syndrome, but the special non-atherosclerotic inflammatory etiology of myocardial infarction required also the use of prednisone with dose 150 mg/day in parenteral administration along 7 days, then methylprednisolone 28 mg/day, as well as azathioprine 100 mg bid.

Thus, patients with COVID-19 may present with ST-segment elevation suggestive of myocardial infarction in the absence of atherothrombosis. This situation requires a specific diagnostic approach and management.

Shuper V.O.

INQUIRY OF THE NON-ADHERENCE TO THE PATIENTS THERAPY WITH CORONARY HEART DISEASE

Department of Internal Medicine, Clinical Pharmacology and Occupational Diseases
Bukovinian State Medical University

Most causes of deaths all over the world can be attributed to chronic diseases. Approximately half of patients with chronic diseases do not take their medication as prescribed. Many researches have shown that non-adherence leads to increased morbidity, mortality and the cost of healthcare. Coronary heart disease (CHD) has become a global health problem and a primary cause of morbidity and premature death worldwide. The levels of non-adherence among patients with CHD is typically in the range of 33%–50%. Non-adherence to secondary prevention medications has been associated with a 10%-40% increase in the risk of cardiac hospitalization and a 50%–80% increase in mortality.

The aim of the work was to investigate the adherence to secondary prevention medications among patients with Coronary Heart disease and identify factors associated with it. 40 patients diagnosed with CHD with age more than 50, which has been prescribed with optimal medication for 1 year during hospitalization were examined. Patients‘ adherence was defined according to MMS-8 Morisky values for secondary prevention medications prescribed by doctors. Also, questionnaires about individual reasons of non-compliance and for individual patient‘s opinion about importance and usefulness of knowledge according risk factors of the increase cardiovascular mortality was designed and proposed to the patients. Simple descriptive statistics were used to elucidate the characteristics of the patient population and results from individual adherence tools. Final score was analyzed and correlation between patients’ data and level of adherence to prescribed treatment were identified. A correlation matrix (using Spearman’s coefficient) was reviewed for any evidence of collinearity.

Our study demonstrated higher level of non-adherence with secondary prevention medications in patients with CHD (60.0%). This fact can be explained by the socioeconomic reasons, less informative strategies from the medical staff to the patients. Severe regress of adherence was demonstrated after discharge from the hospital due to subjective improvement of the patients‘ condition with absence of supervision by out-patient specialists.

Demographic characteristics of the patients suggested that some non-modified factors can affect compliance with the prescribed treatment. Better adherence was demonstrated by female married patients with higher educational level, with family history about cardiovascular death. Also, too much prescribed medications with difficult regime of usage with non-adequate out-patient supervision may significantly decrease adherence causing development of complications which may lead to re-hospitalizations and cardiovascular death.

Our investigation demonstrated also non-complete information of the patients about lifestyle and medical risk factors of the cardiovascular mortality increase.

So, results of our study can provide useful practical information on the prevalence and severity of non-adherence among patients with CHD. Analysis of the factors influencing the adherence demonstrated the main reasons from patients and healthcare professionals affecting the level of compliance with the prescribed treatment. The step towards improving adherence can be initiated by the healthcare professional to overcome the patient’s concerns about the prescribed medication. It is important to continue personal monitoring of patients by healthcare professionals in the form of

regular inspections of intentional and unintentional non-adherence, including factors and reasons that may change and lead to such behavior.

Slukhenska R.V.

CREATIVE SELF-DEVELOPMENT OF FUTURE DOCTORS

Department of Emergency and Military Medicine
Bukovinian State Medical University

Harmonious combination of humanitarian training of future specialists with their professional development is very importantfor medical education. One of the tasks of professional training of future doctors should be the creation of pedagogical conditions for professional and creative self-expression of medical students. This idea is based on the principle of humanization of professional training, capable of realizing one's own potential.

Despite a significant interest of scientists in the issues of development of a future specialist, the problem of forming the personality of a future doctor (including its creative potential, speech-thinking component) in the process of professional training currently remains unexplored, which is manifested in the absence of a single understanding the meaning of this phenomenon, developed model and tested pedagogical conditions.

That is why it is important to describe mental-speech component of a creative potential of future doctors and determine the criteria, indicators and levels of its formation.

The culture of amedical specialist combines the culture of behavior, communication culture, patient care culture, organizational culture, professional ethics, etc. Professional and ethical culture is the system of moral values and ethical norms, which became the inner convictions of an individual based on the altruistic imperative. The subject of research of professional ethics of medical workers are objective bases, essence, specificity, structure and main functions of morality of medical workers. The level of moral culture of an individual is detected by certain criteria, including the moral consciousness of the individual, moral norms, principles, categories, motives, value orientations, regulates the moral side of their activities in the form of appropriate representations (norms, principles, social and moral ideals, the concept of good and evil, justice and injustice).

Spiritual and moral culture of a future doctor is a complex integrated system of his personal qualities, characterizing the degree of development and self-development of his moral values, beliefs, motives, knowledge, skills, feelings and abilities, which he manifests in various situations of moral choice andmoral activity in comparison with those highly humane values, principles, rules, which in the modern socio-cultural environment and activities are considered standard and (or) ideal. Thus, the doctor must be a cultured person in the broadest sense of the word.

The effectiveness of doctors is currently determined not only by their professional competence, but also by the norms of intercultural professionally oriented communication, the ability to build an effective dialogue on the rules of ethics of professional communication, correct their behavior, overcome conflicts in communication. These components of professional communicative competence should become the objects of comprehensive professional training of future doctors, the basis for their self-realization in accordance with world standards.

The professional training of specialists (including future doctors) should focus on expanding the medical horizon, forming professional consciousness of future doctors, strengthening the focus on self-development of the student's personality, which contributes to his self-realization and professional self-expression. Professional training of a future doctor is a long process of forming him not only as a specialist, but also as a person.