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Intercultural Competences in Health Care - Jehovah's Witnesses

Kompetencje Międzykulturowe w Ochronie Zdrowia – Świadek Jehowy

1. Elżbieta Bernaciak, Department of Emergency Medicine and Catastrophes, Faculty of Health Sciences, Collegium Medicum in Bydgoszcz Nicolaus Copernicus University in Torun, 10th Militaty Research Hospital and Polyclinic in Bydgoszcz, Poland
2. Paulina Farbicka, State Higher Vocational School in Koszalin, 10th Military Research Hospital and Polyclinic in Bydgoszcz, Poland
3. Aleksandra Jaworska-Czerwińska, Department of Gastroenterology and Nutrition Disorders, Collegium Medicumi n Bydgoszcz, Nicolaus Copernicus University in Torun, 10th Militaty Research Hospital and Polyclinic in Bydgoszcz, Poland
4. Renata Szotkiewicz, Elbląg University of Humanities and Economics, Faculty of Health Sciences Elbląg, Poland

Summary

After Poland's accession to the European Union, borders were opened and migrations from many culturally different countries intensified, which led to an increase in immigrants and refugees assimilating in Poland. Numerous ethnic, religious, linguistic and cultural groups existed and exist in Poland. All of these groups benefit from health services. The above situation requires medical personnel to perceive the patient through the prism of his biological, psychological, social and health problems, as well as in terms of spiritual needs of religions, as well as beliefs and socio-cultural origin. Therefore, knowledge about the cultural differences of healthcare service recipients and shaping intercultural sensitivity among healthcare workers is essential. This work examines multiculturalism in health care based on the example of the confession of Jehovah's Witnesses. Its aim was to get to know the health service opinions regarding cultural competences in specific work with patients.

Key words: jehovah's witness; patient; culture; medical care

Streszczenie

Po wstąpieniu Polski do Unii Europejskiej, otworzyły się granice i nasiliły się migracje z wielu krajów odmiennych kulturowo, co doprowadziło do wzrostu imigrantów i uchodźców asymilujących się w Polsce. Na terytorium Polski istniało i istniej wiele grup etnicznych, religijnych, językowych oraz kulturowych. Wszystkie wymienione grupy korzystają ze świadczeń zdrowotnych. Powyższa sytuacja wymaga od personelu medycznego postrzegania pacjenta przez pryzmat jego potrzeb biologicznych, psychicznych, społecznych oraz problemów zdrowotnych, jak również pod kątem potrzeb duchowych wyznawanych religii, a także wierzeń i pochodzenia społeczno- kulturowego. Zatem wiedza na temat różnic kulturowych świadczeniobiorców usług zdrowotnych oraz kształtowanie wśród pracowników służby zdrowia wrażliwości międzykulturowej jest niezbędna. Niniejsza praca rozpatruje wielokulturowość w ochronie zdrowia na przykładzie wyznania Świadków Jehowy. Jej celem było poznanie opinii służby zdrowia dotyczących kompetencji kulturowych w konkretnej pracy z pacjentami.

Słowa kluczowe: świadek jehowy, pacjent, kultura, opieka medyczna

Basic concepts

The concept of multiculturalism derives from the English term multi culturalism. It has 3 meanings:
1) in the descriptive aspect, indicates the multiplicity of cultures and states the fact of cultural diversity of a given society, as well as the fact that there are different ethnic cultures, religious groups, subcultures etc in the world;
2) also means a government policy aimed at eliminating social tensions in a given population;
3) is also the name of a certain doctrine, movement, and even philosophy, which means the activities of minority communities aimed at emancipation and fuller participation of various communities in the social, political and cultural life of the country[1].

The term "multiculturalism" is used primarily for highly-industrialized, developed multi-ethnic societies, especially immigrant societies. Multiculturalism is the main ideological position referring to the participation of minorities in cultures and national societies and the attitude to the changing nature of the very concept of national and supranational culture. According to many proponents and propagators of multiculturalism, the term culture has no theoretical status, but is a kind of mirror reflecting political, educational and socio-economic relations in multi-ethnic societies. Culture understood in this way is the source of social inequalities. The concept of culture has become the main determinant of separateness for multicultural ideology.

The very concept of multiculturalism is recognized in various ways. It has become universal to say that the 21st century is a century of multiculturalism - the age of contact, dialogue and clashing of different cultures, their mutual relations, and the necessity of co-existence of the societies of a given country. This statement reflects the reality of modern times, but it must be realized that this is not a domain of exclusively modern times. For centuries it was known, but it was not given a scientific interest [1].

According to E. Możejko, "multiculturalism refers to a society characterized by far-reaching ethnicity and cultural heterogeneity and that it means the ideal of equality and respect for ethnic minorities and cultural groups, regardless of the range of research in the field of cultural studies, history, literary studies, ethnology, which in turn entails a revision of the curricula " [10].

