. The perception of the social role of persons with intellectual disability can be changed by various means, such as the attribution of awards, the media, awareness-raising campaigns amongst professionals, etc. (1) Even though there are a number of good initiatives from the Government side, the level of information of those who come in contact with persons with disability in the medical, educational, technical, psychological, legal and administrative fields, and sometimes even the knowledge of professionals working in those fields systematically, falls short of expectation. (10, 13)

Concerning the **medical care** (UN Standard Rule 2) provided for persons with intellectual disability, parents are in general satisfied with the duality (9, 19, 20). However and according to them, there are difficulties in terms of communication and attitudes of the medical personnel. The group of parents in Brno stated that the medical personnel often do not inform parents of infants with intellectual disability of the possibilities, methods and good practice for bringing up their children in an early stage. Parents also highlighted the pessimism of medical personnel about the child's further development. One of the parents in Brno described his experience in the early days of his new-born child with intellectual

disability as: "They [the doctors] told us something like: a moron will remain a moron forever". (5, 46, 47).

The chapter on **community-based support services** (UN Standard Rule 4) of this report emphasizes the idea that the aim of modern social services should be to enable and support persons with intellectual disability to live as far as possible at home or in the least restrictive environment (14, 20, 31, 42). However, the current legislative framework in the Czech Republic does not provide room for modern forms of social services. Although general statistics do not contain data concerning where or with whom people with intellectual disability live, it can be estimated that the majority of persons with intellectual disability still lives in approximately 200 institutions. Therefore, this report points out the main weaknesses of the present social services and provides the recommendations in the final paragraph of this chapter. (8, 36, 29, 26)

As far as **accessibility** (UN Standard Rule 5) of written information is concerned, there are no guidelines for making various information material accessible for persons with intellectual disability. In this report, one self-advocate described her experience with understanding an official information as follows: "I usually do not understand what I am told at the social security office (9, 15, 20, 31, 44). Officers are not willing to spend more time with me and with the others." However, the successful

process of integration of persons with intellectual disabilities into mainstream life depends on breaking various barriers. Parents and self-advocates highlighted mainly human barriers such as arrogance, which they face when communicating with public servants.

The Czech Government regards the **employment** (UN Standard Rule 7) of persons with disability as one of the most serious human rights problem in the country (15, 44). Despite introducing several measures for supporting the employment of persons with disability, the latter still belong to the most disadvantaged group of employees. The pension system also plays a negative role and the system of evaluation of reduced working ability, which focuses dominantly on negative diagnosis, as well. Concerning employment the Association for Help to the Mentally Handicapped in the Czech Republic suggests several recommendations for a more efficient integration of persons with intellectual disability into the labour market.

The present report also deals with the living conditions in a **large residential institutions** and recommends the way towards an efficient de-institutionalization process, for which the current legislative framework of social services does not provide necessary instruments (27, 42). Despite the positive changes in residential institutions, many of the services are located in poor-quality and

overcrowded buildings where the system of communal living arrangements offers little privacy. In many cases clients live in unsatisfactory conditions. Only less than 20% of the buildings are new (built in last ten years). The recent buildings provide modern furnishing comparable to European standards, but most of them are old (from the 19th and 20th centuries). According to data from the National Association of Institutions, bedrooms have more than one bed and nearly 50% have from three to five beds each. Most bedrooms have six to ten beds. Lastly, the geographical isolation of the institutions breaks the clients' family and social networks. Some residents with severe disability spend their entire lives in one room. Uniformity and standardisation of provision, block treatment, and in some instances harsh regimes, mean extremely limited opportunities with little emphasis on educational, therapeutic and social activities. Poor medical and therapeutic resources, and fatalistic views of individual potentials, resulted in people acquiring additional disabilities due to the lack of activities and treatments, leading to an even higher degree of dependence.

## 2. THE INDIVIDUAL ISSUES

As other experts from western European countries (37) have pointed out, it is important to recognise the extraordinary changes that have taken place in social care services since the Velvet Revolution (1989).

This is evidenced in the shift from the dominant ideology of ‘socialist utopia’ (where people with intellectual disability had a hidden place in society), to the resurgence of citizenship in the new democracy with opportunities for persons with intellectual disabilities to live alongside others in the community. This has been made possible by the rejection of discredited ideologies and the growth of alternative services forms provided by NGOs. The voice of the user (silent in the past) is slowly being heard, particularly in the new and reformed services run by NGOs. During a period of unprecedented change, intellectual disability services have begun to demonstrate the potential of new and more responsive approaches, but a sustained commitment to further reform is nevertheless required. There are still a lot of issues, which must be addressed. Based on the findings of this Country Report, the authors want to make the following recommendations for action at regional, national, European and international level and within the network of disability organisations. Each chapter in the report describes the legislation, government policy, statistical information, views of NGOs and reactions of persons with intellectual disability and their parents on the particular subject. From the report it can be concluded which laws the Government of the Czech Republic adopted and to which extent they were implemented.

In the further course of the project “Advancing the Human Rights of Persons with Intellectual disability in Civil Society”, the Association for Help to the Mentally Handicapped in the Czech Republic (SPMP) and Inclusion Europe will develop Inclusion Action Plans based on the above recommendations. These Action Plans will actively pursue changes in selected key areas to improve the human rights situation of persons with intellectual disability in the Czech Republic (33, 38, 40).

#### *Awareness raising*

1. Maximum support needs to be given to all forms of secondary and university institutions training personnel working with persons with intellectual disability (in mainstream and specialised services likewise);
2. To keep the public well informed about intellectual disability and thus gradually change their attitudes towards persons with intellectual disability and other categories of disability;
3. To implement intellectual disability topics into schools of medicine and inservice training for medical personnel (2, 3, 4);

#### *Medical Care*

4. To improve the quality, accessibility and funding system of early medical care services;
5. In conjunction with health insurance companies, to resolve the problem of payment for the medical rehabilitation provided at special schools, institutions

and special educational centres (21, 23, 16);

### ***Rehabilitation***

6. To achieve a closer cooperation between the Ministry of Labour and Social Affairs (and its subordinate Czech Social Security Administration offices), the Ministry of Health, the Ministry of Education, Youth and Physical Education, civic associations and health insurance companies in what concerns rehabilitation services;

### ***Community-based support services***

7. To ensure personal assistance, home and respite care services when needed;
8. To systematically develop and improve community and home care services with respect to the needs of the users;
9. To ensure that adults and children are protected against low levels of care;
10. 10 Human Rights of Persons with Intellectual Disability
11. To enable clients and their families to have a choice, which would be in harmony with their individual needs and circumstances, and to maximise the use of services by the clients through a sufficiently wide and reasonable offer;
12. To protect the communities and to prevent social exclusion of individual families and/or their members, through the timely recognition and flexible ensuring of needs of the communities,

towns and regions concerning the desirable support of families and children in difficult life situations;

13. To reduce the number of children placed in institutions and through the system of interconnected and comprehensive services, to support the life of children in their natural environment, where their needs will be professionally evaluated, adequately satisfied and further examined. If the latter is not possible, to promote the development of a substitute family care system;
14. To ensure that children with disability living in institutions and foster families have the best possible conditions of education, health and social care (48, 49);

### ***Accessibility***

15. To promote the use of guidelines for making various information material accessible to persons with intellectual disability;
16. To create comparable conditions for the governmental and non-governmental sectors in the provision of services, by means of uniform criteria of payment for the current system (not according to the number of beds in a institution);
17. To develop a system for the accreditation and funding of counselling centres operating outside the department of education;
18. NGOs and civic associations should inform their members

about changes in the social services (22, 41, 39, 25);

**Education**

- 19. To recognise the child rights to inclusive education
- 20. By means of new legislation in the education sector, to strengthen the parents' right of choice as regards to the line of education for their children with disability;
- 21. To define the number of teaching instruments and the compensatory and rehabilitation tools (paid from the school budget), as well as the state contribution to these instruments helping in the education of children with special needs (24, 34, 35);
- 22. To ensure the reimbursement for transport costs, personal assistance and guides for integrating pupils and students with disability in mainstream schools;
- 23. To promote lifelong learning activities for the youth and adults with intellectual disability (6, 7, 12);

**Employment**

- 24. It is necessary to develop and legitimise a supported employment model, in which personal assistants help a person with intellectual disability to understand and cope with required operations, and attain the expected degree of performance;
- 25. In the process of amending the Employment Act, to revise the disability pension system and the

wording of the concept of "person with reduced working ability";

- 26. To continue the reimbursement of social security payments and furthermore, to support employers giving jobs predominantly to persons with disability whilst doing business in a normal competitive environment;
- 27. To change the system for rating the degree of fitness reduction of insured persons with disability for sustained gainful activities, and change also the classification of disability into positive recommendations;
- 28. To provide a legal framework granting the right to persons with disability or his/her legal representative to choose his/her real provider of care, regardless of whether this is a close person, a personal assistant, a sheltered Libiny service, or a governmental or non-governmental institution of social care (30);

**Family life and integrity**

- 29. To prepare a methodology and conception for the citizen advocacy;
- 30. To create a network of NGOs who are willing to work on the field of guardianship and to prepare information for legal cases;
- 31. To prepare a methodology for prevention the bulling of persons with intellectual disability (11, 17);

### *Large Residential Institutions*

32. To establish a programme of de-institutionalisation
33. To support persons with intellectual disability who live in institutions to develop the capability to speak for themselves and express their needs and wishes (as other persons in mainstream life do);
34. To promote the establishment of self-advocacy groups by providing training to self-advocacy members;
35. To create guidelines for individual programme plans and their assessment;
36. To enable persons with intellectual disability to contribute to their communities and therefore to enhance their valuable social status; and
37. To introduce a new policy on the funding of services for persons with disability, which will prevent discrimination on the provision of social services between the private and non-governmental sector. (18).

### **3. DISCUSSION AND RECOMMENDATIONS OF THE QUESTIONS**

This chapter of the report provides the recommendations to the Government of the Czech Republic, local authorities and the international donor community about possible steps to be undertaken to bring about an enforcement and implementation of legislation which is generally positive and favours the interests of

children and adults with intellectual disability. The greatest challenge for the Government of the Czech Republic will be to prepare a strategy ensuring the full inclusion of persons with intellectual disability into the community. Inclusion Europe sincerely believes that this report provides decision-makers with important background information and that the recommendations show vital step forward towards the full recognition and realisation of the human rights of persons with intellectual disability.

*Awareness Raising:* The quality of life of persons with intellectual disability is in great extent influenced by the attitudes and values shared by society in general. The perception of the social role of persons with intellectual disability can be changed by various means, such as the attribution of awards, the media, awareness-raising campaigns amongst professionals, etc. Some examples of National Awards are: the Government Board's award prize for the best work publicising the problems of disability, the Minister of Health's Annual Award to recognise the work done for the benefit of persons with disability, the annual Olga Havlová Prize, the NGO - Rytmus annual award for teachers, who successfully integrate pupils with disability into mainstream education, the competition "The Architecture of Humanity" announced in the spring of 2001 by the Ministry of Labour and Social Affairs (MOLSA), with the aim of

celebrating good examples on designing building for social care purposes and sport events such as the Special Olympics and Abyolympics, which take place at a national level, maximum support needs to be given to all forms of secondary and university institutions training personnel working with persons with intellectual disability (in mainstream and specialised services likewise), to keep the public well informed about intellectual disability and thus gradually change their attitudes towards persons with intellectual disability and other categories of disability, to implement intellectual disability topics into schools of medicine and inservice training for medical personnel.

**Medical Care:** Despite the financial difficulties, the general health care system and the early services for children with intellectual disabilities maintain relatively good standards. Parents see difficulties in communicating with the medical personnel and in their attitudes towards their children with intellectual disability. Parents from rural areas also highlighted the limited access to specialised services, such as early care centres. To improve the quality, accessibility and funding system of early medical care services, in conjunction with health insurance companies, to resolve the problem of payment for the medical rehabilitation provided at special schools, institutions and special educational centres.

**Rehabilitation:** The purpose of rehabilitation is to minimise the immediate consequences of lasting or long-term disability. Its main components, early care, medical rehabilitation, vocational rehabilitation, etc., are provided in the Czech Republic. However, all the components are separated from each other. Therefore, a comprehensive rehabilitation system needs to be set up and legislatively codified. To achieve a closer cooperation between the Ministry of Labour and Social Affairs (and its subordinate Czech Social Security Administration offices), the Ministry of Health, the Ministry of Education, Youth and Physical Education, civic associations and health insurance companies in what concerns rehabilitation services.

**Community-Based Support Services:** The aim of modern social services is to enable and support persons with intellectual disability to live as far as possible at home or in the least restrictive environment. However, the current legislative framework does not provide room for a modern form of social services. Although general statistics do not contain data concerning where or with whom people with intellectual disability live, it can be estimated that the majority of persons with intellectual disability still lives in approximately 200 institutions. The main weaknesses of the present social services system can be pointed out as the following: The net of social services is deficient in terms of range,

types and capacity, and the regional proportion of the services is unbalanced. Institutional services highly outweigh community services. De-institutionalisation is not taking place. The legislative framework is out-of-date. The personnel in the public utility sphere is not sufficiently educated and trained. The system of financing services - governmental and non-governmental - is unequal. The system for monitoring quality and efficiency of services does not exist. The complex data base/information system about service providers is not available and clients have limited opportunities to participate on the decision-making process of these issues. Interviewed parents, who care after children with intellectual disability at home made several statements during the roundtables expressing various examples of difficulties and problems, which they are facing: The financial support for families allows us only to survive, better to have a grown-up child in an institution than under a bridge (parent in Brno), in view of some financial benefits being only provided to the family member with intellectual disability until he/she is 26 years old, one parent said: "Do they [state authorities] think mental disability lasts only 26 years?", aware of the alarming lack of day centres, respite care services, personal assistance and the nonexistence of living places such as supported living schemes, one father said: "What will happen to our child when we die? Will he go to live under a

bridge?" Another parent also said: "I am quite happy with the agency [provides sheltered living], but such a weak financial mechanism [state system of financing NGOs] forces me to put my daughter on the waiting list of an institution. Just in case...". Some services are too far away from the users and their families placing them in a certain geographical isolation, local governments do not warrant social services for their Citizen, legislation does not fully regard a member of family providing home care as an employed person, there is no link between different services, which are focused on the age of clients. Therefore during the child development course, it is difficult for families to find an appropriate place for a family member according to her/his needs. There should be a transition of programmes from school to the employment field and there is a lack of facilities for elderly persons with intellectual disability. To ensure personal assistance, home and respite care services when needed, to systematically develop and improve community and home care services with respect to the needs of the users, to ensure that adults and children are protected against low levels of care, to enable clients and their families to have a choice, which would be in harmony with their individual needs and circumstances, and to maximise the use of services by the clients through a sufficiently wide and reasonable Orfee, to protect the communities and to prevent social exclusion of individual families

and/or their members, through the timely recognition and flexible ensuring of needs of the communities, towns and regions concerning the desirable support of families and children in difficult life situations, to reduce the number of children placed in institutions and through the system of interconnected and comprehensive services, to support the life of children in their natural environment, where their needs will be professionally evaluated, adequately satisfied and further examined. If the latter is not possible, to promote the development of a substitute family care system, to ensure that children with disability living in institutions and foster families have the best possible conditions of education, health and social care.

**Accessibility:** The successful process of integration of persons with intellectual disabilities into mainstream life depends on breaking various barriers. Although legislation in terms of architecture has been significantly improved, there are other barriers, which discriminate persons with intellectual disabilities and their families. Parents and self-advocates highlighted mainly human barriers such as arrogance, which they face when communicating with public servants. A basic system of counselling for citizens with disability and their parents has been developed in the Czech Republic with the aim of improving information accessibility. The

information providers following this system include: Local and regional authorities, early care centres, institutions of educational-psychological counselling (e.g., state-run as well as private special educational centres, educational-psychological counselling centres, etc.), medical rehabilitation centres and NGOs, to promote the use of guidelines for making various information material accessible to persons with intellectual disability, to create comparable conditions for the governmental and non-governmental sectors in the provision of services, by means of uniform criteria of payment for the current system (not according to the number of beds in a institution), to develop a system for the accreditation and funding of counselling centres operating outside the department of education, NGOs and civic associations should inform their members about changes in the social services.

**Education:** Every citizen of the Czech republic is entitled to education. However, conditions for educating children with severe or profound intellectual disabilities are far from satisfactory. There are problems, which must be addressed such as teacher assistance, transport to schools, and organising education for children with intellectual disabilities inside or outside institutions. The integration process barriers lie on the organising and financing of support services such as: Personal/teacher assistance, transport to schools,

teaching instruments for special needs and unsatisfactory cooperation of governmental bodies (education, health and social affairs departments), to recognise the child rights to inclusive education, by means of new legislation in the education sector, to strengthen the parents' right of choice as regards to the line of education for their children with disability, to define the number of teaching instruments and the compensatory and rehabilitation tools (paid from the school budget), as well as the state contribution to these instruments helping in the education of children with special needs, to ensure the reimbursement for transport costs, personal assistance and guides for integrating pupils and students with disability in mainstream schools, to promote lifelong learning activities for the youth and adults with intellectual disability. Employment: The Czech Government regards the employment of persons with disability as one of the most serious human rights problem in the country. Despite introducing several measures for supporting the employment of persons with disability, the latter still belong to the most disadvantaged group of employees. The pension system also plays a negative role and the system of evaluation of reduced working ability, which focuses dominantly on negative diagnosis, as well. This obligation can be fulfilled in three ways separately or in a combined form: employment of persons with disability, purchase of products

originating from those companies with more than 55% of employees with disability and payments to the State. It is necessary to develop and legitimise a supported employment model, in which personal assistants help a person with intellectual disability to understand and cope with required operations, and attain the expected degree of performance, in the process of amending the Employment Act, to revise the disability pension system and the wording of the concept of "person with reduced working ability", to continue the reimbursement of social security payments and furthermore, to support employers giving jobs predominantly to persons with disability whilst doing business in a normal competitive environment, to change the system for rating the degree of fitness reduction of insured persons with disability for sustained gainful activities, and change also the classification of disability into positive recommendations, to provide a legal framework granting the right to persons with disability or his/her legal representative to choose his/her real provider of care, regardless of whether this is a close person, a personal assistant, a sheltered living service, or a governmental or non-governmental institution of social care.