Nowadays, multiculturalism is very often used as a slogan, slogan or advertisement. Wojciech Burszta writes: "It can be said that a multicultural world is flooding with an unstoppable wave of all socio-cultural and political initiatives and educational. There is no day that we would not be notified that something that has multiculturalism or interculturality in the coat of arms, will just find another competition in the form of a festival, campus, debate, concert of an interdisciplinary conference. " The same author adds that the problem of our time today is not "promoting" multiculturalism, but reflection on interculturality and its practice, that is, what should be done so that people who live side by side, recognize each other in everyday dialogue and are able to at least minimally understand [1,2,15].

Nowadays, multiculturalism is also perceived in terms of ethnic and religious diversity. For many years, this diversity has aroused interest and anxiety of politicians and the public. The very phenomenon of multiculturalism is often considered from the point of view of residents of a specific territory, who have to deal with encounters with other inhabitants representing different cultural traditions. To understand them, we need to use recognized normative rules that will allow us to analyze their attitudes and behaviors resulting from all psychological activities based on a given culture.

Poland is a country where there existed and there are many ethnic, religious, cultural and linguistic groups. In the pre-war period, 30% of residents were representatives of other nationalities and cultures. Poland after the Second World War and the change of borders and displacement action became almost completely uniform in terms of nationality and culture. In Polish society, for a long time, there was a growing conviction that there is only one Polish nation, which led to the non-exploitation of the diversity potential of minority groups and their assimilation. It was only in 1989 that the phenomenon of multiculturalism in Poland began to be noticed. At that time, attention was paid to the existence of historical ethnic and national minorities and inflow the so-called. new communities (refugees, immigrants, as well as repatriates) [2,4,17].

In conclusion, it should be stated that in the age of migration, integration processes on a different scale, multiculturalism has become a necessity under which the following areas lie: respect for the components of other cultures, tolerance for all differences, and broadly understood cultural relativism. Another area of multiculturalism is the integration processes taking place at various scales, which constitute the driving force behind the creation of multinational structures in various areas of social life. It shows the dynamics of many social phenomena, which include individual and social identity undergoing modifications under the influence of acquiring new cultural content, as part of cultural assimilation.

Multiculturalism in medical terms

Analyzing the literature in relation to multiculturalism in a medical approach, we come to the conclusion that both normative culture (values, norms, patterns and patterns) as well as symbolic (ideas, symbols, views, beliefs, beliefs, etc.) to a large extent determines the health behavior of people. Behaviors that are characteristic of a given culture are governed by a system of social norms that requires appropriate behavior in a given situation. The structure of social norms consists of customs and customs. We describe habits as rules of behavior in a given social group, as well as routine activities of everyday life, such as eating habits, hygienic habits, and ways of spending free time. These behavior rules can not cause negative reactions of the environment. On the other hand, customs are the norms of behavior based on the power of tradition. These customs are valid and approved in a given social group and considered as one from the strongest and slowest modifiable forms of social control. Severe sanctions may result in perceiving moral norms. One of the elements of normative culture are values, and especially their system accepted and accepted by a given community and health located in it. In this system, health is a high priority. This is reflected in the health care system, whose task is not only to help sick people, but above all to launch mechanisms that will induce the public to take responsibility for their own health as well as their relatives. The high rank of health in the social value system determines the location of health in the hierarchy of individual values, which ultimately affects their health behavior. However, it should be said that in practice it is not as simple as the theory presents. The shaping of behaviors to a large extent depends on the knowledge and beliefs of man and the symbolic culture. In this situation, the behavior of the state should be taken in various educational initiatives that concern health and a healthy lifestyle, supporting the process of upbringing and socialization. Authors who in their reflections on the relationship between the value system and the location of health in it and the shaping of health behaviors, often refer to the pioneering research by Elsie Worthigton Clews Parasonsa [13,14,29]. He came to the conclusion that the most important value for Americans was success. The success depended on two factors: education and health. To achieve your goal in life you have to be healthy and the disease must be combated. Health in this hierarchy of values is an important factor in achieving success, which has become a value itself. This approach indicates the instrumental nature of the value of health. Iwona Taranowicz, analyzing the results of the above-mentioned research, came to the conclusion that the increase in the importance of health as a value depends on how well health is necessary to achieve other valuable values and is not competitive with them. In the hierarchy of values, the place of health determines the implementation of health behaviors. If it is low, you should not expect actions that are taken to maintain it.

When discussing the cultural determinants of health behavior, it is important to emphasize that the family plays a very important role here, which also has its own culture. This culture is made up of values, beliefs and behavioral patterns, as well as tradition, customs, and customs related to health and disease. These values are determined by social norms that form the basis of our assessments and choices, including health choices. The hierarchy of values accepted by the family and the health placed in it have a significant impact on the health behavior of its members. Social beliefs are the result of individual experiences, which means a subjective view of the truth of things. They also have a dimension of "attitudes" with a high emotional charge, which is why they have a decisive influence on our behavior. If the family is convinced about what is healthy and what harms health, then it translates directly into the behavior of family members [2,4,30,40].

Patterns of behavior, including health behaviors, are culturally defined ways of responding to specific situations. They tell us how to behave in different situations, and what behaviors we should expect from others. The behavior of adult family members influences the shaping of attitudes and behaviors of children. Therefore, it must be stated that the culture of a given "collectivity", including family, shapes the personal culture of individuals and influences the health standard and the way according to which people satisfy their health needs. Therefore, it is necessary to shape knowledge about the cause of disease, the perception and interpretation of disease symptoms, reactions to pain, attitudes and behaviors towards one's illness, as well as other people's diseases, as well as preferring lifestyle patterns. Knowledge of average people, i.e. colloquial or secular knowledge is not a coherent whole, and can also be contradictory. This knowledge is created by beliefs that are based on tradition, beliefs, observations and colloquial experience. The mass media, ie press, radio and television play a large role here and internet. They provide a lot of information to the public and broaden medical knowledge. That's why specific ideas about health and illness arise, as well as suggestions on how to proceed to stay healthy and what to do in a situation when there is some ailment. However, we must state that this knowledge only affects subjectively the understanding of health and illness that is interpreted in different ways in different cultures and is constantly changing over time.

Countries that have more experience in multiculturalism assume that ethnic minorities, within the meaning of all separate social groups, have the same diseases and the same health needs as the rest of society. However, it should be noted that there are significant differences in the spread of certain diseases, as well as ethnic diversity

in health and the occurrence of ethnic inequalities in health. Connections of health with nationality / ethnicity are multifaceted. Genetic factors and patterns of behavior in some minority groups have some significance here. Another factor is social and economic inequalities, which affect many minorities and have a significant impact on the emergence of inequities in health. There is also limited access to health care for individual and institutional reasons of racial and ethnic prejudices. New minorities, those who have recently been displaced, who are adapting to new conditions are particularly at risk of losing their health. Despite the fact that the majority of migrants are mostly young and healthy people it is with their time that their health situation worsens. They live often in poverty, in poor housing conditions and in isolation from the immediate family. Often, they have limited access to social benefits (insurance, supply and caring) as well as health care, what it results from poverty, ignorance of the local language, as well as customs, structures and laws. These people, even when highly qualified, are very often employed in manual work. They often work beyond strength. Their children may also have difficult access to education. Poland is basically a homogeneous country in terms of ethnicity and religion, but global phenomena in the form of migration also affect it. In Poland, ethnic and national groups such as immigrants, repatriates and refugees begin to settle down. Some of them become clients of health care. Available studies indicate that medical staff encounters some difficulties in looking after foreigners. The reason for this is the language barrier and cultural ignorance. There is also a low awareness of the life and health situation of migrants and the way of settling accounts with foreigners. Foreigners have a significant lack of knowledge about access to the health care system in Poland. Therefore, they postpone the visit to the doctor until they return to their country of origin, which means that they often go to hospitals in life-threatening situations. The conducted research indicates that the perception of foreigners by medical personnel in Poland depends on the country of origin of migrants. Patients who come from Western Europe and the United States of America, as well as people using private health care they are received much better than foreigners about the refugee procedure[4,5,33,40].
At this point, however, it should be added that the reluctance towards forced migrants usually results from bad experiences related to cultural difficulties, as well as the result of misunderstandings and not bad faith.

There are also cultural difficulties in the process of building relations between medical staff and a foreign patient. These difficulties can be divided into the following categories:
- religion: cooperation between a doctor and a migrant patient in Poland is hindered by ignorance and misunderstanding of religious principles;
- customs: a culturally defined role of the family in the decision-making process and in the structure of the individual's value, socially accentuated reaction to pain, moral diversity
in the assessment of individual methods and medical procedures and other sense of time;
- awareness and understanding of the sense of health and illness, as well as the principles of functioning of the medical system: low awareness of hygiene, health and the associated treatment process, taboosis of diseases, frequency of occurrence of psychosomatic diseases among foreigners applying for international protection [4,6,8]
- gender perception: gender in the practice of gynecological, venereal and urological practice, the perception of medical personnel by male migrants. In summary, it can be concluded that many European countries, including Poland, are involved in the migration process. The integration of minorities, especially new immigrants, is important from society and economic point of view. Health policy should become more culturally sensitive. It is necessary to develop skills in cultural competence among medical staff. Knowledge in the field of multiculturalism should be provided in the form of training or during medical studies [47,55,61].