**Income Maintenance and Social Security:** The government claims that the purpose of social security is not to increase the number of occupationally unplaceable persons with disability entirely dependent on

unemployment and social care benefits. The purpose is to provide a respectful support to those who, for objective reasons, cannot regularly work. However, according to NGOs the system of health assessment does not fulfil this declaration. In reality the system in many ways works against the employment of persons with intellectual disability. The Government Policy and Practice in the System of Health Assessment – In terms of evaluating health services, the Ministry of Labour and Social Affairs has developed two state systems of health assessment, and the consequences resulting therefore are: one system determines the rate of disability reduction of persons with disability in regards to sustained wage-earning activities for purposes of pensions insurance ( Art. 39 of the Pension Insurance Act No. 155/1995) and the other system establishes a disability classification for purposes of state social support benefits.

***Family Life and Personal Integrity:***

The state supports families who care for a family member with disability with benefits for the care of a relative or another person with the aim of preventing the person in question being sent to an institution. However, the benefits for parents caring for a child with disability at home is much lower than the financial amount allocated to the care of a person in an institution. During interviews, judges highlighted two serious difficulties they face during the juridical process: the difficulty to

decide who is an appropriate judicial expert (psychologist or psychiatrist) for a certain person and the difficulty to find and appoint a public guardian, to prepare a methodology and conception for the citizen advocacy, to create a network of NGOs who are willing to work on the field of guardianship and to prepare information for legal case, to prepare a methodology for prevention the bullying of persons with intellectual disability.

***Large Residential Institutions:*** The current legislative framework of social services does not provide instruments which are necessary for starting de-institutionalisation process. It is partly result of insufficient political support of the reform in social services. Living conditions in many institutions stay in many ways pure mainly due to lack of financial recourses. **Complaints and Control Procedures:** Legislation: concerning complaints and in general, each single complain coming to an authority, such as the MOLSA, is subject to investigation. According to MOLSA officers, complainers are usually not sufficiently informed about their rights. Neither do they know where to turn to with their claims, controls and Inspections: As regards to control and inspection procedures, the present out-dated legislation allows only inspections in the financial, health, social insurance and hygiene spheres. There is neither a legislative tool nor a methodology for controlling the quality of services.

Hence, the control of services is focused only in complying with edicts, instructions and standards in terms of hygiene and boarding. The quality control system shall be a part of the new act on social services, which is expected to be implemented in 2003, to establish a programme of de-institutionalisation, to support persons with intellectual disability who live in institutions to develop the capability to speak for themselves and express their needs and wishes (as other persons in mainstream life do), to promote the establishment of self-advocacy groups by providing training to self-advocacy members, to create guidelines for individual programme plans and their assessment, to enable persons with intellectual disability to contribute to their communities and therefore to enhance their valuable social status and to introduce a new policy on the funding of services for persons with disability, which will prevent discrimination on the provision of social services between the private and non-governmental sector.

**Culture:** There is no official evidence about the discrimination of persons with intellectual disability in terms of culture. However, parents expressed their dissatisfaction at the lack of funding for cultural and sport activities for their children.

**Recreation and sports:** There are recreation and sport activities for persons with intellectual disability provided by NGOs or residential

service providers as part of their daily or weekly programmes. The funding of such activities run by NGOs is not equal compared to the financial provisions in institutions.

**Organisations of Persons with Disabilities:** One of result of political changes in the beginning of nineties was de-monopolisation of the social services. Non-governmental sector took up its traditional role and started to provide modern and missing services. However, the governmental bodies has been unable to "tune" legislation according to new situation which appeared in the terrain.

#### 4. CONCLUSION

The European Initiative for Democracy and Human Rights of the European Commission is co-financing the project "Advancing the Human Rights of Persons with Intellectual Disability in Civil Society" of Inclusion Europe. The partners are eight national organisations of persons with intellectual disability and their parents from Bulgaria, the Czech Republic, Estonia, Hungary, Macedonia, Poland, Romania and Slovenia. This project aims at strengthening the political capacity of the partner NGOs by assuring their active participation in the decision-making processes and introducing them to the European disability policy. It also wishes to raise the awareness of the Governments on national and

European level about the lives of persons with intellectual disability. The Country Report is one of the main outcomes of the project. It is based on a survey carried out by the Association for Help to the Mentally Handicapped in the Czech Republic (SPMP) with the professional assistance of Inclusion Europe and the Netherlands Institute of Care and Welfare (NIZW). NIZW developed the research methodology and guidelines for this report.

In the further course of the project "Advancing the Human Rights of Persons with Intellectual disability in Civil Society", the Association for Help to the Mentally Handicapped in the Czech Republic (SPMP) and Inclusion Europe will develop Inclusion Action Plans based on the above recommendations. These Action Plans will actively pursue changes in selected key areas to improve the human rights situation of persons with intellectual disability in the Czech Republic.

## REFERENCES

1. ACKERMAN, N. Treating the Troubled Family. New York: Basic Books, 1966.
2. ADAMS, E., INGHAM, S. Changing Places: Children's Participation in Environmental Planning. London: The Children's Society, 1998.
3. ALDERSON, P. Young Children's Rights: Exploring Beliefs, Principles and Practice. London: Jessica Kingsley Publishers, 2000.
4. ANDREWS, A. B., KAUFMAN, N.H. (Eds): Implementing the U.N. Convention on the Rights of the Children – A Standard of Living Adequate for Development. Praeger: Westport Connecticut, London, 1999.
5. BALTES, P.B. (Ed.). Life-Span Developmental and Behavior. New York: Academic Press, 1979.
6. BELTER, R.W., GRISSO, I. Children's recognition of Rights Violations in Counseling. Professional Psychology: Research and Practice 15, 1984.
7. BERZONSKY, M. Adolescent research: A life span developmental perspective. Human Development, 26 (4), 1983.
8. BLOS, P. The Adolescent Passage: Developmental Issues. New York: International Universities Press, 1979.
9. BEST, K. Mental disabilities affect method options. Network. 1999; No.:19-22.
10. BURKE, A.E. Child institutionalization and Child Protection in Central and Eastern Europe. Innocenti Occasional Papers: Florence, 1995.
11. CARNES, P. Counseling Sexual Abusers. Minneapolis: Comp-Care Publications, 1990.
12. COHN, I., ABER, J.L. Children's Rights Education and Advocacy: International Perspectives. Child, Youth and Family Services Quarterly 1, 1991.
13. Directory of European Research and Documentation Institutions on Children's Rights. UNESCO – UNICEF, 1995.
14. DOSTÁL, J. Basic information on the pension scheme reform and the current structure of the system, evaluation and prospects of social security reforms. International Social Security Association, 1998.
15. FARBER, A., NUROK, M. Moral progress, mental retardation, and the death penalty. N Engl J Med. 2003.
16. FISCH, R., WEAKLAND, J. H., SEGAL, L. The Tactics of Change. San Francisco. CA: Jossey-Bass, 1982.

17. FLEKKOY M. G., KAUFMAN H. H. The Participation Rights of the Child Rights and Responsibilities in Family and Society. London: J. Kingsley Publishers, 1997.
18. GREEN, J.W. Cultural awareness in the human services. Englewood Cliffs, NJ: Prentice-Hall, 1999.
19. GROUIOS, G., SAKADAMI, N., PODERI, A., ALEVRIADOU, A. Excess of non-right handedness among individuals with intellectual disability: experimental evidence and possible explanations. *J Intellect Disabil Res.*, 1999.
20. KABRA, M., GULATI, S. Mental retardation. *Indian J Pediatr*, 2003.
21. HENAO, S. A systems approach to family medicine. In S. Henao and N.P. Grose (Eds.), *Principles of family systems in family medicine*. New York: Brunner/Mazel, 1996.
22. KEEFE, S.E. Ethnic identity: The domain of perceptions and attachments to ethnic groups and cultures. *Human Organization* 51, 1992.
23. KOSA, J., ZOLA, I.K. Poverty and health: A sociological analysis. Cambridge, MA: Harvard University Press, 1975.
24. KRAL, R. Strategies that work: Techniques for solution in the schools. Milwaukee, WI: Brief Family Therapy Center Press, 1987.
25. LANSDOWN, G. Taking Part: Children's Participation in Decision Making. London: Institute for Public Policy Research, 1995.
26. LUM, D.S. Social work practice and people of color: A process-stage approach. Pacific Grove, CA: Brooks/Cole, 1992.
27. MAIR, M.L. The right to procreate: intellectual disability and the law. *Aust Coll Midwives Inc J.* 1992. No. 16-20.
28. MELTON, G.B. Children, Politics and Morality: The Ethics of Child Advocacy. *Journal of Clinical Child Psychology* 16, 1987.
29. MELTON, G. B., SAKS, M. J. The Law as an Instrument of Socialization and Social Structure. In G.E. Melton (Ed.), *Nebraska Symposium on Motivation*. Vol. 33. The Law as a Behavioral Instrument. Lincoln: University of Nebraska Press, 1985.
30. MELTON, G. B., LYONS, P. M. Mental health services for children and families: Building a system that works. New York: Guilford, 2002.
31. MOHAN, A., SINGH, A., MANDAL, M.K. Transfer and interference of motor skills in people with intellectual disability. *J Intellect Disabil Res.*, 2001.
32. Pension Insurance. Act No. 155/1995.
33. PROCHASKA, J., DiCLEMENTE, C., NORCROSS, J. In search of how people change: Application to addictive behaviors. *American Psychologist* 47, 1102-1114, 1992.
34. RUCK, M.D., KEATING, D.P., ABRAMOVITCH, R., KOEGL, C.J. Adolescents and children's knowledge about rights: some evidence for how young people view rights in their own lives. *Journal of Adolescence*, 1998.
35. SAYWITZ, K.J., JAENICKE, C., CAMPARO, L. Children's Knowledge of Legal Terminology. *Law and Human Behavior* 14, 1990.
36. SALEEBEY, D. (Ed.). *The strengths perspective in social work practice*. New York: Longman, 1992.
37. SCRAGG, T. Learning Disabilities Services in the Czech Republic. In *Tizard Learning Disability Review*. Vol. 1, 1999.
38. SCHWARTZ, I.M. (In)justice for Juveniles: Rethinking the Best Interests of the Child. Lexington, MA: Lexington Books, 1989.
39. SOLOMON, B.B. Value issues in working with minority clients. In *Ethnocultural issues in social work practice: Manual of reading 1991 – 1993*. Needham Heights, MA: Gin, 1983.
40. STANLEY, B.H., SIEBER, J.E., MELTON, G.B. *Research Ethics (A Psychological Approach)*. University of Nebraska Press, 1996.
41. STROUL, B. Series on community-based services for children and adolescents who are severely emotionally disturbed. Vol.1. Homebased services. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1989.

42. ŠVARCOVÁ, I. Mentální retardace. Praha: Portál, 2000. (In English: Mental retardation. Praha: Portál, 2000)
43. TAANILA, A., SYRJALA, L., KOKKONEN, J., JARVELIN, M.R. Coping of parents with physically and/or intellectually disabled children. Child Care Health Dev. 2002.
44. The National plan of equalizing of the opportunities for the citizens with health handicaps. Government Resolution No. 256 on April 14, 1998.
45. The National plan of the employment of the Czech Republic. Government Resolution No. 256 on April 14, 1998.
46. TREMPER, C.R., KELLY, M.P. The Mental Health Rationales for Policies Fostering Minors' Autonomy. International Journal of Law and Psychiatry 10, 1987.
47. WATZLAWICK, P., WEAKLAND, J., FISCH, R. Change: Principles of problem formation and problem resolution. New York: W.W.Norton, 1974.
48. WHITE, M. The externalizing of the problem. Dulwich Centre Review, 1988.
49. ZABRANA, R.E. Ethnic differences in the substance use patterns of low-income patterns of low-income pregnant women. Family community Health 13, 1987.

**გონებრივი უნარშემზღველობის მქონე პირთა  
ადამიანური უფლებები**

**მარკეტა დუნდალკოვა**

ფსიქიკურად უნარშემზღვეული ადამიანების დახმარების ჩეხეთის ასოციაცია წარმოადგენს ნებაყოფლობით არასამთავრობო ორგანიზაციას მშობლებისათვის, ნათესავებისათვის და სხვა ადამიანებისათვის. მას აქვს ერთი საერთო მიზანი: გონებრივი უნარშემზღველობის და კომპლექსური პრობლემების მქონე ადამიანების დახმარება. ასოციაცია მხარს უჭერს ყველა იმ საქმიანობას, რომელიც მიმართულია გონებრივი უნარშემზღველობის მქონე ადამიანების ცხოვრების გაუმჯობესებისაკენ და მათთვის თანაბარი შესაძლებლობების შექმნისაკენ. ამისათვის ასოციაცია ახორციელებს სამოგადოების ინფორმირებისა და განათლების გაუმჯობესების ღონისძიებებს. ასოციაციამ თავისი საქმიანობა დაიწყო 1969 წლიდან. მისი ორგანიზაციული სტრუქტურა ეფუძნება რეგიონალურ კომიტეტებს, რომლებიც ახორციელებენ ძირითად საქმიანობებს. ასოციაცია შედგება დაახლოებით 70 ფილიალისაგან. იგი მოიცავს სკოლებს, დაწესებულებებს, საცხოვრებელ სახლებს და მრავალ კლუბს, ასევე გამოსცემს ცენტრალურ ჟურნალებსა და მრავალ ადგილობრივ ბიულეტენს.

## MUTUAL PREJUDICES OF MAJORITY POPULATION AND MINORITY ROMANY POPULATION

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### ABSTRACT

Mutual prejudices of majority population and minority Roma population were surveyed, with the help of the technique of semantic differential, in two demographically different towns – Ústí nad Labem and Ěeské Budì jovice. Majority population takes negative attitude in all groups classified by different criteria. Minority Roma population takes surprisingly few negative prejudices and more positive prejudices.

### Key words:

*Majority population – minority population – prejudices – Roma*

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### 1. INTRODUCTION

Since the 15<sup>th</sup> century, a peculiar ethnical group of Roma lives on the territory of the Czech Republic, being a special socio-cultural phenomenon in the composition of the population of our country. It distinguishes by specific cultural traditions, value attitudes, language situation, life ambitions (4) and also by being perceived as different by others.<sup>1)</sup> This peculiar social system developed parallelly with the development of non-Roma civilization, and often in a certain contraposition. This dissimilarity of these populations, based on historical causes<sup>2)</sup>, is considered as a reason for conflicts and tension between the majority and the Roma population, and it will probably continue in the long term. The intersection of both social systems,

existing one beside the other during centuries (the greatest blending has occurred in the sphere of economic activities), seems to be one of serious sources of social tension (13).

The work discusses only a part from the complex Roma issue, the prejudices that, nevertheless, can be one of the reasons and simultaneously consequences of conflicts and tension between the majority population and the minority Roma population. They are often a cause of discrimination (8).

At present, the Czech majority population shows highly negative attitudes towards other nationalities and ethnical minorities (up to 85% of the population), these being taken also by groups of persons who in western countries show neutral attitudes: persons with university education, persons with high school

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education, religious persons or persons without personal negative experience with foreigners (16). We perceive the Roma as a whole, we do not look with favour upon their presence in our environment, their problems do not provoke sympathy in us. But it must be remarked that the relation towards the Roma is changing very slowly, but still to their favour (5).

The research was carried out in 2002, in order to map both the level of prejudices of majority population towards Roma, and of members of minority Roma population towards the majority, because, as Friřtenskŕ writes:... unfortunately, the respondents are always members of the majority society, and never the other side, the Roma (5). Information about attitudes and intentions of the Roma themselves is missing... (6).

## 2. MATERIAL AND METHODS

The basic tool of data collection was the technique of semantic differential which is a very efficient tool to detect what stereotype concepts do people have about members of other social groups, i.e. a tool to measure the dimensions of prejudices we have (2).

The respondent was asked to describe his/her opinion of the minority Roma population, when it was a member of majority population, and vice versa, on a scale with odd number of categories (5) defined in antithetic pairs of words, e.g. clever - stupid. The semantic

differential was completed by a question about personal experience of the respondents and the kind of this experience with the population the questionnaire was about.

The basic complex consisted of citizens of the Czech Republic who have reached full age (i.e. adult population, the quota is the age of 18) and who acknowledged Czech or Romany nationality, or Roma ethnic group. The research complex consisted of individuals from adult majority population and minority Roma population in Ěstř nad Labem and in Ľeskŕ Budmŕovice<sup>3)</sup>.

The respondents stated 3 identification characteristics in the questionnaire: age, sex and the highest education reached. Other data of the individual respondents, obtained on the base of the place of filling out and of the questionnaire version, were: pertinence to majority population or minority Roma population and place of residence – Ľeskŕ Budmŕovice or Ěstř nad Labem.

Altogether 197 respondents took part in the research, 110 from Ěstř nad Labem (49 Roma and 61 non-Roma respondents) and 87 respondents from Ľeskŕ Budmŕovice (20 Roma and 67 non-Roma).

When dividing the respondents into the individual age groups, I took use of the knowledge from developmental psychology, because in each life period of a person, his/her view of the world, his/her

thinking influenced by experience and his/her social role change, which could have influence on the creation of the opinions of the respondent.

### 3. RESULTS

#### 3.1. Personal experience

49% of the respondents of majority population stated negative personal experience with Roma (in ЂstH nad Labem it was even 59%), only 15% of the respondents had positive experience (16% both) and 20% did not have any personal experience with Roma. All Roma respondents had personal experience with members of majority population. In 51% of the respondents, it was positive experience (in Ђeskŭ Budmĵovice 60%), 26% stated experience of both kinds and 23% stated negative personal experience.

#### 3.2. Semantic differential

The opinions of the Roma population by respondents from the majority population were surprisingly uniform. In the resulting number processing of the semantic differential, there were small differences in contrast to expectation, regardless of whether the respondents were evaluated by the highest education reached, by age, sex or place of residence.

The general results of the semantic differential for non-Roma population are represented in Table 1. These characteristics assigned to Roma by majority population correspond exactly to the generally

widespread prejudices about Roma, stated in literature as asocial and at the same time free, unrestrained individuals (15).

Quite a positive finding is neutrality of opinions of majority population in characteristics that are not included in generally widespread prejudices about Roma (e.g. quality of parenthood), and in that the respondents answered naturally (see Table 1).