Jehovah's Witness
Jehovah's Witnesses are their full name, the Christian Church of Jehovah's Witnesses.
They are a religious association that claims that Jehovah (Yahweh) is the only God and that the Kingdom of God is approaching power over the world. They belong to the so-called a badatic trend, belonging to Millennial denominations. The founder of Jehovah's Witnesses is Charles Taze Russell, generally known as Pastor Russell. In 1870 he initiated the operation of the "research movement". First, Bible meetings took place in the closest family and three friends, at Russell's house. Officially, this movement was registered in 1914 in London under the name "International Association of Bible Researchers". In 1881, Charles Taze Russell founded a publishing corporation called the "Watchtower of the Zionist - Treaty Society", which he officially registered in Pennsylvania in 1884 as a joint-stock company, holding almost 100% of shares. In 1909 a new corporation was established, which was called the "Kazałnica Ludowa Association", and from 1956 it was known as: "the registered New York Bible and Tract Society - Watchtower". The modern name "Jehovah's Witnesses" owes this confession to Joseph Franklin Rutherford, who was the successor of Charles Russell, and introduced it in 1931 year at the Columbus congress. Until 1931, activists of this movement were called: "explorers", "russellites",

"Watchtower people" and "people of the dawn of the millennium"[4,34,59].
Charles Taze Russell called the congregations he called "ecclesia" or "classes." In their operation, they enjoyed great freedom because the founder was not interested in what was happening in them. At that time, he was involved in the activities of the Watchtower Treaty Society, and also awaited the near end of the world. After 1881, the situation changed when the ranks of researchers grew. He began to publish articles that talked about the necessity of introducing "order" during the congregation of saints, and also about the necessity to choose elders who would be able to watch over the "ecclesias".
Charles Taze Russell also censored the Bible. He instructed his faithful to write from the Bible, among others Mk 16.9-20; Lk 22.43, 23.34; J 5.25; 1 P 2.5; 2 P 1.1; Jk 5.16; Ap 5.3.13. He did not accept the tradition of the Catholic Church, as well as any testimonies of faith dated in the first centuries of the Church's existence. He called idolatry and superstition the taking into account of tradition. Despite the radical denial of tradition, he saw the need to refer to predecessors who were known in history and identified with his doctrine. To the group of his "religious ancestors" he included heretics of the Catholic Church, among others Jan Wiclif for rejecting the Holy Mass; Arius for rejecting the teaching of the Holy Trinity; Piotr Waldo for the negation of confessions, prayers for the dead, the sacrament of baptism and the priesthood; Martin Luther for spreading the doctrine of justification by faith, omitting his deeds. He wanted to summarize and complicate his complicated and elaborate science in "Lectures", which appeared in parts: "The Divine Plan of the Ages" (1886); II "The time has come" (1889); III "Thy Kingdom come" (1891); Fourth day of vengeance (1897); V "Reconciliation between God and a man "(1899); VI "New Creation" (1904). The seventh volume, which is attributed to Russell's authorship, was released only a year after his death in 1917, almost entirely in the hands of his successors Fisher and Woodworth. The entire "Lectures" counts over 3 thousand. pages and was supposed to include all the teachings of Jehovah's Witnesses. Russell's great involvement in publishing was the reason why in 1912 he became the most widespread authority of Christian publications in the United States of America. Charles Taze Russell died on October 31, 1916, at the time of his return from an evangelistic journey. After his death in January 1917, Joseph Franklin Rutherford was elected President of the Watchtower Society. I would like to add that in 1996 there were over 5 million active Jehovah's Witnesses around the world, and in 2000 this number increased to 6 million. In 2013, there were almost 8 million active publishers in 239 dependent countries and territories.
In most countries around the world, Jehovah's Witnesses are registered as a legitimate religious association. In many international organizations, both secular and judicial, Jehovah's Witnesses are considered as religion. In some countries, they are mentioned as a sect. An example is France, where in 1996 the Court of Appeal ruled that Jehovah's Witnesses are a sect. On June 30, 2011, the European Court of Human Rights ruled that the French government violated the rights of Jehovah's Witnesses. By contrast, on July 5, 2012, the same Court ruled that the French government must pay 4.5 million euros (including interest) to compensate Jehovah's Witnesses for violating their religious freedom and for illegal taxation.
There are also countries in which Jehovah's Witnesses refuse to participate in military training and are sentenced to imprisonment. On July 7, 2011, the Grand Chamber of the European Court of Human Rights ruled by a majority that Armenia violates the right to freedom of conscience of a Jehovah's Witness, convicted for evading military service, because of conscientious objection. From April 2000 to 2013, they won 20 cases at the European Court of Human Rights. A total ban on operations or its restriction takes place in 30 countries. These are the communist countries (China, North Korea, Laos, Vietnam), Islamic (Algeria, Afghanistan, Saudi Arabia, Bahrain, Djibouti, Egypt, Eritrea, Iraq, Iran, Yemen, Jordan, Qatar, Comoros, Kuwait, Libya, Maldives, Morocco, Oman, Somalia, Syria, Tunisia, Uzbekistan, United Arab Emirates, Turkmenistan, Tajikistan),
as well as in Bhutan and Singapore [45,46,49].
The history of Jehovah's Witnesses in Poland begins in 1891, when Charles Taze Russell arrived in Kraków. Due to government restrictions, his public appearance did not take place then, but he conducted several individual conversations. In 1882, V. Antoszewski returns to Poland from the United States, distributing Bibles among the immigrants in Chicago, as well as books of the Bible Students. In 1895, for three months to Poland, Hipolit Oleszyński came from the USA. He was an investigator of the Holy Bible. In Poland, he wanted to familiarize himself with the teachings of the Bible Students in his family and friends. Later, despite many difficulties, literature in German came to Poland and English.
This literature was sent by expatriates. In 1898, Margarete Giesecke from Germany, at that time, was involved in the composition of literature in Berlin intended for sending to Germany and other European countries, she introduced the Protestants of the Holy Scripture to the teachings of the Protestant missionary who was active in Poland. This missionary shared his knowledge with other people who lived in Poland. Already in 1901, a German-speaking group of 15 people gathered in Warsaw. Johann Weinz belonged to this group.
Another researcher of the Holy Bible who was in Poland was the Swiss E. Bente. In 1905 he took over the position of director in the Warsaw lace factory. He organized a group that discussed Bibie with the help of publications published by the Bible Students. The first registration of a group of Polish Bible Students was made

October 17, 1905. In Gdańsk, the organization of meetings on which the Bibles were analyzed was also started. Under the influence of these meetings in 1909 it was published many publications in Polish, and in 1925 it was published regularly "Watchtower" in Polish. The Warsaw congregation, numbering 14 people, on May 3, 1910, visited J.F. Rutherford, and next year Lviv and Warsaw again [3,19,27,59].
The tsarist police interfered in the meetings of Bible Students. During his visit to Poland, Russell applied to the authorities for legal registration of religion. General general - the governor of Warsaw issued a rescript, under which religious activity was enabled. In 1911, the Warsaw congregation numbered about 25 people, in Pabianice 20, in Raszyn 8. In 1913 the activity of Bible Students in Poland was legalized. A religious statute was then obtained that was recognized by the state. Legalization of Bible Students was confirmed after World War I, March 6, 1923, by the Ministry of Religions and Public Education. In 1928, in Poland, it was already 256 publishers and 24 congregations. Antoni Bida, director of the Office for Religious Affairs, July 2, 1950, outlawed the activities of Jehovah's Witnesses. He announced the dissolution of their organization because of "criminal activities" that could lead to "a threat to security, peace and public order." At a conference that took place a few days later, the Minister of Public Security, Stanisław Radkiewicz, described Jehovah's Witnesses as "spies of imperialism sowing war hysteria." During this period, about 5,000 prisoners were imprisoned. followers and over 40 people died in the investigation and in prisons. The confiscation of the organization's property was also ordered. In May 1963, by a resolution of seven judges of the Supreme Court, individual worship of religious worship was allowed. Jehovah's Witnesses referred to this resolution during detention by security services. In the 60 years of the 20th century, over 30,000 Jews were under Jehovah's Witnesses. court hearings per year. Prisoners of Jehovah's Witnesses were also imprisoned for refusing military service. Condemning sentences were not released until 1988. The official registration of Jehovah's Witnesses in Poland took place on May 12, 1989. They were registered under the name "Watchtower - Bible and Tract Society. Registered Association of Jehovah's Witnesses in Poland. " This group is entered in the Ministry of the Interior and State Register under number 34, currently as "Jehovah's Witnesses in Poland." In 2011, as a result of the Population and Housing Census, which took place in Poland, the number of people declaring themselves as Jehovah's Witnesses was 137,308 [5,8,9].

Common difficult situations that appear when dealing with representatives of Jehovah's Witnesses

Doctors who treat Jehovah's Witnesses face a specific problem. Increasingly, they are forced to take a stand on the question of dispute, which is a blood transfusion. In the past, many doctors, as well as hospital administration employees, refused to accept a blood transfusion, considered a legal issue. For this reason, the court was requested to issue a decision that would allow them to apply medical treatment justified from a medical point of view. Today, to perform a blood transfusion treatment and its components, the patient's consent for treatment is needed. The Constitution of the Republic of Poland of April 2, 1997 in article 41; 47, as well as the Act on the profession of doctor and dentist of December 5, 1996, as well as the Penal Code or the Code of Medical Ethics, refer to the necessity of such consent. For all medical interventions with higher risks, consent must be given in writing. The blood transfusion is considered to be such a treatment. Therefore, before the procedure is performed, the patient's written consent should be included in the medical documentation. Consent should be granted voluntarily. There must be no pressure either from the doctor or from the medical staff or from other people (even those close to you). Jehovah's Witnesses use a ready-made document that includes a statement for health care. In this document, they categorically oppose any blood transfusion. This document is signed by the patient and confirmed by two witnesses is a declaration of will compatible with the requirements of the Civil Code, and is binding on the doctor. If the patient refuses blood transfusion, the doctor is required to provide comprehensive information on available treatments for blood substitutes, as well as other alternative methods that are used during surgical procedures. The Law on the Medical Profession (Article 38) gives the doctor the option of withdrawing from the patient's treatment, subject to Article 30, in which it states:
"The doctor is obliged to provide assistance whenever the delay in granting it could lead to the risk of loss of life, serious injury or serious health disorder, and in other urgent cases" [7,10,21,62]. In the analyzed situation, it would be reasonable if the physician considered that it was impossible to perform a given procedure without a blood transfusion. In such a case, he or she should inform the patient or his representative in advance, as well as inform about the possibility of getting help at another health facility. This fact and justification should be noted in the medical documentation. The problem arises in the case of an emergency and there is a real threat to the health or life of the patient. When the patient is conscious and expressly opposes the transfusion, or when it is unconscious, but with a statement, or it will be provided by the patient's family, from a legal point of view, this situation seems clear. However, there are situations when the patient is unconscious, does not have an adequate statement with him, and his family claims that he is a Jehovah's Witness and opposes blood transfusion. In this case, the doctor should not succumb to family pressure and, if necessary, transfuse. It should be emphasized that