Majority population has the following negative prejudices about the minority Roma population – the Roma are in their opinion: stupid, repelling, bad neighbours, untidy, lazy, dissatisfied, irresponsible, dishonest, they lie and steal, i.e. they are asocial persons with whom an average member of majority population gets along badly and whom he cannot trust (15), they are an ethnic not living according to rules of majority society.

Respondents in the age group from 46 – 60 years of age (older adulthood) had the highest number of negative prejudices.

Respondents in the age group from 61 – 75 years of age (early old age) and respondents with basic education had the lowest number of negative prejudices.

When evaluating the results by the highest education reached, respondents with university education had the highest number of

**TABLE 1. Attitudes of majority population towards minority Roma population**

Note: Characteristic in bold print corresponds to the result. The numbers in the middle means deviation to the left (1,2) or right (4,5) characteristic, the number 3 means the centre, the neutral point.

sad	4	<b>cheery 84%</b>
good friends	<b>3</b>	bad friends
deliberate	5	<b>spontaneous 93%</b>
envy	<b>3</b>	do not envy
bad	<b>3</b>	good
generous	<b>3</b>	egoistic
<b>59% repelling</b>	2	attractive
<b>64% stupid</b>	2	clever
responsible	4	<b>irresponsible 79%</b>
<b>73% they steal</b>	2	they don' t steal
independent	<b>3</b>	dependent
diligent	4	<b>lazy 78%</b>
poor	<b>3</b>	rich
clean	4	<b>untidy 74%</b>
satisfied	4	<b>dissatisfied 68%</b>
non-self-confident	4	<b>self-confident 64%</b>
honest	4	<b>dishonest 76%</b>
good parents	<b>3</b>	bad parents
rational	4	<b>emotional 84%</b>
<b>65% bad neighbours</b>	2	good neighbours
<b>92% lively</b>	1	quiet
<b>76% they lie</b>	2	they don't lie
beautiful	<b>3</b>	ugly
creative	<b>3</b>	non-creative
unhappy	4	<b>happy 48%</b>
loners	4	<b>sociable 86%</b>
stressing themselves	4	<b>relaxed 83%</b>

negative prejudices, having even more of them the respondents from ЁstH. Respondents with basic education had the lowest number of prejudices.

There were no differences between the results of both sexes.

When we compare the age groups of respondents by the highest number of negative prejudices, we get the following scale 46 -60 years, 21 - 34 years, 35 - 45 years, 18 - 20 years and 61 - 75 years.

In respondents from Ľstn nad Labem, the level of negative prejudices was higher than in respondents from Veskň Budmjovice.

The results were surprisingly positive in the minority Roma population. Positive prejudices prevail over negative ones, regardless of whether we divide the respondents by age, sex or education. The only exception are the results in respondents from Veskň Budmjovice in age groups from 18 - 20 years and 35 - 45 years, in which negative prejudices prevail.

General results of minority Roma population are represented in Table 2.

Minority Roma population has the following negative prejudices about the majority population - the members of majority population are in their opinion: envious, stressing themselves, egoistic, they lie, are rational and rich.

Except the results of respondents from Veskň Budmjovice in the age from 18 - 20 years of age, the kind and number of negative prejudices towards majority population did not differ significantly, regardless of whether the results were evaluated by education, sex or age of respondents.

The following two age groups had the highest number of negative prejudices: 35 - 45 years and 18 - 20 years.

The age group from 21 - 34 years of age, further men and the age group from 46 - 60 years of age had the lowest number of negative prejudices, only two.

There were no differences in the number of negative prejudices between women and men and between respondents with different highest education reached.

The scale of age groups of respondents by the highest number of negative prejudices is as follows: 35 - 45 years, 18 - 20 years and 61 - 75 years, 46 - 60 years, 21 - 34 years.

#### 4. DISCUSSION

One of the reasons why such researches do not take place in greater measure is certainly more difficult cooperation with Roma in collection of the necessary data. As Uhl states (2000): Fear from abuse of the data or rather fear from the fear of the Roma from such a possible abuse of the data and questioning the moral aspect of expert estimations have made almost impossible the implementation of expert researches in recent ten years (20). Another problem is the tendency of the Roma to stylize themselves more or less unintentionally according to what the "gadjo" (= white member of majority population) wishes to hear from them: we often hear his idea of our opinion instead of the own opinion from a Roma (15), sociologically expressed - effect of the questioner.

**TABLE 2. Attitudes of minority Roma population towards majority population**

Note: Characteristic in bold print corresponds to the result. The numbers in the middle means deviation to the left (1,2) or right (4,5) characteristic, the number 3 means the centre, the neutral point.

sad	4	<b>cheery 57%</b>
good friends	3	bad friends
<b>55%</b>	2	spontaneous
<b>deliberate</b>		
<b>55% they</b>	2	they do not
<b>envy</b>		envy
bad	3	good
generous	4	<b>egoistic 57%</b>
repelling	3	attractive
stupid	4	<b>clever 68%</b>
<b>57%</b>	2	irresponsible
<b>responsible</b>		
they steal	3	they don' t
		steal
independent	3	dependent
diligent	3	lazy
poor	4	<b>rich 58%</b>
<b>65% clean</b>	2	untidy
satisfied	3	dissatisfied
non-self-	4	<b>self-</b>
confident		<b>confident</b>
		<b>61%</b>
honest	3	dishonest
<b>67% good</b>	2	bad parents
<b>parents</b>		
<b>64% rational</b>	2	emotional
bad	3	good
neighbours		neighbours
lively	3	quiet
<b>51% they lie</b>	2	they don't lie
beautiful	3	ugly
creative	3	non-creative
unhappy	3	happy
loners	4	<b>sociable 59%</b>
<b>48%</b>	2	relaxed
<b>stressing</b>		
<b>themselves</b>		

From the addressed members of majority population, people pertaining by their age into the period of older adulthood (46 – 60 years) were the least willing to fill out the questionnaire. The reason can be just this age when a person helps himself with stereotypes giving him security, and concentrates only on his close persons, selecting so the displays of openness and affection to disadvantage of strangers (18), further this age group corresponds to the generation of two revolution and to an intergeneration used to play contradictory official and private roles (9), which showed also in addressing potential respondents, when persons in this age were afraid from expressing their opinions and did not believe that the questionnaire was anonymous.

In Roma, I met mistrust and in the younger ones also affirmations that they were not Roma but Italians, which reminds the problems of the present identity of this ethnic group.

The results from the semantic differential were surprisingly uniform in majority population, the differences were minimal, regardless of whether they were evaluated by the highest education reached, sex, age or place of residence of the respondents. (This finding matches with the information of Лы́ковъ: They are taken even by groups of persons who in the western countries show tolerant or neutral attitudes – persons with university education, persons with high school education, religious

persons or people without personal negative experience (16); it is an alarming discovery when the same negative prejudices go across the whole population. So they must be a certain standard, tradition for perception of the Roma, and they advert to a high conservatism of the majority population, naturally related with an aversion to changes, which are necessary for the solution of the Roma matter – or better the Czech matter. The Project of Tolerance of the Government of the Czech Republic points out the rigidity of the stereotypic opinions of the Roma as well – the values and features characterizing the Roma were, according to the opinion of the respondents, unchangeable and fixed features following from the character of the Roma, i.e. inborn characteristics. (The characteristics were in contradiction with life values of the majority Czech society (PROJECT OF TOLERANCE)).

Majority population has the following negative prejudices about the minority Roma population – the Roma are in their opinion: stupid, repelling, bad neighbours, untidy, lazy, dissatisfied, irresponsible, dishonest, they lie, steal (in the characteristics followed by the Project of Tolerance, the results were identical – honesty – 2,5, diligence – 2,4, responsibility – 2,5, where 10 goes for “matches fully” and 1 for “does not match at all” (PROJECT OF TOLERANCE). The results correspond to the description of a typical Roma in the eyes of the

majority according to Ø íèan):... a dark-skinned asocial who cannot be trusted, from whom principally violence, lie and theft can be expected, a person tricky on the one hand, and infantile, incapable to plan and to take care of his own long-term interest, uneducated, unreliable, lazy, a dirty and randy primitive on the other hand (15).

The majority population in the Czech Republic is annoyed when somebody behaves otherwise than the majority (8 respondents out of ten (PROJECT TOLERANCE)). When we put together this fact, the rigidity of the opinions of the majority and the so called self fulfilling prophecy (when the prejudice influences the prejudice carrier who behaves so as to demonstrate the rightness of his prejudice, so after a longer period of his influence, he causes the reaction of the object of the prejudice who behaves in the sense of the prejudice so as to defend himself (7)), we see quite clearly that the Roma could not keep the Roma identity based on Romipen and that a change of this identity had to come sooner or later - with suppression of positive features of Roma identity (language, culture, warm interpersonal relations, musicality, craft skills) and reinforcement of the negative ones. This is connected with the origin of a certain group inferiority complex, when members of a long-term oppressed and disdained minority have tendency to take over the negative picture that majority has of them (15).

Another fact for reflection is the measure of influence of the respondents by media and by own experience with the Roma. 49% of non-Roma respondents state negative personal experience with the Roma. In a few descriptions (16 in total) of this experience that was several (four) times attack with the purpose of theft. Crime of the Roma is the best example, and sufficiently tell-all, on which a certain "justifiability" of the prejudice could be showed: a high share of facts encouraging to the origin of the prejudice that the Roma steal. For example in Ёstн nad Labem, the situation is such that most families have something to do with crime (1). According to Veierkov (1999), the share of the Roma on the total cleared-up criminality is three to four times higher than it would correspond to their number in the republic (15).

This influences the members of majority population, and a prejudice towards all members of minority Roma population originates, but there is another side to this issue as well: The Roma are often caught because of insufficient premeditation of the delict, they generally do not have so good lawyers, the judges can be influenced by their prejudices, and there are also a lot of causes of high Roma criminality - unemployment, rootlessness, pressure of expectances of the public and tension between the "gadjos" and the Roma (15). But only few

members of majority population can see that far.

A positive finding is the fact that the respondents had no prejudices in the following pairs of characteristics: bad or good friends, beautiful or ugly, creative or non-creative, bad or good, bad or good parents (in the Project of Tolerance, the sense for family of the Roma is evaluated with the mark 2,7 - 10 going for "matches fully" and 1 for "does not match at all" (PROJECT OF TOLERANCE)), poor or rich, generous or egoistic, and envious or non-envious. These are the characteristics about which there are no generally widespread prejudices in the majority society. When the member of majority population wanted to mark the Roma down somewhere, he would have to know them, but only 4% of the respondents of the Project of Tolerance met Roma as their friends or acquaintances (PROJECT OF TOLERANCE). The absence of prejudices in these pairs of features indicates that majority society would be open to change their negative prejudices. One of the possible ways is to learn to know this ethnic group, at least through teaching at schools, which runs in universities already, but it is mostly only about the history of the Roma ethnic group.

A second layer of thinking by the majority population about the minority Roma population projected itself into the results as well. It is the freedom, the unrestrained life of the Roma, that we envy them sometimes,

knowingly or unknowingly. This was projected in the results in the following positive prejudices - the Roma are, in opinion of majority population, happy, cheerful, spontaneous, sociable, they do not stress themselves, they are self-confident, lively and emotional.

The highest number of negative prejudices was showed by respondents in the age group from 46 - 60 years, who come under the age group (older adulthood) that was the least willing to fill out the questionnaire. This life period is one of the most demanding in the life of a person - he must cope with reduction of his physical abilities and physiological functions, prepare himself for pension, cope with pressure of both extreme generations - parents who often die and children who go away and establish their own families (18). In this period, the stereotypes help, being more easy to master and reinforcing the feeling of security (12), further the displays of affection and altruism are selected to the benefit of close persons (18). The Czechs have a tendency to seek enemies artificially, which is one of the consequences of real socialism (3). When we add that this respondent group corresponds with their age to the generation of two revolutions and to an intergeneration, the generations particularly adapted to socialist moral (9), we seem to have explanation for the attitudes so hostile.

Respondents in the age group from 61 – 75 years of age and respondents with basic education had the lowest number of negative prejudices. The explanation is simple. These persons are in the closest contact with the Roma because Roma perform mostly non-qualified work thanks to their education, and also in personal contact, if I draw from my experience of a native ĽstĽ citizen. The Project of Tolerance confirms this indirectly too: More persons who are in closer contact with the Roma were in the region of ĽstĽ (PROJECT OF TOLERANCE). It can be seen even better on the results - for respondents with basic education, the Roma are independent, creative and good friends (in ĽstĽ nad Labem, they are also evaluated as good persons).

The majority population seems to show other results than the western society. According to above quoted ĽĽĽkovĽ, persons with university and high school education. (16) have negative prejudices as well, this was confirmed, but the difference is that respondents with basic education were the second ones who had the lowest number of negative prejudices. In the Czech Republic, when prejudices originate, the psychological mechanism of transfer probably does not apply so strongly; in this mechanism, the feelings of hostility or anger turn against something that is not their actual cause. This phenomenon often occurs when two disadvantaged groups compete against each other to reach economic positions (8), most

often persons with lower education and immigrants, national minorities, because common scapegoats are often groups that differ markedly and have relatively small power, so that they offer an easy object (8). In our country, this phenomenon does not occur with regard to Roma probably for the reason of a very low competitiveness of the Roma ethnic group on the job market.

The respondents from ĽstĽ showed generally more negative prejudices. It could almost be expected because in ĽstĽ nad Labem, the Roma population is much more represented than in ĽeskĽ BudĽjovice. This represents a much stronger visibility of the problems with the Roma, which occur in certain localities of the town. The opinions of the citizens of ĽstĽ were certainly influenced by the case of the construction of the fence in the street MatĽĽĽ as well, when 76% of the respondents of the Project of Tolerance perceived it as a consequence of the unwillingness of the Roma to adapt themselves to the rules of citizen coexistence (PROJECT OF TOLERANCE). Besides, 59% of non-Roma respondents state negative personal experience with the Roma.

F. Peroutka declared already that we had no understanding, being a nation of the centre, with distinct tendencies to small-mindedness and submission (3).

Less than a tenth of the respondents (8%) of the Project of Tolerance

perceived Roma as a racist group. But the Roma intellectual Vlado Olšh says categorically: Roma are not racists (15). ШНИан describes Roma nationalism as a more adequate denomination of reactive and defensive aversion of the minority than racism is.

But we can find certain displays of racism in Roma too. If we can believe the security report for the year 1998, the Roma had a significant share on extremist or racism motivated crimes (17) (15). In spite of it, we have to consider to which level it is a defensive, counterattack reaction, while the Roma perceive the gadjos and their institutions as enemies, having general feeling of danger, not identifying themselves with the political system, feeling as second category citizens (15). And no wonder, because they meet moderated forms of racism almost every day (for example a lot of restaurants in ЪstH nad Labem refuse entry to unwanted clients with the words – we have all reserved), and an example of discrimination is for example the law from the year 1993 about obtaining citizenship of the Czech Republic.

According to Lackovč (1997), the basic Roma anti-gadjo prejudice, a stereotype gadjo image, can be expressed as follows: Imbecile, fool, niggard, varlet that would eat even shit when it didn't stink (15).

The results do not correspond fully to the above mentioned – the Roma

respondents perceived the majority population, on the contrary, as clever, self-confident, independent, clean, cheery, sociable and as good parents and neighbours.

There were not many negative prejudices – envious, stressing themselves, egoistic, they lie, are rational and rich.

When we look at the resulting evaluation of personal experience of the Roma respondents with majority population, we can see that in 51% it was positive experience (in Тeskū Budmjovice 60%) and 26% of the respondents stated experience of both classes.

The question is whether they do not perceive moderate “everyday” forms of racism as a norm, and so their sensitivity threshold against racism is not higher. The reason can be possibly seen also in the effort of the Roma ethnic group to live as the majority society. The Roma have taken over most values of majority population and it is more advantageous for them to try to live as majority population. So majority population can have become a model that the Roma want to reach. In the above mentioned inferiority complex, the Czech majority society is, probably, really a model for the Roma. The effort to live as members of majority society is confirmed by such trivialities as: bleached hair of the women, appreciation of marriage with a gadjo partner and also non-declaring Roma nationality by Roma elites.

The lowest number of negative prejudices was expressed by the age group of respondents in the age from 21 - 34 years of age, corresponding to young generation that has a tendency to humanization of behaviour (9). In this age, the person takes into consideration all components of the problem, is able to make compromise (18) and tries to assert himself/herself in the society.

The highest number of negative prejudices were declared by respondents in the age from 35 - 45 years of age (middle adulthood), corresponding to the generation particularly strongly adapted to post-normalization substitute values (9). Furthermore, the adaptation of Roma was related to a special social care imposed by the government in the year 1970 (in 1976, this care became a part of the law of security (16)) that does not exist in such a measure today. These persons must have got used to new condition after the Velvet Revolution of 1989 particularly hardly, while the interethnic tension was "released" by increase of the number of incidents of racial violence. Besides, in the period of middle adulthood a crises arrives, the past is balanced, the person puts more stress on individual needs (18).

Absolutely highest number of negative prejudices towards majority population was expressed by respondents from Veskň Budmjovice in the age from 18 - 20

years. Developmental psychology says that in this age, the person is not loaded by experience, and that's why he/she sometimes thinks too radically (18). The respondents from Veskň Budmjovice in the same age did not show any other negative prejudices in comparison to total results.

It is possible that 38% of respondents of the Project of Tolerance could be right when stating that the present Czech society is more tolerant to national and ethnic minorities than ten years ago (PROJECT OF TOLERANCE) and this fact could reflect in the prejudices of the Roma towards majority society?

## 5. CONCLUSION

This work was a probe, a try to monitor the level of negative prejudices as one of the possible reasons and at the same time conflicts and tensions on both interested parties, which had been carried out only several times before in the minority population.

There are mutual negative prejudices between majority population and minority Roma population, but the Roma show also a lot of positive prejudices towards majority population. That means that the Roma show less hostile attitudes towards majority population than majority population towards them. Further, we must become aware of the fact that from the Roma quarter, it is mainly a defensive, counterattack reaction.

Majority population perceived Roma as asocial persons who are hardly to get on and cannot be trusted to by members of majority population, as an ethnic group not living after the rules of majority society, and at the same time as free, unrestrained individuals, which matches to literature.

The conservatism in the kind and number of negative prejudices was startling - the results did not differ, regardless of whether the respondents were classified by sex, education, age or towns where they live. This refers us back to the aim and to the program of solution of this interethnic conflict, including prevention, for which the knowledge of negative prejudices is necessary, because they rank among the motives of the problem and are unconscious in most cases. It would be appropriate to include their knowledge into public discussion and teaching at schools, because only in this way, they can become conscious and possibly be changed.

In spite of considerable conservatism of majority population in negative prejudices towards Roma, the result in characteristics not ranking among generally widespread prejudices indicates the possibility of a change. In these pairs of characteristics, the respondents did not show any prejudices (e.g. in the question of the quality of parenthood).

An important fact is that the Roma have a lot of positive prejudices towards majority population, although they are exposed to moderate "everyday" forms of racism displays. The question is whether their perception of these displays did not become standard and the sensitivity threshold did not become higher.

It is necessary to put together all the fragments of the mosaic that should be pieced together on the way towards mutual perception and behaviour between majority population and minority Roma population.

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## REFERENCES

1. Bajgerová, E. Personal communication. Romany coordinator of the town Ústí nad Labem, 2002.
2. Disman, M. *Jak se vyrábí sociologická znalost: pø í ruèka pro u•ivatele*. Praha: Karolinum, 1993.
3. Fibich, J. Problémy transformace a demokratizace mentality èlovì ka. In: *Transformace èeské spoleènosti 1989-1995*. Brno: Doplnì k, 1996, p. 249-289.
4. Friš tenská, H. Romové a státní politika. In: *Romové – reflexe problému*. Praha: Sofis, 1997, p 34-45.
5. Friš tenská, H. Interetnický konflikt po roce 1989 s ohledem na sou•ití s Romy. In: *Romové v Èeské republice (1945-1998)*. Praha: Socioklub, 1999, p. 244-266.
6. Gabal, I. Zahranièní inspirace k integraci Romù . In: *Romové v Èeské republice (1945-1998)*. Praha: Socioklub 1999, p. 67-90.
7. Geist, B. *Sociologický slovní k*. Praha: Victoria Publishing, 1992.

8. Giddens, A. *Sociologie*. Praha: Argo, 1999.
9. Kabátek, A. Sociologie generace. In: *Sociologické texty II (Speciální a aplikovaná sociologie)*. Praha: Karolinum, 1995, p. 13-40.
10. Kalibová, K. Demografické a geodemografické charakteristiky romské populace v České republice. In: *Romové – reflexe problému*. Praha: Sofis, 1997, p. 20-33.
11. Lacková, E. *Narodila jsem se pod š •astnou hv ě zdou*. Praha: Triáda, 1997.
12. Langmeier, J. *Vývojová psychologie pro di tské lékaø e*. Praha: Avicenum, 1991.
13. Pekárek, P. Romové mezi námi. In: *Romové – reflexe problému*. Praha: Sofis, 1997, p. 11-19.
14. Pribád, J. K sociologii etnických vztahù (Sociální a právní postavení Romù ). In: *Sociologické texty II*. Praha: Karolinum, 1995, p. 154-165.
15. Ø í èan, P. *S Romy • í t budeme – jde o to jak*. Praha: Portál, 2000.
16. Š iš ková, T. Rasismus, xenofobie a intolerance z hlediska práva, sociologie a antropologie. In: *Výchova k toleranci a proti rasismu*. Praha: Portál, 1998, p. 9.
17. Uhl, P. *Koncepce romské integrace. Materiál pø ipravený pro jednání vlády*, verze z 11.1. 2000.
18. Vágnerová, M. *Vývojová psychologie*. Praha: Portál, 2000.
19. Veøerka, K. Romové a speciální patologie. In: *Romové v Èeské republice (1945-1998)*. Praha: Socioklub, 1999, p. 417-446.
20. Rychetský, P.; Uhl, P. *Informace o plni ní usnesení vlády týkající cí se integrace romských komunit a aktivní ho postupu státní správy pø i uskuteèò ování opatø ení pø ijatých i mito usnesení mi ke dni 31. prosince 2000*. Praha: prosinec 2000, Èj.: 3625/00 – LRV.
21. Èeský statistický úø ad. *Prù bi •né výsledky sè í tání lidu, domù a bytù 2001*. Poslední aktualizace: 2001.
22. Dostupné z: <<http://www.czso.cz:8005/sldbr-win/owa/gtuz?xjazyk=cz&xtab=02>>
23. Rada vlády Èeské republiky pro lidská práva. *PROJEKT TOLERANCE vlády Èeské republiky*. Poslední aktualizace: 10.5. 2000.
24. Dostupné z: <<http://www.vlada.cz/vrk/rady/rlp/projekt-toletance/index.htm>>

## **ორმხრივი ცრურწმენები მოსახლეობის უმრავლესობასა და უმცირეს ბოშა მოსახლეობას შორის**

### **მარკეტა ელისოვა**

ორმხრივი ცრურწმენები მოსახლეობის უმრავლესობასა და უმცირეს ბოშა მოსახლეობას შორის შესწავლილ იქნა სემანტიკური დიფერენცირების გამოყენებით ორ დემოგრაფიულად განსხვავებულ ქალაქში. სვადასხვა კრიგერიუმებით კლასიფიცირებულ მოსახლეობის უმრავლესობის ყველა ჯგუფს ნეგატიური განწყობა ახასიათებს. გასაკვირია, მაგრამ ბოშა მოსახლეობას ნაკლებად აქვს ნეგატიური განწყობა და უფრო მეტად პოზიტიური დამოკიდებულება გააჩნიათ.

## ANNEXE 1

### Note 1

In the Czech Republic, there live 11 746 Roma who have declared their nationality in the census of people, houses and flats in 2001, but their number is estimated as 200 000 in total. Present Roma population in Czech Republic represents actually the third or fourth generation of Slovak and in limited quantity Hungarian Roma who came immediately after the end of World War II in connection with borderland colonization (Pribáð, 1995).

### Note 2

Eight respondents out of ten complained that somebody behaves in other way than majority (one of the results of the PROJECT OF TOLERANCE of the Government of the Czech Republic).

### Note 3

These two towns were selected because of their dissimilarity. In the region of Ústí , about a fourth of the whole number of Roma live, representing also the highest share of total population. In contrast to that, the lowest number of Roma lives in South Bohemian Region, except Èeský Krumlov (Kalibová, 1997). These two localities differ also in other respects: industrial North, agricultural South.

## THE ROMA MINORITY IN SOME COUNTRIES OF THE EUROPEAN UNION IN CONNECTION WITH THEIR INTERNATIONAL PROVISION

Petra Vojtová<sup>1</sup>, Eva Davidová<sup>1</sup>, Petr Lhotka<sup>1</sup>

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### ABSTRACT

The legal status of Roma people is different in particular states of the European Union and their position depends on intrastate legislative and ratification international convention thus possibility of the state. In some countries (e.g.: France, Greece and part of Spain) they don't recognize de jure national or ethnical minorities. The other states legally accept existence of these minority groups but except Roma people. Officially, the Roma people have a status of national minority particularly in new member state (from central and east Europe) of the European Union where numerous Roma communities live (e.g.: in Czech Republic, Slovak Republic, Hungary, Slovenia) as well as in some other member state (from west Europe) Austria, Germany, Finland, Netherlands.

In most new member state of the European Union including Czech Republic Roma have a legal status of national or ethnical minority. Confession of this status doesn't guarantee the real equality and doesn't improve their social status. Many Roma people don't declare own nationality (on basis of negative historical experiences and present social prejudices) and many of them even deny their origin and don't want to identify with in some situation. The Roma will probably start to benefit from their national and ethnical laws, when most of them are not counted as socially excluded community and they stop to be dependent on poor-relief and than social-economical situation improve including their employment. The next condition is the improvement of majority's view towards Roma as well as need to change negative xenophobe attitude to Roma.

### Key words:

*Roma, Sinti, Travellers, legal status, minority right, European Union, national group, ethnical group, international protection.*

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### 1. INTRODUCTION

The article describes the research project "The legal status of Roma in the countries of the European Union - No. RB 10/2/03" (see below), which was concerned in legal status of Roma people in some countries of the European Union. The object of the project was to collect data about legal status of all minority groups

including Roma communities in six particular states (The United Kingdom, Finland, Spain, Austria, Germany and Greece). From the documents and research findings was on basis of exploring (theoretical, practical, field research, etc.) in these countries done summary analysis and also final report. The project pays attention to how the collective minority rights are

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asserted and to social status of these minorities. These rights ensure not only the preservation but also the development of collective minority identities. This right was asserted since 90's of 20. century (e.g.: Framework Convention for the Protection of National Minorities and European Charter for Regional or Minority Languages – the both are international instrument of Council of Europe to minority protection). The report follows the change of International institutions' attitude to these problems, concerning the description of this ethnical group as well as how this group is entitled.

## 2. ROMA PEOPLE

### 2.1. Roma communities

Roma and itinerant live not only in almost all countries of Europe, but they also in other continents within world of the assumed number 12-14 millions. Many Roma communities are living till now in Northern and South America where they came during the colonization effort in 19. century. Among the most noticeable transatlantic groups of Roma belong the Romanichal, who found their home in Ohio, Pennsylvania and Virginia as well as the Ludary (Rudary) who stated for some time in New York and worked as the acrobats, the actors, and the animal tamers. Some of them left their community and went across Canada, Cuba and Mexico to another continent to Australia, (12). Groups of Roma were subsequently arrived in the European continent during the

middle ages. They came from middle Asia and Balkan Peninsula. Till now they represent the most numerous ethnical or national group with estimated 8-10 millions Roma, (24). Roma are joint together not only by collective Indic origin, similar language, analogy of historical development particularly their collective foundation of culture, traditions and value orientation. All these particularities are binding them to one Roma ethnical unite within the Europe and whole world. They are not single homogenous unit, but they are distinguished according to particular country where they settled and live now and according to the internal identification, subgroup membership and according to their position and lifestyle.

Collective title the Rom, Roma which is used by most Roma as ethnonym (the term created by their community) and is officially used since 1971, (1). The minor part of Roma which doesn't use the collective title Roma are Sinti (they live mainly in Germany, Austria, in France, Netherlands and in Czech Republic). The other groups are Travellers (they live in England, Wales, Scotland and Ireland) to them belong also Roma people. On the other side the exoethnonym Gypsy is appellative which most of majority society use in many (inter)national documents or historical publication in all Slavic countries till 1990. In other countries we can meet the parallel of this title for example: Zigeuner (German), Zingari (Italian),

Tsiganes (French), Gypsies (English), Gitanos (Spanish) – (22).

## 2.2. The history of Roma communities

The historical development and growth of standard of minority groups protection was started in Europe in second part of 20. century. The issue of national and ethnical groups was solved in international treaties after the end of World War I. After the Second World War – the time of genocide were adopted fundamentals of individual human rights protection. The development led from bilateral international agreements towards organizations and treaties not only within Europe. That is important not only to strengthen responsibility of particular state in keeping the standards and minority groups rights. We should pay attention to international responsibility for assertion of human or minority group rights. Position of minority groups still stays the issues for particular state. In this respect there is a difference between states on the west from River Ryn (e.g.: France, Italy and Spain) and east from River Ryn (e.g.: Germany, Austria, Czech Republic). The west states are referring to republican model based on civil principles; they have not wholly adopted collective minority groups rights in their legislation. In east states there has already been tradition of adoption the collective rights of national minorities (the countries in the area of old Austria-Hungary).

Non existence one's own state has till today as consequence that many of Roma are dependent in frame protection of their minority rights on government particular state in some case international organization, (20)

Regarding the fact that European legislation has collective rights of minority group always connected with the issue of citizenship (only citizen of the state have these rights), it's important that Roma are recognized as all-European minority group because the part of Roma (especially, the emigration group, who hasn't citizenship of the host state) would stay out of these rights. Roma are often victims of discrimination and racism in all states and it is necessary to provide them with protection in all-European context. Provision of this protection would mean to guarantee the equality in possibilities for personal realization minority rights, (32).

Struggle against discrimination of Roma was mostly connected with struggle for Itinerant rights (particular in Great Britain and France, etc.). The first documents concerning this problem in European context were based on this above mentioned problem. The cause of European institutions' interest about Roma problems was the migration of Roma from the central and south-eastern European states, (where live most of Roma population, in 90's of 20.century). The conditions of Roma life became worse when these states

transformed their economic to marked economy. This transformation caused a large unemployment which resulted in negative affect on their social conditions. The position of Roma minority group is different from their position in west countries because they represent the settled down community which is excluded from the life of majority population (especially in Romania, Bulgaria and Slovakia).

### 2.3. THE ROMA COMMUNITIES, EUROPE AND THE WORLD

*The Human Rights and the Legislation, United Nations Institutions.* The consequence of these facts was increasing rate of emigration of many Roma from the East Europe to West Europe (Great Britain, Canada, Germany, Sweden, Belgium, etc.) at the beginning of 90's of last century. The issue of Roma position in central and south-eastern Europe countries became all-European problem. Roma from central and south-eastern Europe started to participate in international Roma movement after the fourth world congress of International Roma union in Warsaw, 1990. There were appointed to deputies the Roma from central and south-eastern Europe for first time, (8)

Within the Europe there were adopted some international documents, were regulated rights concerning the position of national minorities. In the states where these

collective rights collection instrument were adopted, the Roma are considered as one of these minorities. This process was successful for Roma people of all Europe including the western countries. The western states started to take the issue of Roma position into account. The new member accession to European structures for example Council of Europe meant retrospectively the pressure on provision of collective minority rights for Roma in western Europe living.

As the first the international forum pointed out the problem of racism in connection in Roma at the Conference for Security and Cooperation in Europe (CSCE/OSCE). At the conference in Copenhagen, 1990<sup>1</sup> there were first mentions in summary documents that it is necessary to recognize in particularly states the problems that Roma must face. These problems are mostly connected with racial and ethnical hate and discrimination. In 1993 was represented by High Commissioner for national minority CSCE summary report concerning the position of Roma in CSCE/OSCE member states (see Report of the High Commissioner on National Minorities, 1993).

The Roma were described as very different population which hadn't access to basic rights and to full participation in life of society. There are collective Roma features because of collective origin, language,

culture, historical experience and current problems. According to this report the present position of Roma was influenced especially by economical and political situation. As main Roma problems were identified the poorness, massive unemployment, low level education, insufficient health care and substandard life conditions.

Relative small attention was paid to Roma from central-eastern Europe and till new problems came after social-political changes in 90's and particularly after Roma migration from these countries.

The United Nations institutions responded to the situation and position of Roma in their resolutions. The Subcommittee for prevention of discrimination and protection of minority group adopted the Resolution No. 2/1990 where pronounced disconcertion of prejudice and discrimination based on ethnical, national, religious and language's minorities. One year later was adopted the Resolution No. 21/1991 about minority protection, where was paid attention to the fact that there are barriers for realizations of Roma rights. These barriers lead to their discrimination and this minority group came to be "especially vulnerable group". As the break point in European institutions perception of Roma we can mark the Recommendation 1203 (1993) on Gypsies in Europe. According to this recommendation the Roma have special position in

society as minority group without own country. Although according to this document they are really minority group, they are not considered as national or linguistic minority in some countries yet. They were described as non-territorial minority, which needs special protections (29).

The legal status of Roma is different considering collective rights in particularly EU countries. We can divide EU states to countries which recognize the national minority conception and the countries which don't. All countries guarantee the rights for individual protection against discrimination and racism.

The dividing into these groups reflects different development of western EU states which unified their population in 16.-17. century. The western area was controlled by main political centers which made the nations including ethnical groups which are now in south-eastern EU states understood as national minorities. The south-eastern countries, where the process of state building took place two centuries later (19.-20.) didn't achieve the cultural dominance of political centers. They awarded already during their foundation some collection of rights especially to the minorities who lived at the border. With these human rights contains the right to use minority language in official acts and in state education, the claims for financial support of cultural activities, were provided

also Roma communities in eastern EU states to eliminate their social exclusion. Unique model of minority authorities is in Hungary, where the state guarantees the foundation of the minority authority to Roma people (according to the results of the election). The use minority suffrage is certain rights of Hungarians, (see Monitoring - the EU Accession Process).

However, in many new EU member states including Czech Republic is legally recognized the status of nationality and ethnical group for Roma, doesn't guarantee the real equal in rights and doesn't help to improve their social position. Many of them don't declare Roma nationality (in population census) because of negative historical experiences and prejudices and many of them even hide Roma identity. They will not use national and ethnical rights until many of them are counted as social exclusion community until they are dependent on social benefit so after their social position and existent conditions (for example employment) will improve. The second condition to improve is the perception of Roma by majority society, because there are still negative prejudices and discriminating positions.

Inside Roma community (in their representation) there are two different views on position of Roma, Sinti and Travellers within the Europe and within particular states. One part is follower of this view of

non-territorial European Roma nation (vide the efforts of International Roma Union - IRU, formulated in Memorandum, 2001). The followers of this way are from EU states - Great Britain, Austria, Germany, Finland, Netherlands, Sweden and Belgium as well as from south-eastern countries of Europe. The second part prefers identification with homeland and doesn't effort for recognition of specific Roma nationality, especially Spain, Greece, in part of Germany. In particular states there are the Roma followers of both opinions, but one is only prevailing.

In some member states (for example Austria, Germany, Netherlands, Italy and Nordic states) there are new numerously Roma communities, that created by migration from south-eastern and central Europe (from Balkans countries, Czech Republic and Slovak Republic). The destination countries recognize new Roma as immigrant communities in contrast from old settled Roma communities, who distance from new immigrants and don't like them.

From 90's of 20 century there is developed new form of Roma representation (European Roma and Travellers Forum). The idea took a more concrete form when in 2001 Mrs. Tarja Halonen, President of Finland, (21). It was the Roma themselves who started thinking of a body that would help them express their concerns at the European level. The Roma deputies from south-eastern

countries brought to international conferences new opinions and mainly they formulated more offensive political strategy than their colleagues from west Europe did. The Forum is open to Roma, Sinti, Kale, Travellers and other related groups. The members of the Forum are the national umbrella organizations and the Roma international organizations. These members will nominate delegates to sit in the plenary meetings and in the Executive Committee.

The role of international organizations (International Roma Union, Committee on the Elimination Racial Discrimination) is in relation to Roma unsubstitutable because these organizations substitute their "mother state" and effort to assert and formulate Roma rights. International organizations are become the guarantors Roma rights.

The main international institutions (UNO, Council of Europe, European Union) are participate at formation of human rights protection by forming international legal instruments for their provision.