we are talking about an adult patient and unskilled patients. A more complicated problem arises in the case of minors (under the age of 18). In Article 34 of the Law on the Medical Profession it is written, that a doctor may perform a given treatment for a minor, incapacitated person or incapable of informed consent after obtaining it from a statutory representative [6,7,8]. When the patient does not have a representative, or it is impossible to contact a representative, then the consent of the guardianship court is necessary. Therefore, when the child's parents do not agree to a blood transfusion, which is necessary in the course of treatment, the doctor may ask the competent family court to issue a blood supply order or its preparations. In the event that procrastination due to the aforementioned procedure would endanger the risk of loss of life, serious bodily injury or serious health disorder, the doctor, after taking the opinion of the other doctor, may perform the procedure without the consent of the legal representative and the guardianship court. The physician should immediately notify the competent statutory representative or the guardianship court, about the actions taken. In such cases, the court, after taking expert opinions, most often upholds the doctor's decision. The case of minors who have reached the age of 16, consent is also required from them. If the consent is for higher-risk treatments, which include a blood transfusion, it should be in writing. In this case, the consent of the statutory representative of the minor must also be obtained. The matter starts to get complicated when the child in the age at hand is opposed to certain medical activities, and his guardians agree. At that time, consent from the competent guardianship court is necessary. Children under 16 years of age also have the opportunity to participate actively in the therapeutic process, provided that they are able to properly recognize their own state of health. The doctor must take into account their opinion, but the decisive vote belongs to the statutory representatives or the guardianship court. Doctors who treat Jehovah's Witnesses should be prepared for the above-mentioned situations. Therefore, it is necessary to know the relevant provisions that will allow the doctor to take an appropriate legal position.

Treatment of Jehovah's Witnesses raises the dilemma of doctors who feel obliged to protect life and health, using all available means. To fulfill your duty, the doctor is to follow the most important ethical imperative, which is the good of the patient. When providing a medical service, the doctor, as the one who provides help, should respect the dignity of the human person, resulting from natural law, regardless of race, nationality, sex or religion. The doctor should perform this task in accordance with medical knowledge, as well as in accordance with his own conscience. Doctors' problem arises when they are to decide on a blood transfusion in order to save the health and even the life of the patient, who is Jehovah's Witness. So what is the doctor supposed to do and what law is to be followed? Is his behavior to be consistent with the Hippocratic oath, applying all healing procedures? Or should he respect the patient's right to consent to the medical procedure? There is no explicit indication of the proceedings in this respect. This problem remains to be resolved in the conscience of two physicians and patients. The technological progress that has been made more and more often comes with help in such cases, patients can be safely undergoing surgery. Today's medicine has equipment and minimally invasive methods that allow you to minimize the need for blood transfusion. You can also use autotransfusion, as well as blood substitutes that help in maintaining circulation. Today, many surgeons who undertake the treatment of Jehovah's Witnesses consider the use of blood products as an additional difficulty that is a kind of challenge to their skills and experience. Jehovah's Witnesses have no objections to colloidal or crystalloid replacement fluids, as well as electrocautery, hypotensive anesthesia or hypothermia, which is why doctors can use it [9,53]. Currently and in the future, the use of hydroxyethylated starch (HES), intravenous injection of high doses of iron with dextran, and the use of an "ultrasound scalpel" does not raise religious objections of Jehovah's Witnesses. It can therefore be said that Jehovah's Witnesses, as well as their opposition to blood transfusions, can cause many problems for clinicians, especially with specialization. Instead of conducting ineffective polemics, as well as religious or ethical discussion, one should respect the will of an adult and conscious patient, even if their health or life is at risk. Such behavior is the result of obligatory doctor's regulations. Controversies, however, arise from controversy regarding minors. There are often legal proceedings against parents on charges of failing to properly care for a child. According to Jehovah's Witnesses, this kind of behavior is criticized by many doctors and lawyers. In their opinion, parents who are Jehovah's Witnesses are trying to provide their children with good medical care. These parents do not try to shirk parental responsibility, nor do they want to pass it on to a judge or someone else. They demand, therefore, to take into account religious principles respected in their family. They also have the right to opt in on the treatment of their children. Jehovah's Witnesses only ask for the treatment of a child who is not religiously objectionable. Harmonizes it, in their opinion, with the medical principle of treating "the whole man". Another problem that arises in dealing with Jehovah's Witnesses is their mental health. Any practicing psychologist or psychiatrist, sooner or later, meets a patient who announces that he grew up as a Jehovah's Witness, belonged to or was influenced by the confession. It is extremely difficult to help these people, especially if you do not know what driving force is a consequence of the teaching process of the community and what stressors result from the current worldview, as well as from the social environment. In addition, it is difficult for people who are reasonably stable to understand the position of those who are authoritarian in faith, like Jehovah's Witnesses [9,10,14]. Very often, mental illness is even among Jehovah's Witnesses, even above