In frame of United National Organization:

- Convention on the Elimination of All Forms Racial Discrimination
- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights

- Convention on the Elimination of All Forms of Discrimination against Women

In frame of Council of Europe:

- The European Convention on Human Rights
- Framework Convention for the Protection of National Minorities
- European Charter for Regional or Minority Languages

### 3. DISCUSSION AND CONCLUSION

The legal status of Roma is guaranteed in EU only within the protection of minorities and generally protection against discrimination. In last few years, the provisions concerning people of social exclusion community (it is not good, to apply the term of social exclusion only to all Roma communities and take the term as a basic for their definition of ethnicity). Protection of minorities is particularly provided by Council of Europe instruments, which are accepted by European Union, and based on memberships in these all-European structures.

The particular legal status of Roma in EU states is different according to domestic laws about minorities' position in each country. Some states don't legally accept the existence national or ethnical minorities for example France, Greece, in part of Spain. The other states accept the existence of ethnical or minority groups but they don't include Roma to these groups. Formally, the Roma

nationality is legally recognized in new member states of EU, where many numerous Roma communities are (for example: Czech Republic, Slovak Republic, Hungary and Slovenia) and also in some older member states of EU (for example: Austria, partly of Germany, Netherlands) whereas in some of them is term nationality identified as

ethnic group. But these terms are not synonyms. Ethnic group is wider term, that expressive ethnical citizenship, whereas nationality is narrower political or legal term. In legal forms of some countries is the term ethnical group used instead of the term nationality (for example: Austria, Germany).

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### REFERENCES

1. Acton, T.- Klímová, I.: The International Romani Union: An East European answer to West European questions? In Between past and future. The Roma of Central and Eastern Europe. Guy, W. (ed.), University of Hertfordshire Press 2001, p.158
2. Acton, T. (ed.): Gypsy politics and Traveller identity, University of Hertfordshire Press 1999
3. Activities of the Council of Europe concerning Roma/Gypsies and Travellers, MG-S-ROM (2000) 17, Strasbourg 2000
4. Candidate States, Open Society Institute, Budapest, October 2002
5. Convention on the Elimination of All Forms of Discrimination against Women, 1979
6. Country reports: France, Germany, Spain, United Kingdom. Open Society Institute, Budapest, October 2002
7. Cleaning operations – Excluding Roma in Greece. ERRC – Greek Helsinki Monitoring, 2003.
8. Danbakli, M. (ed.): On Gypsies: Texts issued by International Institutions, Interface Collection, vol.5, CRDP
9. Midi-Pyrenees 1994 p. 44
10. Davidová, E. – Cesty Romů /Romano Drom. Olomouc: UP, 1995
11. European Charter for Regional or Minority Languages, 1992
12. Fraser, A.: The Gypsies. Blackwell, Oxford/Cambridge (Mass.) 1995 p.195
13. Framework Convention for the Protection of National Minorities, 1995
14. Gedlu, M. (ed.): Romové a Evropa – The Roma and Europe (textbook of symposium), Štípín 1998.
15. Guy, W. (ed.): Between past and future. The Roma of Central and Eastern Europe, University of Hertfordshire Press 2001
16. Guy, W. - Uherek, Z. - Weinerová, R. (ed.): Roma Migration in Europe: Case Studies, EU AV CR, Prague 2003.
17. International Convention on the Elimination of All Forms Racial Discrimination, 1966
18. International Covenant on Civil and Political Rights, 1966
19. International Covenant on Economic, Social and Cultural Rights, 1966
20. Karoly, M.: Roma in Österreich. Zur Genese einer Minderheit, dipl. práce Univerzita Wien, 1998 p.112
21. Křištof, R.: Finská iniciativa – návrh na ustanovení Evropského romského fóra (ERF). The research project RB 11/17/03 Of Ministry of Foreign Affairs, Czech Republic, 2003 p. 2.
22. Horváthová, J. – Kapitoly z dějin Romů Praha: Lidové noviny, 2002 p. 14
23. Kenrick, D. - Clark, C.: Moving on- The Gypsies and Travellers of Britain, University of Hertfordshire Press, 1995.
24. Liégeois, J. P.: Roma, Gypsies and Travellers, Strasbourg 1987. p. 76

25. Monitoring - the EU Accession Process. Minority Protection, Vol. II, Case Study in Selected Member States, , Open Society Institute, Budapest 2002 p. 103
26. Monitoring - the EU Accession Process: Minority Protection, Vol. I the Assessment of Selected Policies. Právní nástroje k ochranì národnostní ch menš in. Praha 1997
27. Roma (Gypsies) in the OSCE Region. Report of the High Commissioner on National Minorities. Meeting of the Committee of Senior Officials 21-23.9.1993
28. Report of the High Commissioner on National Minorities. Meeting of the Committee of Senior Officials 21-23.9.1993
29. Recommendation 1203 (1993) on Gypsies in Europe. Assembly debate on 2 February 1993 (24th Sitting) (see Doc. 6733, report of the Committee on Culture and Education, Rapporteur : Mrs Verspaget).
30. Salo, S., Csaba, P. (ed.): Ethnic Identities in dynamic Perspectives. (Gypsy Lore Society – Conference). Ethnical and National Minority Studies, Institute-HA of Sciences, Budapest 2003.
31. The European Convention on Human Rights, 1950
32. Walek, C.: Status prawny i faktyczny Romów w Republice Czeskiej w œwietle europejskich standardów ochrony praw mniejszoœci. Diplomová práce, Krakow 1999, p.21

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## ბოზა უმცირესობები ევროკავშირის ზოგიერთ ქვეყანაში

პეტრა ვოლტოვა, ევა დავიდოვა, პეტერ ლოტკა

ევროკავშირის სხვადასხვა ქვეყნებში ბოშების იურიდიული სტატუსი განსხვავებულია და მათი მდგომარეობა დამოკიდებულია ქვეყნის კანონმდებლობასა და მის მიერ საერთაშორისო კონვენციების რატიფიკაციაზე, აქედან გამომდინარე კი ქვეყნის შესაძლებლობებზე. ზოგიერთ ქვეყანაში (მაგ. საფრანგეთში, საბერძნეთში და ესპანეთის ნაწილში) ისინი არ არიან იურიდიულად აღიარებული როგორც ეთიკური ან ეროვნული უმცირესობა. ბოშებისათვის ალბათ სარგებელის მომგანი იქნება მათი ეროვნული და ეთიკური კუთვნილების შესახებ კანონების მიღება იმ პირობებში, როდესაც მათი უმრავლესობა არ აღიქმება საზოგადოების სრულუფლებიან წევრად და ეს ბევრად გააუმჯობესებს მათ მდგომარეობას დასაქმების თვალსაზრისითაც. კიდევ ერთი პირობაა მათ მიმართ უმრავლესობის დამოკიდებულების გაუმჯობესება და მათზე შეხედულების შეცვლა.

## THE ROMA POSITION IN CONNECTION WITH EDUCATION IN FINLAND

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### ABSTRACT

Roma people have inhabited Finland since the sixteenth century. The Roma transferred to Finland from Sweden, but also from the east. The first people were seen in the Aland Islands in 1559, and in the town of Turku they were seen in 1580. Their exact number is not known because Finnish citizens are not registered according to their ethnic origin. According to the latest estimates, there are at least 10.000 Roma people in Finland. In addition, about 3 000 Finnish Roma people live in Sweden.

Today the Roma in Finland have full civil rights and civil duties. The Roma are both Finns and Roma people. Majority of the Roma lives in cities and they have permanent residences. The unsettled life has come to an end. Majority of the Roma living in Finland (about 90 percent) belong to evangelical Lutheran church. The Roma have usually adopted the majority religion of their country of residence. The Roma are, on the average, in a poorer socio-economical position than other Finns, due to insufficient education, among other things.

As Finnish citizens, Roma communities are entitled to the same education as the majority population. However, in practice the position of the Roma as regards education is more difficult than that of the majority. In recent years, the educational level of the Roma has improved considerably, but compared to the majority population, it remains low. The problem for Romany children continues to be failure to complete the comprehensive school, which makes it difficult for them to enter further education. On the other hand, it must be recalled that the Roma educational tradition is still relatively young. Various reports show that the education received by older people remains inadequate and that they even include illiterates. The Advisory Board participates with the Roma people and N-GO in state or interstates to improve Roma situation in country. The Advisory Board noticed the situation of the Roma is inconsistent with international treaties, with basic human rights.

### Key words:

Roma people, education, legal status, minority right, international protection

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### 1. INTRODUCTION

The article describes the research project "The legal status of Roma in the countries of the European Union - No. RB 10/2/03" (see below), which was concerned in legal status of Roma people in some countries of

the European Union. The object of the project was to collect data about legal status of all minority groups including Roma communities in six particular states (The United Kingdom, Finland, Spain, Austria, Germany and Greece). From the documents and research findings was on basis of exploring

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(theoretical, practical, field research, etc.) in these countries done summary analysis and also final report. The project pays attention to how the collective minority rights are asserted and to social status of these minorities. These rights ensure not only the preservation but also the development of collective minority identities. This right was asserted since 90's of 20. century (e.g.: Framework Convention for the Protection of National Minorities and European Charter for Regional or Minority Languages – the both are international instrument of Council of Europe to minority protection). The report follows the change of International institutions' attitude to these problems, concerning the description of this ethnical group as well as how this group is entitled.

## 2. ROMA PEOPLE

### 2.1. Education of the Roma

As early as in the era of industrialization, and also later as society changed to a fast-paced information society, traditional vocations have no longer provided a living. This finally led to unemployment of the Roma, too. Many new professions have come about and the old ones have been left unused, along with mechanization, for example. Insufficient basic education, lack of professional skills, labors market becoming more inaccessible, special characteristics of Roma culture, and discrimination from majority population are reasons

that make it difficult for the Roma to find employment.

Teaching administration has changed radically during the last few years. The roles of The Ministry of Education and National Board of Education<sup>1</sup> have changed more towards a consultative role as decision making has been dispersed to educational institutions. The consequence of this is a decentralized decision making system that is harder to influence. From the perspective of Roma politics, it should be possible to influence the goals of teaching in a new way that is in accordance with the goals of Roma politics. To prevent social exclusion of the Roma, The Ministry of Education and county government must influence educational authorities on municipal level. However, at this moment it is more difficult than in the past to make changes in local level, due to strengthening of municipal self-administration and state subsidy system.

The purpose of education is to provide facilities for the tasks of daily life encourage and help young people to finish comprehensive

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<sup>1</sup> In 1994, the National Board of Education established the Education Unit for the Roma population. The Unit is assigned to develop and implement nation – wide training and education for the Roma population, to promote the Roma language and culture, to engage in information and publicity activity on Roma culture and education, and to carry out the increasing number of international tasks which have arisen as a result of Finland's EU membership.

school. Education also tries to improve the basic education and knowledge of society of adults, and through that, improve their situation in labor market. Thus education improves the facilities of Roma people to act as culture interpreters between the Roma and majority population. The aim of Roma Education Unit is to increase knowledge of Roma culture among majority population by organizing different events.

When it comes to education, a crucial document is Framework Convention for the Protection of National Minorities that was ratified in European Council ministerial committee in 1994 and this Convention came into force in 1998. In the same time the Framework Convention came into force in Finland, too. According to the Convention, contracting parties take up the following measures, when necessary: knowledge about culture, history, language and religion of national minorities as well as majority population must be preserved. In the 14<sup>th</sup> article the contracting partners commit themselves to acknowledge, that "every person who belongs to a national minority has the right to learn the language of that minority. In case there is a sufficient demand in areas with traditional minority population or with a significant number of people who belong to minority groups. Contracting parties shall try, as far as possible, and within the framework of their

educational organizations, to ensure that people who belong to these minorities have adequate possibilities to get instruction of minority language or instruction in that language. Paragraph 2 of this article shall be applied so that it will not influence learning of official language or instruction given in that language.<sup>2</sup>

About 220 pupils out of 1500-1700 pupils under compulsory education in 1998 participated in instruction of Roma language in eight municipalities. There are several reasons for scarcity of pupils. The Roma live far apart from each other, and that is one reason the best possible solution for the pupils to get instruction of Roma language has not been found yet.

## 2.2. Day Care and Preschool Education

The Act on Children's Day Care (36/1973) incorporates a special obligation for the municipality to arrange (day care). This provision is contained in paragraph 1 of § 11 of the Act on Day Care. On the basis of the provision, all the parents or other guardians of children of preschool age have been entitled since the beginning of 1996 to obtain for their child the day-care centre of family-care place arranged by the municipality, referred to in paragraph 2 or 3 of § 11 of the Act. Under paragraph 1 of § 2, the core

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<sup>2</sup> Definition according Framework Convention for the Protection of National Minorities. Council of Europe. Strasbourg, 1995.

task of day care is to support the homes of children attending day care in their upbringing task, and to further the balanced development of the child's personality in collaboration with their homes, (9).

Amendment of Children's Day-Care Act came into force as late as 1995. The decree provided juridical grounds for day care of Roma children. This document requires that Finnish, Swedish, Sami language, Roma language, and sign language, and the language and culture of immigrants must be taken into consideration and it is supported in day care in cooperation with representatives of the cultures in question. The Act on Children's Day Care doesn't include special provisions on preschool instruction. As part of the early education which forms part of day care, a large number of municipalities have arranged preschool instruction targeted in particular at six-year-olds but also at younger children.

According to an estimate, the number of Roma children in day care and preschool is relatively lower than the number of other children. Taking Roma language and culture into consideration during early education reduces prejudices by providing schools and day care centers with correct information. That would also promote a more positive attitude towards school in Roma homes, and it would be easier for Roma children to adjust themselves to school. Day care centers shall encourage Roma

homes to contact the centers to start and develop the care of children. The municipal day-care system thus provides children with opportunities for day-care services while their parents are out at work. Preschool instruction, on the other hand, is arranged as far as possible for all children who wish to receive it. In the Roma culture, children have traditionally been looked after at home (15). Nowadays, Roma children attendance day care and preschool instruction has a very important role to play in preparing Roma children in particular for school. Roma personnel need to be recruited to child day-care centers and preschool instruction; so that the Roma language and culture are already taken sufficiently into account before the children start school. The most difficult problems of Roma children who enter school are command of Finnish and regularity of school attendance. Thus it would be important for a Roma child to attend preschool. By attending preschool the child could develop a facility for schooling.

### 2.3. The Comprehensive School

When it comes to Roma children it is important that during the first years in lower levels **of comprehensive school** the basic skills of student are at least average, or preferably above average. However, nowadays classes are, regrettably, too often very big and that means there is no time or resources for individual instruction to students. The wide problem of a

Roma child during first school years seems to be connected to command of language and that exactly would demand individual instruction and a strong effort from teaching staff. One of solution is a new book for these children, ABC-book in Roma language from 1995.

The frequent occurrence is that a student just passed the lower level of comprehensive school along with the others, and problems start piling up on upper level. On upper level students are expected to have a degree of independent initiative and an ability to cooperate. A research done in the County of Turku and Pori (1990) showed that only one fourth of Roma students got a certificate of graduation from comprehensive school and many of them got the certificate from special classes (8). After dropping out of comprehensive school, there are not many people who seek vocational training. In the end the sources of income for a young Roma might be income transfers and state support, like subsistence support. Doing business with social welfare office might already be a part of everyday life. A young person learns to be a client of social welfare office. However, in this situation it is justified to point out that the young people are excluded from education, working life, or from subsistence only according to the terms and norms of majority population.

The cultural differences between populations and prejudices towards

Roma children and teenagers in comprehensive schools can lead to such a stress that they may drop out. Older Roma people often have an insufficient facility for going to school, because they often have no reading or writing skills due to their educational background. This means children should be offered, at a very early stage, the linguistic and social skills they will need later in life. This would ensure equal opportunities between individuals in the beginning of comprehensive school.

#### **2.4. Adult Education for the Roma people**

Adult education for the Roma population in Finland has mainly been arranged by means provided under labor policy. Education tied to labor policy has been arranged both as vocational training and as guidance training. Guidance training has made it possible to fill gaps in previously inadequate basic education and has thereby improved the students' chances of entering the job market. Nowadays, education relating to labor policy in Finland is arranged regionally rather than centrally, as was the case previously with education for Roma population. This means that a large number of people now have to share educational resources, and smaller groups are not always taken sufficiently into account.

Vocational training began being arranged for Roma community in 1979 fields which are close to their way of life, such as horse-keeping

and trotting-race training, sewing the Roma national dress and other handicrafts associated with Roma culture. Training in practical nursing has also been provided. Nowadays, training is oriented increasingly towards educational sectors which meet the requirements of modern society.

Each year, the National Board of Education has also funded adult education for the Roma population at open colleges and folk high schools. The instruction provided by these colleges and schools is important especially for Roma who have not completed the syllabus required under compulsory school attendance. Primarily, the instruction aims to teach the Roma literacy and numeracy and to help them to complete the comprehensive school syllabuses in the various subjects. Study of the Roma language and culture has also been felt to be important. There has also been found to be a need for arranging courses in social studies for Roma in their own areas of residence (9).

### 3. DISCUSSION AND CONCLUSION

#### 3.1. Position of the Roma in Legislation

The basic point for protection and fortify minorities rights was reform of constitution in 1995, which clauses 5 and 14 are especially important for the Roma. The fifth clause forbids discrimination: "It is forbidden to put anyone, without an acceptable

reason, to an in equal position due to their origin, language, religion, convictions, opinions, state of health, disability or other personal reason." Section 14, clause 3 provides that "The Sami as indigenous people and the Roma and all other groups have the right to maintain and develop their own language and culture (16). General prohibition of discrimination that came into force in connection of the reform of constitution, gets support from criminal code article 11, section 9, that states: "...if person in official act or in client service does not treat everyone equally regardless of race, national or ethnic origin, skin colors, sex, religion, or any similar reason, the person is to be imposed a fine or to serve a person sentence of six months at the maximum" (15).

In 1998 the Finland adopted Framework Convention for the Protection of National Minorities. Finland has not defined in connection with ratification, which groups should be considered as "national minorities", because the general view was that the existence of minorities does not depend on the declaration of state, but it depends on the actual situation in the country. In practice this country has, in the past, reported to the control organizations of the UN on the Sami, the Roma, the Jews, the Tatars, the Old Russians, and the Swedish-speaking Finns.

European Charter for Regional or Minority Language was came into

force in Finland in 1998. This Charter is the first binding international document, which tries to strengthen the status of minority languages. The Charter divides minority languages into three groups: 1) regional languages and minority languages (Sami language), 2) official languages that are not spoken widely in state territory (Swedish language), 3) non-territorial languages (Roma language).

The Finland is also signatory of international documents UN concerning elimination of discrimination. Finland was adopted International Convention on the Elimination of all Forms of Racial

Discrimination, which guarantees protection of national groups against discrimination. Committee on the Elimination of Racial Discrimination, which monitoring the obligations in single EU countries, expressed anxieties about increasing number of racial acts against minorities groups. Despite the various provisions the discrimination is occurred in all areas of social life.

The other document of UN is Convention on the Elimination of All Forms of Discrimination Against Women, which Finland ratified in 1989. Contracting parties will have obligation to make safe equality of men and women.

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## REFERENCES

1. European Charter for Regional or Minority Languages. Strasbourg 1992
2. Finland's Romani People – E Roma and Finland, 2.vyd. Helsinki: Ministry of Social Affairs and Health, 2001.
3. Framework Convention for the Protection of National Minorities. Strasbourg 1995
4. Fraser, A: The Gypsies. Blackwell, Oxford/Cambridge (Mass.) 1995
5. Hancock, I.: Zemì utrpení –Dì jiny otroctví a pronásledování Romù . Praha: Signeta, 2001
6. Health Care in Finland. Helsinki: Ministry of Social Affairs and Health, 1999.
7. Human Rights and Finland's Foreign Policy. Report by Minister for Foreign Affairs, Helsinki, 2001.
8. Lillberg, E. – Droben, M.: Mapping on the Education Needs of Romani Population, 1995. p. 15
9. McDonald, CH.: Kovács, J.- Fényes, C. (ed.): The Roma Education Resource Book. Budapest: Open Society Institute, 2000. p.107-108 and 111-112.
10. Machiels, T.: Keeping the Distance or Taking the Chances. Roma and Travellers in Western Europe, ENAR 2002
11. National Action Plan against Poverty and Social Exclusion for 2003-2005. Working Group Memorandum of the Ministry of Social Affairs and Health, Helsinki 2003
12. Report: Education for Romanies in Finland. National Board of Education, Romany Education Unit, Helsinki – Finland (Eine Lillberg, Janette Gröfors)
13. Rómské hlasy-Rómovia a ich politická participácia v transformaènom období . Bratislava: IVO, 2002.
14. Romano Voï i, vol.4, r.II, duben 2004-05-09
15. Strategie of the Policy on Roma, Suonoja, Kyösti and Lindberg, Väinö, Helsinki: Ministry of Social Affairs and Health, 2000. p. 9-10 and p. 82-83
16. The Constitution of Finland. Ministry of Justice, Finland 1999
17. The 15th Periodik report of the Government of Finland on the

- Implementation of the Convention on the Elimination of All Forms of Racial Discrimination, report for the Secretary – General of the UN in August 1999
18. The Roma People in Finnish Society and Church, material od Sarita Friman – Advisory Board on Romani Affairs, Helsinki 2002
19. JOIN-project Promotion of Anti-diskrimcrimination at Local Level, Network Report. www.join.fi
20. Finland's Romani People, www.stm.fi
21. <http://virtual.finland.fi/finfo/english/minorit4.html>
22. [http://www.errc.org/rr\\_nr4\\_2003/noteb5.shtml](http://www.errc.org/rr_nr4_2003/noteb5.shtml) (European Forum for Roma and Travellers: From
23. the Finnish initiative to the Franco-Finnish proposal)

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## ბოშების მდგომარეობა ფინეთში მათი განათლების თვალსაზრისით

პეტრა ვოლტოვა

როგორც ფინეთის მოქალაქეებს, ბოშებსაც იგივე განათლების უფლება გააჩნიათ, რაც მოსახლეობის უმრავლესობას. თუმცა პრაქტიკულად განათლების თვალსაზრისით ბოშები ბევრად უფრო ცუდ მდგომარეობაში იმყოფებიან, ვიდრე მოსახლეობის უმრავლესობა. ბოშა ბავშვებისათვის პრობლემად რჩება სრული საშუალო განათლების მიღება, რაც შეუძლებელს ხდის მათთვის უმაღლესი განათლების მიღებას. მეორეს მხრივ, უნდა გვახსოვდეს, რომ ბოშების საგანმანათლებლო გრადიცია ძალიან ახალგაზრდაა. მრავალი კვლევა გვიჩვენებს, რომ უფროსი ასაკის მოსახლეობის განათლება სრულიად არაადეკვატურია და ბევრი მათგანი უწიგნურია. ქვეყნის მრჩეველთა საბჭო და არასამთავრობო ორგანიზაციები მუშაობენ ბოშა მოსახლეობასთან ამ საკითხზე, რომელთა მიზანია ქვეყანაში და საერთაშორისო მასშტაბით მდგომარეობის გაუმჯობესება. მრჩეველთა საბჭომ აღნიშნა, რომ ბოშების მდგომარეობა შეუსაბამოა საერთაშორისო ხელშეკრულების პირობებთან და აღამიანთა უფლებების დაცვის მოთხოვნებთან.

## ANALYSIS OF PARTICULARITIES OF ROMA CHILDREN

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### ABSTRACT

Comparative study on psychological particularities of Roma children was carried out in two localities with the lowest and the highest density of Roma population in the Czech Republic. Professional tests on personal traits, intelligence, creative thinking, self-image and school readiness were used for collecting data. Roma children reached lower level in the ability tests and higher above-average values in the personality and self-image tests.

### Keywords:

*Roma children – psycho-diagnostic tests (Rohner's questionnaire of child's self-image, B-JEPI, Raven's progressive matrixes, Test of school maturity, Urban's test of creative thinking – artetherapy)*

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### 1. INTRODUCTION

The Roma are an ethnic group and at the same time also one of the national minorities living on the territory of the Czech Republic considered traditional, the members of which can assert all the rights of national minorities in the Czech Republic (12).

No other ethnic or social group shows such a low level of education and qualifiedness, is so endangered by social slump, unemployment (about 70% are estimated) and criminality. All negative phenomena in the society, permanent and conjunctural, endanger the Roma population more, and more quickly,

than the rest of population (now e.g. drug addiction or gambling). They are, at the same time, the group of persons that is in our country the most frequent object of racism, discrimination and racial violence (3).

As experts state: To certain, so far not completely known specific characteristics of the Roma rank undoubtedly different mentality and personality structure... but sociologically and psychologically founded research of different characteristics of this minority is missing so far (6). Besides, information of the own self-reflection, attitudes etc. of the Roma is missing (4), particularly concerning Roma children, although age structure of the Roma ethnic group has progressive character (5). I try to fill this niche at least partially in my researches.

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In the last Census of people, houses and flats carried out in 2001, 11 746 persons declared their Roma nationality (Czech Statistical Office, 2003), but qualified estimations speak about another number, approximately 200 000 – 250 000 persons (12). The present Roma population in the Czech Republic represents actually the third or fourth generation of Slovak and in limited quantity Hungarian Roma who came immediately after the end of the World War II in relation to borderland colonization (8). Roma population has progressive type of age structure for which a high share of children and a very low representation of old persons is typical (3). At present, children represent 51% of Roma population and 4% children population of the Czech Republic (6). Corresponding to this is also the fertility of the Roma that is about twice as high in comparison with the population sum (5).

Almost 80% of children end the compulsory education in lower school grades, 42% of Roma children attend special schools (6). 90% of children under 15 years of age live predominantly with parents, but 7,7% spend certain part of life in children's home and 2,3% in diagnostic institution (7). The health condition of Roma children is worse than of non-Roma ones (9).

## 2. MATERIAL AND METHODS

The data for the research were collected in two demographically different territories – in the South

Bohemian Region and in the Region of Ъstн.

The South Bohemian Region is the region where the lowest number of Roma live. The data collection took place in the town of Veskй Budmјovice where, according to the estimation of the Roma coordinator, 1300 – 1500 Roma live (10). In Ъ. Budmјovice, Roma first classes are opened, but most children fulfil their compulsory education in lower grades.

The Region of Ъstн is typical by its highest proportional representation of Roma in the number of citizens of the Czech Republic, about a quarter of their total number live here. According to the estimation of the Roma coordinator, 10 000 Roma live in Ъstн nad Labem (1). In the town, localities evolve where mostly Roma citizens live and where more problems with drug abuse, gangs of minors, unemployment, overcrowded flats, non-payment of rental, absenteeism from school and criminality exist. Preparatory classes are opened in schools, Roma assistants work here and some Roma have graduated from high schools and universities. A lot of non-profit organizations concentrated on Roma problems work in the city and the Centre of Intercultural Education exists at the university.

The basic technique of data collection was professional standardized questionnaires selected with regard to the fact that the respondents are children out of the Roma population.

The following questionnaires were used:

**2.1 B-JEPI** is Eysenck's questionnaire of extraversion, psychoticism, neuroticism and tendency to answer in socially desirable way.

The scale of psychoticism describes predisposition to development of different psychiatric abnormalities. When describing psychoticism in children, we speak about special isolated and problem individuals insensitive towards people and animals, who are aggressive, malicious, hostile even towards the closest persons, like to seek exciting experience, do not accept danger. They are not tormented by guilt, their socialization is usually difficult. The scale E covers sociability, conviviality, friendliness... The scale N (lability) indicates anxiousness, worriedness, concernment, apprehension, tendency to depression, high sensitivity, intensive reactivity and psychosomatic problems. The scale L is the measure of desirability, effort to appear better, dissimulation (11).

**2.2. Raven's progressive matrixes.**

This is a non-verbal intelligence test detecting the level of general g factor. This test depends on inborn dispositions and less on education. In solving it, three basic psychical processes apply: perception, attention and thinking. At the same time, learning plays a role during

filling out the test. To find the right solution, understanding of the relations between the matrix elements is a precondition. The test is specially suitable for culturally neglected children who have limited vocabulary, small range of knowledge and lack of experience.

**2.3. Orientational test of school maturity.**

This is a modification of the test of A. Kern with three tasks: to draw a figure, to imitate script-type face and to trace a group of points. All tasks make demands on the maturity of fine motoric abilities and coordination of seeing and hand movements.

The drawing gives opportunity to creations at different developmental levels, making it possible to judge general intellect level. The script and point tasks represent tasks in authentic sense of the word, the child has to do his/her best, to get himself/herself with his/her will to do something, to persist. When the test is given to a group, it can be found out whether the child is able to work in collective conditions.

Significant dependency between the results and adaptation at the beginning of school attendance and also school marks in the 1st and the 2nd classes is discovered (13).

**2.4. Rohner's questionnaire of self-image of the child** (adapted by Matmјnek and Vбgnerovб), detects the self-image of the personality

characteristics of the child. Rohner proved with the help of a lot of studies that this method is universally usable, regardless of cultural sphere. The questionnaire for the child who evaluates his/hers characteristics and behaviour here has 42 items divided into 7 subscales:

- 1) hostility and aggression,
- 2) dependency,
- 3) negative self-evaluation,
- 4) negative evaluation of own abilities,
- 5) inhibition of emotional displays,
- 6) emotional lability,
- 7) pessimism.

**2.5. Urban's test of creative thinking** offers a view of creative potential of the individual. The test consists of figural fragments finished by arbitrary drawing of the proband. Fourteen criteria are evaluated, as e.g. willingness to risk, sense of humour, ...

Besides, during the year of data collection, meetings with a group of

Roma children in "designer workshop" in a non-profit organization in Veskã Budmjoice took place. (The meetings go on taking place.) The aim of my **artetherapeutic** working with Roma children was, besides analyzing thematic drawings on the base of which the identity of Roma authors could be processed qualitatively, also a complementary aim - development of creativity and personal development of the child, because I discovered after several designer meetings that this was not an average sample of Roma children population, but mostly children with retarded art development (sometimes several periods retarded - according to Lurwenfeld's ontogenesis of art expression), some of them with pseudo-oligofrenia, some of them deprived and with problems in the family. Therefore, the need of arteterapeutical work with the personality of the authors emerged; the authors had stiff stereotypes in art production - most often "unhealthy" houses. (see Annex 1)

### 3. RESULTS

B-JEPI (x means average)

The level of significance under 0,01 appeared in the results of Mann-Whitney U Test in comparing Roma (R) and non-Roma (N) complex in scales of psychoticism and neuroticism:

**nR = 209, nN = 184**

**P:** Z = 3,37    p = 0,00076    xR = 87,09 ± 16,69,    xN = 81,9 ± 19,7

**N:** Z = 3,21    p = 0,0013    xR = 77,37 ± 22,89,    xN = 70,07 ± 24,55

On the whole, both complexes reached high values in scales P, N and L, low ones in scale E.

Spearman Rank Order Correlations did not confirm connection between the results of Roma complex and sex and between the same complex and the town. On the contrary, there is connection between values in scale L and age - the older the respondents, the more they answer in a socially desirable way, this is even more noticable in the Roma respondent complex.

RAVEN'S PROGRESSIVE MATRIXES

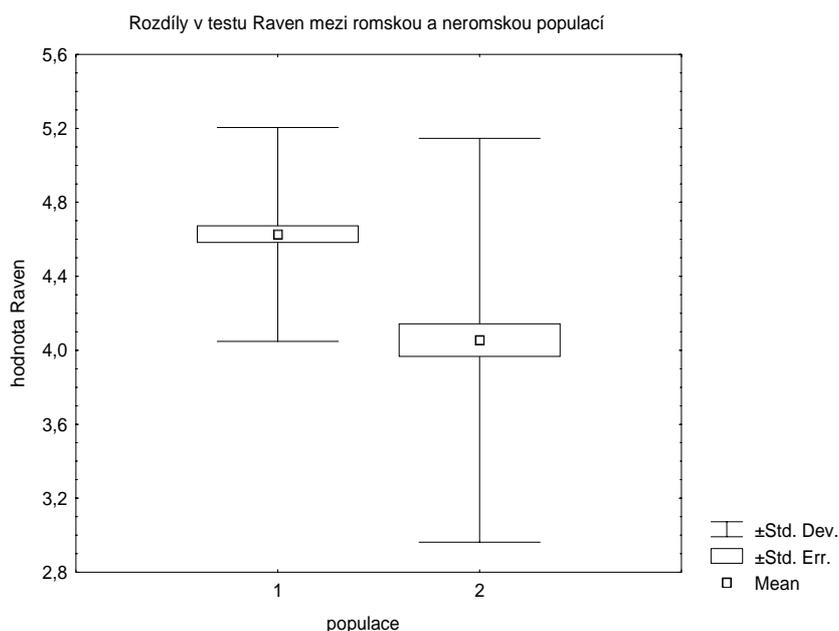
Results of Mann-Whitney U Test in comparing Roma and non-Roma complex:

**nR = 160, nN = 149**

Z = 4,51      p = 1,4E-06      xR = 4,62 ± 0,58,    xN = 4,05 ± 1,09

Roma children reached, in comparison to non-Roma ones, only average and worse results. The values 1 and 2 mean above-average, 3 average, 4 below-average and 5 intellectual damage. It is necessary to point out here that almost 2/3 respondents attended special schools.

DIAGRAM 1    Graphically Box and Whisker Plot.



(legend in the picture: Differences in Raven's test between Roma and non-Roma population, axis y: Raven value, axis x: Population)

Results of Mann-Whitney U Test in comparing complexes of Roma girls and boys:

**nD = 93, nCH = 93**

Z = -2,37      p = 0,018      xD = 4,5 ± 0,66,    xCH = 4,75 ± 0,44

Difference of results between complexes of Roma children from ĽstH and V. Budmjoice was not confirmed.

#### TEST OF SCHOOL MATURITY

Results **nN = 134** and **nR = 53** (mark 1 and 2 means above-average and average result, i.e. school maturity):

1: 49,2%      1: 30,2%

2: 45,5%      2: 60,4%

3: 5,4%      3: 9,4%

Significance level under 0,01 in Mann-Whitney U Test appeared in comparing the complex of Roma and non-Roma children in general results and in point task:

**nR = 53, nN = 134**

Results  $Z = 2,98$   $p = 0,003$   $xR = 1,79 \pm 0,59$   $xN = 1,47 \pm 0,57$

Points  $Z = 2,59$   $p = 0,009$   $xR = 2,02 \pm 1,00$   $xN = 1,60 \pm 0,87$

The respondent sex has no influence on the results. Mann-Whitney U test also showed difference of results in the task of phrase between Roma children from ĽstH nad Labem and V. Budmjoice:s

**nIB = 31, nUL = 22**

$Z = 3,37$   $p = 0,00076$   $xIB = 2,19 \pm 1,08$ ,  $xUL = 3,40 \pm 1,18$

#### SELF-IMAGE

The questionnaire of self-image was filled out correctly by 491 children, 219 from them Roma ones. The average age of the respondents was 12 years.

**Table 1 - Results for Roma children (above-average values are marked in bold print):**

	age	subscales	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
average	12,91	7,53	6,22	5,65	6,89	6,12	6,82	7,76	
modus	14,00	<b>8,00</b>	<b>7,00</b>	6,00	<b>9,00</b>	6,00	6,00	<b>9,00</b>	
median	13,00	8,00	7,00	6,00	7,00	6,00	7,00	8,00	

**Table 2 - Results for non-Roma children:**

	age	subscales	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
average	11,42	7,27	6,02	6,20	6,49	6,57	6,80	7,56	
modus	12	<b>8</b>	6	6	<b>8</b>	6	6	<b>7</b>	
median	11,00	8,00	6,00	6,00	6,50	6,50	7,00	8,00	

In both respondent complexes, above-average values appeared in the scales: 1 – hostility and aggression, 4 – negative evaluation of own abilities and 7 – pessimism; in the complex of Roma children also in the scale 2 – dependence.

The meaning of the above-average values in the scale is as follows:

1 – Increased tendency to aggressive displays and more easy induction of hostility are often related to tendency to negative self-image.

2 – Roma children have higher tendency to rely on emotional and factual support of another person. It can be characterized also as the display of a certain immaturity and inner uncertainty. It means that the child remains dependent, although it should become independent in puberty. Above-average values are not significantly related to negative self-image.