average. Research on this problem is difficult because the Watchtower Society advises its members not to seek specialist advice. Lack of help, in the initial stage of the disease, leads to its further development. All activity in the social sphere, which is extremely important for the human psyche, is inhibited. The exception is the activity in the organization's ranks, which can lead to full identification with this doctrine. This identification is the reason that the follower of this doctrine sees everything through the "glasses" of faith. The reality with which he meets is not always consistent with the truth and the authentic feelings of the observer. Most often for the occupied position, regarding the treatment of blood transfusions, serial publishers are punished, the fault is that they believed people who were appointed judges of this world and should be listened to as if it was God himself. Followers of Jehovah's Witnesses often face the decision whether to allow their child to give blood or some of its components. When the doctor disproves their arguments, the elder of the congregation watches behind him so that sometimes his lamb does not break down. Therefore, the role of a hospital should not only be limited to asking the Court for deprivation of parental rights, but to present arguments that are authoritative for a given believer, that is, the overthrow of these sciences based on their literature. The greatest enemy of followers of Jehovah's Witnesses is their own literature. That's why you have to convince a follower, that he certainly did not mislead him. The doctor is in this case the most competent person to save the life of a particular Jehovah's Witness and those closest to him. In the United States, schizophrenia is 4-6 times more common in Jehovah's Witnesses than in the rest of the population. Depression occurs approximately 6 to 10 times more of ten and the severity of this disease in Jehovah's Witnesses is much greater. It also appears they lack the purpose and meaning of life. Nervous diseases affect not only members of the religion, but also functional and strict management.
Followers of Jehovah's Witnesses often live in fear and guilt. Extreme sacrifices and work for the organization are required of them. This is often done at the expense of professional work, health and the extreme limitation of their material needs. It is difficult even to list all activities that are forbidden, condemned and unwelcome.

Here are some of them:
- wearing or possessing symbols, not only religious ones, is referred to as a false deity;
- any relationship or participation in religious ceremonies of other religions and related activities, such as funerals;
- celebrating birth is called idolatry;
- the bright at the time of weddings and other celebrations is called a false deity;
- participation in elections is considered as mixing in the affairs of this world;
- work in the arms sector, (supporting wars);
- celebrating any holiday is called idolatry;
- blood transfusion and blood donation (blood sanctity);
- reading books and publications of other religious denominations is called littering the mind;
- activity in youth associations as a waste of time;
- any participation in politics is forbidden;
- watching movies, as a sinful influence, a lost time that can be sacrificed for preaching;
- wearing mourning clothes is called a pagan custom;
- interest in well-known personalities and their philosophy is considered to be worshiped by people and not biblical values;
- donations to the Red Cross or similar charities as support for religious organizations;
- showing too much passion during sexual intercourse with a marital partner, as immorality;
- participation in out-of-school activities (this free time should be used for preaching);
- reading the old literature of the Society as a waste of time;
- participation in military service and civilian formations as an exercise for war;
- exercise of self-defense techniques as a military origin;
- leaving joint meetings and preaching activities as disobedience to God;
- a visit to a psychiatrist or psychologist as something that might be misleading;
- playing checkers, chess or cards as a military character;
- working overtime as the time needed for preaching;
- friendship with people outside the organization as a global company;
- wearing trousers by women, as inappropriate clothing, becoming similar to men - only allowed at home.

For some of the above-mentioned deficiencies, you can stand before the Judicial Committee and risk expulsion from the organization. Living in so many stressful situations, under the threat of denouncing, Jehovah's Witnesses come to suicide, committed even in Kingdom Halls. Summing up, it should be noted that in Poland it is difficult to determine the number of cases of psychiatric consultations by Jehovah's Witnesses. If some of them use this advice, they most often cover their affiliation with the Watchtower organization for fear of exclusion [12, 13,15,62].