4 – Children who evaluate themselves in this way are often unsuccessful, uncertain, feel incapable in confrontation with demands of common life, and have inferiority complex. These are often children who are underestimated by their parents. These children are, in comparison with the average, often more hostile and more aggressive, often in the sense of defence of their own uncertainty (see results of subscale 1). Sometimes they are generally pessimistic and have increased feeling of danger (see result of subscale 7).

7 – The respondents have higher level of negative view of the world, of the feeling of danger, uncertainty and peril. Pessimistic children evaluate themselves worse, they are also less successful and worse socially integrated. A frequent cause of such attitude is negative experience, depreciation and excessive critique by parents.

A part of Rohner's theory is also the premise that depreciated children become hostile, emotionally shallow and aggressive themselves. Their lack of positive experience shows in form of immaturity, uncertainty and lack of self-confidence with regard to their abilities, their attitude towards themselves and towards surrounding world is rather pessimistic. So the results seem to point out the problem of today's family as an institution that, according to a lot of authors, is in crisis.

#### URBAN'S TEST OF CREATIVE THINKING

The test was made by 302 children, 88 from them Roma ones. The average age of the respondents was 10 years.

**Table 3 - Results for Roma respondents:**

	<b>Romany respondents</b>	<b>Romany boys</b>	<b>Romany girls</b>
<b>average</b>	43	43,35	42,67
<b>median</b>	44	44	43,5
<b>modus</b>	44	44	37

**Table 4 - Results for non-Roma respondents:**

	<b>non-Romany respondents</b>	<b>non-Romany boys</b>	<b>non-Romany girls</b>
<b>average</b>	48,48	48,02	49,12
<b>median</b>	48	48	48
<b>modus</b>	48	48	48

The rough results show that Roma respondents are less creative. The values in the results appear in these result scales:

deeply under-average: 37,  
under-average: 38 - 43,  
average: 44 - 56.

In Roma children, boys are more creative than girls. It will be interesting here to seek the relations with the results of the questionnaire of self-image and identity that is being processed now.

#### ARTETHERAPY

The result of the work of one year is a shift in art production of some Roma children, which means a positive change, generally. For example one girl is now, at the end of the year, already able to draw a picture using warm colours, and not only with the theme of a central cold house with smoke hurtling from an over-dimensioned chimney.

#### 4. DISCUSSION and CONCLUSION

During the research, I faced traditional problems related to researches of Roma ethnic group - Roma mistrust in general and with respect to anonymity of the respondent, problem with determination of members of the ethnic group and difficult obtaining of greater number of respondents.

Certain particularities of Roma children were proved. Roma

respondents are, in comparison to non-Roma ones, more dependent on close environment, they are less creative, they reach school maturity at the age of 6 at a lower level or later, and the level of general g factor is lower in them. Quite alarming finding is that both Roma and non-Roma respondents reached high values in the scales of psychoticism and neuroticism (Roma respondents even higher ones) and aggression, pessimism and negative evaluation

of own abilities, which shows, among other things, high uncertainty of present children. The demographic differences of both research territories and sexes do not seem to have significant influence on the results.

Now it is necessary to put the results of the individual tests into

connections and to interconnect them with biological and social spheres – e.g. the results of the questionnaire of identity, health condition, level and influence of racism, because man is a bio-psycho-social creature; so that more general regularities can be found and an efficient concept of work with Roma children in many spheres can be devised.

#### REFERENCES

1. Bajgerová, E. Personal communication. Romany coordinator of the town Ústí nad Labem, 2004.
2. Friš tenská, H. Romové a státní politika. In: *Romové – reflexe problému*. Praha: Sofis, 1997, p. 34-45.
3. Friš tenská, H.; Haiš man, T.; Víšek, P. Souhrnné závěry. In: *Romové v České republice (1945-1998)*. Praha: Socioklub, 1999, p. 473-507.
4. Gabal, I. Zahraniční inspirace k integraci Romů. In: *Romové v České republice (1945-1998)*. Praha: Socioklub, 1999, p. 67-90.
5. Kalibová, K. Demografické a geodemografické charakteristiky romské populace v České republice. In: *Romové – reflexe problému*. Praha: Sofis, 1997, p. 20-33.
6. Kovařík, J. *Děti v České republice*. Český výbor pro UNICEF, 1996.
7. Nesvadbová L.; Rutch J. et al. Determinanty zdraví romské populace v České republice 1999 – 2001. *Praktický lékař* 83: 139-145, 2003.
8. Pribád, J. K sociologii etnických vztahů (Sociální a právní postavení Romů). In: *Sociologické texty II*. Praha: Karolinum, 1995, p. 154-165.
9. Øíčan, P. *S Romy • í t budeme – jde o to jak*. Praha: Portál, 2000.
10. Slivka, R. Personal communication. Romany coordinator of the town Česká Budejovice, 2004.
11. Svoboda, M. *Psychodiagnostika dětí a dospívající ch*. Praha: Portál, 2001.
12. Sulitka, A. Personal communication. Council of Government of the Czech Republic for National Minorities, 2005.
13. Švancara, J. *Diagnostika psychického vývoje*. Praha: Avicenum, 1980.
14. Český statistický úřad. *Sětání lidu, domů a bytů 2001*. Poslední aktualizace 18. 10. 2003. Dostupné z: <<http://www.czso.cz/csu/edicniplan.nsf/p/4114-03>>
15. Rada vlády pro národnostní menšiny. *Národnostní menšiny*. Dostupné z: <<http://wtd.vlada.cz/vrk/vrk.htm>>

## ბოშა ბავშვების თავისებურებების ანალიზი

### მარკეტა ელისოვა და ჯიტკა დგორაკოვა

ბოშა ბავშვების თავისებურებების შედარებითი კვლევა ჩაგარდა ჩეხეთის რესპუბლიკის ორ რეგიონში, სადაც აღინიშნება ბოშების ყველაზე დაბალი და ყველაზე მაღალი სიმჭიდროვე. მონაცემთა შესაკრებად გამოყენებულ იქნა პროფესიონალური ტესტები პირად თვისებებზე, ინტელექტზე, შემოქმედებით აზროვნებაზე, თვითშეფასებაზე და სწავლისათვის მზადყოფნაზე. ბოშა ბავშვებმა გამოავლინეს ყველაზე დაბალი დონე უნარების ტესტებში და ყველაზე მაღალი პიროვნულობისა და თვითშეფასების ტესტებში.

## DROWNING AND NEAR DROWNING IN THE CZECH REPUBLIC

Magdalena Ěapková<sup>1</sup>

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### ABSTRACT

The second most frequent cause of death as a consequence of injury in the Czech Republic are injuries related to water. In connection to absence of more detailed studies dealing with injuries related to water environment in the Czech Republic, a project concentrated on this issue was implemented in 2002-2004. Monitoring of injuries related to water confirmed the serious character of these injuries and the necessity to solve this situation in the Czech Republic. Most noticeable risks are obvious from the results.

### Key words:

*Near drowning, drowning, children, adults, prevention, Czech Republic*

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### 1. INTRODUCTION

At present, injuries rank among the biggest public-sanitary problems. They affect negatively the mortality and morbidity of citizens of all age groups. They have a significant share in hospitalizations and ambulant treatments. The consequences project seriously into social and economic sphere. The second most frequent cause of death as a consequence of injury in the Czech Republic are injuries related to water. In connection to absence of more detailed studies dealing with injuries related to water environment in the Czech Republic, a project concentrated on this issue was implemented in 2002-2004. Drowning can be defined as death within 24 hours as a consequence of injury related to diving. Near drowning is an injury related to

diving, when the individual survives 24 hours (5). Mortality in persons who drown and pass out is almost 50% (15). Drowning ranks at the second place in death causes of children in our country and in Europe (2). The child can drown within several seconds, quietly and in small amount of water (4).

### 2. MATERIAL AND METHODS

#### 2.1. The data collection

The collection of data about injuries related to water was started in 2002 and took place in fourteen regions of the Czech Republic. The complex consisted of persons who drowned or nearly drowned in the Czech Republic in the monitored period (i.e. 2001 - 1<sup>st</sup> half of 2004), they were individuals from all age categories. The complex consisted of 548 children in ages from 0 - 18 years and

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1423 adult persons in ages from 19 – 81 and more years.

## 2.2. The sources of information

The following sources were used for obtaining information about these injuries: Integrated rescue system, Institute of sanitary information and statistics of the Czech Republic (IŠZIS), Water rescue service of the Czech Red Cross, coroners, hospital departments, authentic media sources. Because of lack of accessibility of a compact information system (or documentation) that would contain all required data, the information obtained from individual information sources were evaluated separately. This methodical procedure prevents “duplication” of pieces of information that cannot be evaluated in one complex because data of anonymous victims are processed, and so errors in application into the complex analyzed in the result could occur.

## 2.3. The statistical evaluation

For statistical evaluation of selected data, the “Chi-square” ( $\chi^2$ ) test was used. At the level of significance of 0,05, the statistical significance of selected data (mechanism, place or circumstance) in relation to injury origin (near drowning, drowning) was determined. For statistical evaluation of data concerning alcohol ingestion in relation to drowning, interval estimation of difference of population frequencies was used.

## 3. RESULTS

### 3.1. Drowning and injuries related to water in children

In the monitored period, altogether 548 cases of injuries of children and youth related to water were recorded from medical records and autopsy protocols. From this, 92 (17%) cases of drowning and 456 (83%) cases of children hospitalized in connection to injury related to water. From this, 227 (41%) children were hospitalized because of near drowning and in 229 (42%), the cause was other injury than (near) drowning, but they were injuries caused by diving (further on only “other injury”).

The distribution of the occurrence of injuries related to water with regard to age confirms the hypothesis of high risk of these injuries in toddler age. In the age over 1 year, altogether 49 children suffered an injury, i.e. 9% of the total number of injuries. Other significantly represented risk group is adolescents. Here, increase of injuries from the age of 12 (6%) is obvious, the group of fifteen-year-old children is most frequently represented, showing 46 cases (8%).

Boys represent altogether 68% of all injury victims, prevailing significantly in age categories of one year and 13-18 years. In the period of adolescence, there is the greatest difference in sex representation, in the group of seventeen-year-olds, the boys represent 95% of the injured individuals.

In 2001-2003, only moderate increase of the number of cases is recorded (2001 - 181 injuries, 2002 - 172, 2003 - 187). Although the prevalence is quite balanced in the monitored years, increase in children at the ages of 5, 13 and 18 years is obvious with regard to injury occurrence in individual categories. Decrease of injuries is obvious in children at the age of one year and further in the age category of 10 - 11 years. The year 2004 cannot be compared objectively, because of data only for the 1<sup>st</sup> semester, but the number of cases in the 1st semester of 2004 represents only 4% from the total number of the year 2003.

### 3.1.1. Children drowning

In the monitored period, altogether 92 cases of children drowning were detected. When observing the development of cases of drowning, both in 2001 and 2002, 33 cases of drowning of children and youth under 18 years were recorded, while

in 2003 only 19 cases (i.e. 42% less) [Tab. 1].

A significant source of information about drowned children was also **coroners**. With detailed analysis of records for the year 2003, altogether 19 drowned under eighteen years were found out, in whom autopsy was carried out by coroners. In five victims (5%), the autopsy proved **alcohol** in blood; in 4 (80%) cases from them, the children drowned by fall into natural water. A thirteen-year-old girl in whom alcohol was proved had drowned during stay in natural water. The youngest victim in which alcohol was proved was a 8-year-old boy, further they were children in ages of 13, 15 and 18 years.

In the scope of the research, authentic media sources were used, extending the data about the drowned children with some important information. In the monitored period, altogether 70 cases of drowned children were

**Table 1. Mechanisms of children drowning**

Drowning	0 – 3 years	4 – 6 years	7 – 9 years	10 – 12 years	13 – 15 years	16 – 18 years	0 – 18 years
Fall into swimming pool	1 (7)	4 (20)					5 (5 %)
Fall into natural water		2 (10)	3 (23)		4 (31)	8 (33)	17 (19 %)
Fall into bathtub	1 (7)						1 (1 %)
Stay in swimming pool	1 (7)	2 (10)					3 (3 %)
Stay in natural water	1 (7)	2 (10)	2 (15)	1 (12,5)	1 (8)	4 (17)	11 (12 %)
Stay in bathtub					2 (16)		2 (2 %)
Water transport				1 (12,5)			1 (1 %)
Vessel accident							0
Other determined (near) drowning	2 (15)		3 (23)		1 (8)		6 (7 %)
Non-determined (near) drowning	7 (50)	9 (45)	4 (31)	6 (75)	4 (31)	9 (38)	39 (42 %)
Flood victim							0
Deliberate self-destruction						1 (4)	1 (1 %)
Attack by (near) drowning							0
Non-determined intention	1 (7)	1 (5)	1 (8)		1 (8)	2 (8)	6 (7 %)
<b>Total</b>	<b>14 (100%)</b>	<b>20 (100%)</b>	<b>13 (100%)</b>	<b>8 (100%)</b>	<b>13 (100%)</b>	<b>24 (100%)</b>	<b>92 (100 %)</b>

processed by media sources. The most frequent place of drowning is the river (39%). The pond was a risk place in 21% of cases, predominantly children of higher age categories (13 – 18 years) drowned there. Other injuries occurred in artificial lakes (7%), water tanks (7%), further in swimming bathes (6%) and swimming pools (6%). In children in toddler age, cases of drowning in a container occurred (3%).

In most cases, media sources describe also the circumstances of the injury, in children in the age of 0 – 8 years, cases of drowning caused by lack of supervision over the child by adults (95%) prevail. On the base of the observed data, the lack of supervision in cases of near drowning and drowning is statistically significant at the significance level of 5%. It means that insufficient supervision affects significantly near drowning and

drowning of children in this age category. From nine years of age, the circumstances of the injury are more varied, besides lack of supervision, there is usually overestimation of power, carelessness (e.g. play in dangerous water - weir; walking over ice and its subsequent inburst; drowning during water activities - swimming, other water sports). In four cases, drowning occurred during rescue of other person or animal from drowning; 2 victims drowned in connection with a sudden health disturbance - epilepsy.

### 3.1.2. Children near drowning

In the monitored period, 227 children nearly drowned. Most cases were recorded in children in the age of 0 – 3 years – altogether 64 nearly drowned children, i.e. 28% of all cases of near drowning [Tab 2].

**Table 2. Mechanisms of “near drowning” in children**

Near drowning	0 – 3 years	4 – 6 years	7 – 9 years	10 – 12 years	13 – 15 years	16 – 18 years	0 – 18 years
Fall into swimming pool	17 (27)	4 (16)	2 (7)	2 (7)	3 (6)		28 (12 %)
Fall into natural water	15 (23)	4 (16)	14 (48)	12 (41)	17 (36)	12 (38)	74 (33 %)
Fall into bathtub					2 (4)		2 (1 %)
Stay in swimming pool	3 (5)	7 (28)	4 (13)		3 (6)	4 (13)	21 (9 %)
Stay in natural water	5 (8)	5 (20)	4 (13)	8 (28)	12 (26)	3 (9)	37 (17 %)
Stay in bathtub	2 (3)		1 (3)		2 (4)	1 (3)	6 (2 %)
Water transport	1 (2)						1 (0,5 %)
Vessel accident						2 (6)	2 (1 %)
Other determined (near) drowning	8 (12)	3 (12)		2 (7)	1 (2)	1 (3)	15 (7 %)
Non-determined (near) drowning	7 (11)	2 (8)	4 (13)	5 (17)	6 (13)	4 (13)	28 (12 %)
Flood victim	2 (3)						2 (1 %)
Deliberate self-destruction					1 (2)	3 (9)	4 (2 %)
Attack by (near) drowning						1 (3)	1 (0,5 %)
Non-determined intention	4 (6)		1 (3)			1 (3)	6 (2 %)
<b>Total</b>	<b>64 (100%)</b>	<b>25 (100%)</b>	<b>30 (100%)</b>	<b>29 (100%)</b>	<b>47 (100%)</b>	<b>32 (100%)</b>	<b>227 (100 %)</b>

Prevailing mechanism of near drowning was **fall** into water, causing 46% of injuries. Fall as mechanism of injury origin is the highest risk factor for the youngest age group of children (0 - 3 years), when fall into swimming pool and into natural water represents altogether 50% causes of children near drowning in this age. On the base of the monitored data, the conclusion can be drawn that in children in ages of 0 - 6 years, fall is statistically significant in relation to near drowning and drowning at the significance level of 0,05.

From total number of near drowning, fall into swimming pool was the cause in 28 cases (12%). Alarming is fall into swimming pool in children in ages of 0 - 3 years - 17 cases (27%). Children from 0 to 1 year (35 children) represent 36% of victims of fall into swimming pool. From the total number of one-year-old "nearly drowned" toddlers, 29% of children nearly drowned as a consequence of this cause. In natural water "nearly drowned" 17% children in connection to **stay** in water, 32% from them children in ages of 13 - 15 years.

**Swimming pool** became, regardless of the injury mechanism, place of

near drowning of 21% of children. The swimming pool is a risk place mostly for children in ages of 0 - 6 years, but on the base of the detected data, statistical significance of near drowning or drowning in swimming pool and at another place was not proved at a significance level of 0,05.

### 3.1.3. Other children injuries related to water

In the scope of the monitoring, 456 children were hospitalized in connection with a water related injury during the monitored period, 229 from it being other injuries than (near) drowning caused by diving. By diving, individuals in ages of 13 - 18 years are injured most often. [Tab 3] Alarming is the number of these injuries in the group of 13-15-year old children 71 (31 % of these cases; 54 % of all thirteen-fifteen-year-old injured children). This injury cause prevails in male individuals, e.g. in the group of 15 - 17 years, boys represent 82% of the injured individuals. These injuries have permanent consequences.

## 3.2. Drowning and injuries related to water in adults

In the monitored period, altogether 1423 cases of injuries of adult population related to water were recorded from medical records and

**Table 3. Number of "other injuries" in relation to sexes**

Other injury	0 - 3 years	4 - 6 years	7 - 9 years	10 - 12 years	13 - 15 years	16 - 18 years	0 - 18 years
Total	16 (7)	12 (5)	28 (12)	38 (17)	71 (31)	64 (28)	229 (100 %)
Girls	7 (3)	7 (3)	12 (5)	18 (8)	13 (6)	13 (6)	70 (31 %)
Boys	9 (4)	5 (2)	16 (7)	20 (9)	58 (25)	51 (22)	159 (69 %)

autopsy protocols. From this, 811 (57%) cases of drowning and 612 (43%) injuries related to water with non-fatal consequences. These injuries represent 239 (17%) cases of near drowning and 373 (26%) other injuries caused by diving. From the point of view of individual age categories, the occurrence of injuries is markedly increased in the category of 19 - 30 years (27%), in which other injuries than near drowning or drowning prevail. Adults in ages of 41 - 50 years were victims of injuries related to water in 17%, further the group of persons in ages of 51 - 60 years (16%) follows. From the total number of injured adults, 406 (29%) were women and 1017 (71%) men. The injury occurrence in the monitored years can be characterized as very balanced, because in 2001, altogether 438 adults suffered an injury related to water, in 2002 they were 466 persons and in 2003 443

individuals. In the first semester of 2004, altogether 76 injuries related to water were recorded.

### 3.2.1. Adult drowning

Injuries with fatal consequences represent more than a half of all injuries related to water in adults. Drowning is most frequent injury in adult population in the age categories of 51 - 60 years and 41 - 50 years. [Tab 4]

The most risky mechanism of adult injury related to drowning is fall into natural water, related to 21% of these cases. **Fall**, regardless of the place (natural water, swimming pool, bathtub) where the injury occurred, caused 23% of cases of drowning in adults. From 185 cases of drowning caused by fall, 26% victims were persons in ages of 61 - 70 years. From the obtained data, statistical significance of fall of seniors in

**Table 4. Mechanisms of adult drowning**

<b>Drowning (%)</b>	<b>19 - 30</b>	<b>31 - 40</b>	<b>41 - 50</b>	<b>51 - 60</b>	<b>61 - 70</b>	<b>71 - 80</b>	<b>81 and more</b>	<b>0 - 81 and ?</b>
Fall into swimming pool	3 (3)			2 (1)	1 (1)	1 (1)	4 (6)	<b>11 (1%)</b>
Fall into natural water	19 (17)	23 (24)	36 (22)	27 (16)	42 (36)	11 (12)	9 (14)	<b>167 (21%)</b>
Fall into bathtub	1 (1)	2 (2)			1 (1)	3 (3)		<b>7 (1%)</b>
Stay in swimming pool		1 (1)	1 (0,5)	1 (1)	2 (2)			<b>5 (0,5%)</b>
Stay in natural water	14 (13)	14 (14)	18 (11)	19 (11)	5 (4)	5 (5)	1 (2)	<b>76 (9,5%)</b>
Stay in bathtub	3 (3)	6 (6)	10 (6)	7 (4)	8 (7)	3 (3)	4 (6)	<b>41 (5%)</b>
Water transport			1 (0,5)					<b>1 (0,1%)</b>
Vessel accident	1 (1)							<b>1 (0,1%)</b>
Other determined (near) drowning	5 (5)	6 (6)	4 (2)	3 (2)	3 (2)	6 (7)	2 (3)	<b>29 (4%)</b>
Non-determined (near) drowning	50 (46)	31 (32)	64 (39)	80 (47)	31 (27)	35 (38)	17 (27)	<b>308 (38%)</b>
Flood victim				1 (1)	1 (1)	1 (1)		<b>3 (0,3%)</b>
Self-destruction	6 (6)	9 (9)	17 (10,5)	23 (13)	15 (13)	17 (19)	20 (32)	<b>107 (13%)</b>
Attack by (near) drowning			1 (0,5)	1 (1)	2 (2)	1 (1)		<b>5 (0,5%)</b>
Non-determined intention	7 (6)	6 (6)	13 (8)	5 (3)	4 (4)	9 (10)	6 (10)	<b>50 (6%)</b>
<b>Total</b>	<b>109 (100%)</b>	<b>98 (100%)</b>	<b>165 (100%)</b>	<b>169 (100%)</b>	<b>115 (100%)</b>	<b>92 (100%)</b>	<b>63 (100%)</b>	<b>811 (100%)</b>

connection to near drowning and drowning was not proved on the significance level of 5%.

Alarming is the result of non-accidental cases of drowning – **suicides** are the cause of altogether 107 (13%) cases of drowning in the monitored period. On the base of the obtained data, statistical significance of suicides in connection with near drowning and drowning was not detected on the significance level of 5%. Here, the most strongly represented group is the age category of 51 – 60 years (22%), but from the point of view of individual age categories, this phenomenon is most frequently represented in senior categories. From the obtained data, suicide of person in senior age is statistically significant in connection with near drowning and drowning at the significance level of 5%.

In the scope of the research, data from coroners were evaluated, proving the seriousness of alcohol ingestion before the beginning or during water activities. In 2003, altogether 66 (38%) drowned adults with positive alcohol finding were recorded from the total number of 175 (100%) of adult individuals in whom autopsy was carried out. On the base of evaluation of these data, it is not possible to draw conclusion whether alcohol ingestion has significant impact on adult drowning at the significance level of 5%. Alarming is alcohol consumption particularly in persons in ages of 41 – 50 years – 26 individuals (55%) from 47 drowned

persons in this age, in whom autopsy was carried out, had positive alcohol level. In this age category, it was proved by statistical evaluation that alcohol ingestion before or during water activities increases the number of cases of drowning by 27,8 – 31,1% at the significance level of 5%.

### 3.2.2. *Adult near drowning*

In connection with drowning, altogether 239 adult persons were hospitalized in the monitored period. 46% persons from them suffered injury by **fall** into water – 40% into natural water. **Natural water** is the most frequent place of near drowning of persons of all age categories. Altogether 127 persons nearly drowned there, 37% from them persons in ages of 19 – 30 years. In the **swimming pool**, altogether 12% persons nearly drowned, 43% of them individuals in ages of 19 - 30 years. Natural water is, in connection with near drowning, the most risky environment in which these injuries occur - altogether 53% of cases. [Tab 5]

### 3.2.3. *Other injuries related to water in adults*

Besides near drowning and drowning, 373 hospitalized persons in injuries caused by diving were recorded in the monitored period. In connection with risky behaviour, these are predominantly men. In age group of 19 – 30 years, men represent whole 90%. Diving – in age group of 19 - 30 years, altogether 195 persons (52% of persons injured in such way) were injured in such way. (Tab. 6)

**Table 5. Mechanisms of adult near drowning**

Near drowning (%)	19 - 30	31 - 40	41 - 50	51 - 60	61 - 70	71 - 80	81 and ore	0 – 81 and ?
Fall into swimming pool	4 (5)	3 (8)	2 (7)	3 (9)	1 (4)			13 (5%)
Fall Natural water	28 (33)	16 (41)	17 (54)	12 (38)	10 (44)	8 (42)	4 (45)	95 (40%)
Fall into bathtub			2 (7)	1 (3)				3 (1%)
Stay in swimming pool	9 (11)	2 (5)	2 (7)	1 (3)	1 (4)	2 (11)		17 (7%)
Stay in natural water	19 (22)	1 (3)	1 (3)	3 (10)	5 (22)	3 (15)		32 (13%)
Stay in bathtub		2 (5)		2 (6)	1 (4)			5 (2%)
Water transport	2 (2)			1 (3)				3 (1%)
Vessel accident	7 (8)	2 (5)		1 (3)		2 (11)		12 (5%)
Other determined (near) drowning	3 (3)	3 (7)	1 (3)	1 (3)	1 (4)	2 (11)		11 (5%)
Non-determined (near) drowning	8 (9)	2 (5)		4 (13)	1 (4)		1 (11)	16 (7%)
Flood victim		1 (3)				1 (5)		2 (1%)
Self-destruction	4 (5)	4 (10)	5 (16)	2 (6)	2 (9)	1 (5)	3 (33)	21 (9%)
Attack by (near) drowning	1 (1)	2 (5)	1 (3)					4 (2%)
Non-determined intention	1 (1)	1 (3)		1 (3)	1 (4)			5 (2%)
Total	86 (100%)	39 (100%)	31 (100%)	32 (100%)	23 (100%)	19 (100%)	9 (100%)	239 (100%)

**Table 6. Number of “other injuries” in adults in relation to sexes**

Other injury (%)	19 - 30	31 - 40	41 - 50	51 - 60	61 - 70	71 - 80	81 and ?	0 - 81 and ?
<b>Total</b>	195 (100)	71 (100)	51 (100)	21 (100)	15 (100)	15 (100)	5 (100)	373 (100%)
<b>Women</b>	20 (10)	15 (21)	19 (37)	8 (38)	9 (60)	12 (80)	3 (60)	86 (26%)
<b>Men</b>	175 (90)	56 (79)	32 (63)	13 (62)	6 (40)	3 (20)	2 (40)	287 (74%)

The basic factor of injury origin in these injuries is risk behaviour of the individual. These injuries are very serious in connection to permanent consequences in the sense of backbone affection (pareses, incontinenes) influencing negatively the health and social situation of the individual.

#### 4. DISCUSSION

The results of monitoring of all injuries related to water point out the serious character of this issue in children and in adults. Although the

proportional expression of individual injuries related to water in children shows the lowest number of cases of drowning (17%), this data is not a testifying factor of security and protection of children. Ninety two victims of drowning of children under 18 years is an alarming number because they are mainly consequences of inattention, insufficient supervision by adults, so that these fatal injuries occur out of negligence. The number of drowned children is particularly critical, with regard to the possibility of the scale

of preventive measures that could prevent these tragic consequences.

Besides drowning, injuries having no fatal consequences but often related to serious consequences on biological and social health of the individual were monitored as well. Almost half a thousand of children hospitalized because of an injury that the child suffered in connection with water environment is an alarming number. It is necessary to realize that only by lucky chance and quick life saving intervention, this number of injuries did not topple over to the category of fatal injuries.

In order to reduce the number of these injuries with damaging or fatal consequences, the true cause and circumstances of the injury must be defined so that prevention is as efficient and specific as possible (4). One half (229) of these injuries is not caused by fall or other unlucky chance, because the injuries the cause of which is diving show active share of the individual in form of risk behaviour.

The results of monitoring of these injuries confirm the specific character and the connection of the age of the individual with the injury risk. For example risk behaviour characteristic for the period of adolescence was fully confirmed by the monitoring results in relation to these injuries. But on the base of the obtained data, statistical significance of risk behaviour in connection with near drowning and drowning was

not detected on the significance level of 5%. In lower age categories (11 years and less) near drowning prevails, but in categories of adolescents, "other injuries" caused mostly by diving are predominant.

It is evident from the results that drowning is most frequent in the category of 16 - 18 years and in children in toddler and preschool age. The lowest number of drowned individuals was in the category of 10 - 12 years. Boys prevail in most categories. Foreign studies also prove that boys drown four times more often than girls (12).

The place of drowning is, in most cases, natural water (28%) and the cause mainly fall (25%). A risk group with regard to falls and subsequent drowning is children in ages of 0 - 3 years, in whom 50% of cases of drowning is caused by fall. Preventive measures in connection to near drowning and drowning in natural water and minimization of fall risk must be oriented to all age groups.

In swimming pools, no significantly higher number of cases of drowning was recorded, but in cases of near drowning, it is a highly risky place, particularly for the children group in ages of 0 - 3 years, because 27% of them nearly drowned in the swimming pool. The results show that in the swimming pool, 21% of victims nearly drowned (in natural water they are 50%!). The results of near drowning in swimming pools

are alarming, and in connection with the trend of increasing number of private swimming pools, continuously increasing risk of near drowning and drowning in swimming pools can be supposed. The data of drowning in swimming pools is strongly monitored e.g. in the USA where this drowning mechanism in children is the most frequent one (6). According to American studies, 60 - 90% of children in ages of 0 - 4 years drown in swimming pools, 50% of them in swimming pools just next to their own house (3, 10)). Effective prevention of these injuries is indispensable use of protective devices, barriers and particularly increased supervision and attention during presence of children at the swimming pool or other water surfaces. Supervision is the most important preventive measure (8). The adults should not swim alone on non-guarded places either and they should motivate children by their right behaviour to observe the principles of security. Swimming training is also important in drowning prevention (14). Already children in ages of 24 - 42 months who pass swimming training achieve success. But swimming training does not mean 100% prevention, and continuous supervision is indispensable also in cases when the child can swim (1, 9).

A serious personal factor affecting the probability of drowning is alcohol and drug consumption before and during water activities. Quand and Cummings state in their study taking

16 years altogether 10 cases (23%) of drowned individuals in ages of 15 - 19 years in whom alcohol consumption before drowning was detected (6). By the analysis of data from coroners, positive findings were detected in the Czech Republic in the monitored period in five child victims of drowning, the youngest victim was only 8 years old!

The results of the research carried out in adult population show prevailing incidence of drowning, to the contrary from children population where near drowning or other injuries originated in connection with water environment prevail significantly.

By analysis of causes of near drowning and drowning in adult population we mostly come to different conclusions. Only prevalence of men in injuries related to water is identical. The most frequent cause is fall into water and drowning during stay in natural water. Drowning in natural water represents a risk particularly for persons in productive age, being probably caused by increased presence of persons near natural water sources for holiday, sport etc. This fact is confirmed also by Quan and Cummings who recorded in their research three times higher number of incidence of drowning in natural water in persons in productive age (i.e. under 65 years) than in population in senior age. Bathing, swimming and other water sports (vessel riding) are stated as most frequent causes (6).

A significant share in causes of near drowning and drowning corresponds to alcohol consumption in adults, related to fall or risk behaviour. In age category of 41 – 50 years, it was statistically confirmed on the base of analysis of obtained data that alcohol consumption increases noticeably the number of cases of drowning. Quan and Cummings state alcohol as one of the main causes of drowning of persons in productive age as well, but prevention spheres do not deal with this factor (6).

Injuries related to water are very frequent in seniors. But statistically significant difference from other population was not proved.

Much more often than in children, the place of near drowning and drowning is the bathtub, both in the category of persons in productive age and in seniors. This trend was observed also in the above mentioned American research where more than 50% of seniors drowned in the bathtub were recorded.

In senior age, the injuries are predominantly caused by fall; this fact is closely related to the health condition of the senior, to his ability of self-service etc. In the scope of prevention of injuries in this population, individual knowledge of risks and effort to maximal minimization of them is indispensable. These results prove the urgency of concentration of prevention on domestic environment, lying in high-quality

information of prevention principles and possible risks when not observing them. In connection with prevention in domestic environment, high-quality enlightenment of availability and use of devices preventing injury origin is indispensable.

The results of the research point out the serious character of frequent incidence of injuries related to self-destruction and suicide. The relation between suicide and senior age is statistically significant.

## 5. CONCLUSION

Monitoring of injuries related to water confirmed the serious character of these injuries and the necessity to solve this situation in the Czech Republic. Most noticeable risks are obvious from the results. One of them is near drowning in natural water related to risk behaviour (diving), in children risks related to fall into water occur on the base of inattention, insufficient or fully lacking supervision. In child age, swimming pools and particularly falls into them play a significant role in occurrence of water injuries. In senior age, accidental falls into natural water or water tanks play a significant role. Seniors choose water in solving life crisis. Alcohol consumption particularly near water tanks prove very dangerous. Near drowning and drowning are accidental injuries that can be efficiently prevented particularly in child age by appropriate prevention, avoiding irreversible losses in this way.

## REFERENCES

1. Aster, K.N., Rivala, F.P., Felix, D. Water safety training as a potential means of reducing risk of young children's drowning. *Injury Prevention*, 1995, Is. 4, p. 228 – 233.
2. Barss, P., Smith, G., Baker, S., Mohan, D. *Injury Prevention: An International Perspective*. New York, Oxford University Press Inc., 1998, p. 151-165.
3. Brenner, R.A., Trumble, A.C., Smith, G.S., et. al. Where children drown, United States, 1995. *Pediatrics*, 2001, Vol.108, p. 85 – 89.
4. Grivna, M., Nencka, P. Utonutí di tí. In Grivna, M. a kol. *Dì tské úrazy a možnosti jejich prevence*. Praha: CÚP UK 2.LF a FN Motol, Praha. 2003, p. 49 – 55.
5. Kallas, H.J., O'Rourke, P. P. Drowning and immersion injuries in children. *Curr Opin Pediatr*. 1993, Is. 5, p. 295 – 302.
6. Quan, L., Cummings, P. Characteristics of drowning by different age groups. *Injury Prevention*, 2003, Vol. 9, p. 163 – 168.
7. Quan, L., Gore, E.J., Wentz, K., et. al. Ten year study of pediatric drownings and near-drownings in King Country, Washington: lessons in injury prevention. *Pediatrics* 1989, Vol. 83, p. 1035 – 1040.
8. Widome, M.D. (ed.) *Injury prevention and control for children and youth*. American Academy of Pediatrics. 1997. p. 219-232.
9. Wintemute, G.J., Kraus, J.F., Teret, S.P., et. al. Drowning in childhood and adolescence: a population-based study. *American Journal of Public Health*, 1987, Vol. 77, p. 830 – 832.
10. CDC. *Drowning Prevention: How Large is the Problem of Unintentional Drowning in the United States*. CDC, Atlanta, 2003.
11. Dostupné z : <http://www.cdc.gov/ncipc/facts-heets/drown.htm>
12. CDC. *Fact Book for the Year 2000: Working to Prevent and Control Injury in the United States* CDC, Atlanta, 2000.
13. Dostupné z : <http://www.cdc.gov/ncipc/pub-res/fact-book/fkwater.htm>
14. CÚP. *Prevence tonutí. Nauèe di ti bezpeènému chování u vody*. Praha: CÚP UK 2.LF a FN Motol, Praha, 2004.
15. ECOSA. *European Child Safety Alliance. Priorities for child safety in the European Union: Agenda for action*. ECOSA , 2001.

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**წყალში დახრჩობისა და დახრჩობის პირას ყოფნის  
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ჩხეთის რესპუბლიკაში გრავით გამოწვეული სიკვდილობის მიზეზებში წყალთან დაკავშირებული გრავმები სიხშირით მეორე ადგილზეა. იმის გამო, რომ დეტალური კვლევა წყალთან დაკავშირებული გრავმების საკითხებში არ ჩატარებულა, ამ საკითხზე კონცენტრირებული პროექტი განხორციელდა 2002-2004 წლებში. წყალთან დაკავშირებული გრავმების მონიტორინგმა გამოავლინა ამ გრავმების სერიოზული ხასიათი და ამ პრობლემის გადაჭრის აუცილებლობა. შედეგებიდან ამჟამად ჩანს ყველაზე თვალსაჩინო რისკები.

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