Good practice in the sphere of health care

In today's times in which we have lived, we see many changes that are taking place in society. Changes also occur in the sphere of health care. Patients who benefit from medical care have many requirements towards it. Today, there is a great increase in the awareness of patients. The needs and expectations regarding health services are changing. There is competition on the medical services market, which makes the maintenance and development of treatment facilities dependent on the quality they offer. For the doctor, quality is an independent control of the services provided, as well as an immanent component of the medical practice. The most important thing for the patient is effectiveness, urgency and safety related to the treatment and care process. It is important for him that, in the event of his health being compromised, both in quantity and in qualitative terms, everything that allows time to start, cure and alleviate the symptoms of illness, suffering or bodily injury has occurred. Quality applies to all aspects of the functioning of a given health facility, such as: the range of services offered, the manner and speed of their implementation, organization and course of the treatment process, as well as the use of modern diagnostic and therapy methods. An important element is the approach to the patient, as well as care for his comfort and satisfaction of biopsychic needs. Introducing constructive changes in the organization of health care is long and complex. This process requires modification of attitudes and behavior of the staff, which is connected with the improvement of competences, both hard (knowledge, specific professional skills), as well as soft (psychosocial), which allow building lasting relationships and effective Communications with patients, members of the therapeutic team, as well as with the management staff. In building efficiency and efficient management of the health care organization, the main obstacle is the behavior of employees. Not only knowledge, specialist skills and compliance with the standards in force in a given field are important in the provision of services, but above all the level of employee involvement. The patient expects to get an accurate diagnosis and also notices all the elements of the service provided, expects support, dialogue, listening to his suggestions and treating them in a subjective way. In health facilities, which have a quality certificate, as a requirement, it is necessary to conduct patient satisfaction surveys. The quality is tested in various areas, for example: human resources management (financial, material and processes) and provision of services, as well as meeting the needs and expectations of patients. When talking about improving the quality of services and patient satisfaction, the attitude of the staff can not be overlooked here. If there is a high level of staff involvement in performing professional duties, as well as the degree of their identification with the mission of the given institution, as well as the acceptance of the pro-quality activities undertaken by the institution, this will be reflected in providing services that are consistent and even exceeding the patient's expectations. Care for improving the working environment of the staff and creating favorable conditions is tantamount to improving the quality of services. At present, the necessity for every branch that wants to succeed is a rational, planned, integrated and orderly operation that permanently improves the quality. One of the ways to introduce internal order in the organization, which is a medical facility, is to implement a quality management system [6,16,21,49].

Good healthcare practice in relation to Jehovah's Witnesses should be changed as follows:

I. the health care facility should follow the rules of conduct for Jehovah's Witnesses regarding blood transfusions: "Any adult patient who is not incapacitated has the right to refuse treatment, no matter how harmful the refusal would be to his health";
II. the "Patient Rights Charter" should be prominently displayed in the hospital,
in which the right to deliberate consent should be included;
III. the patient should be informed about the anticipated consequences of using or not using different treatments, which will allow him / her to make a decision about the treatment;
IV. the hospital should accept a statement on a full understanding of treatments based on blood transfusion. Here

is the content of this statement: "I declare that I have been informed about the effects of rejecting a blood transfusion therapy. I have received information on alternative methods and the risks involved, as well as the risks associated with the use of blood. As a Jehovah's Witness, I am aware that:
1. The Watchtower Society has a constantly changing policy regarding basic and smaller blood components. It did not provide any scientific basis for its position.
2. Jehovah's Witnesses have the choice of agreeing to accept smaller blood components, but this is considered a matter of conscience.
3. Jehovah's Witnesses have the choice of agreeing to accept the basic blood components, but they may as a consequence face the foreclosure of the church in the form of exclusion.
4. The blood components considered by the Watchtower Society as smaller include albumin, fibrinogen, all coagulation factors and immunoglobulins.
5. The blood components considered by the Watchtower Society as primary include red blood cells, white blood cells, plasma and platelets.
6. The blood component of albumin and treated by the Watchtower Society
if it is acceptable, it constitutes a percentage of the greater part of the blood volume than blood components such as platelets and white blood cells, which the Watch Tower Society considers unacceptable.
7. The plasma, which is treated by the Watchtower Society as unacceptable for use, contains various components that are allowed - according to the Watch Tower Society - to be used by Witnesses [1,15,55,88].
the hospital should also accept the patient's statement regarding the directives
and guidelines for medical procedures: "I declare that the attending physician has encouraged me to consider the decision to accept a blood transfusion, and that it may be necessary. I was able to get additional information about blood transfusion, its risks and alternative methods. I'm happy with the explanations and I have no additional questions. I am fully aware of the consequences of my decisions.
I know that bloodless techniques are currently subject to limitations, and that
in some situations, there are no alternative methods, and the result of my choice may be a serious health risk or death. Therefore, I will not make any accusations against doctors, nurses and health care providers who keep my will for my rejection of treatment with blood, no matter how necessary it may seem. "
V. alternative methods to blood transfusions should be used to treat Jehovah's Witnesses. According to Jehovah's Witnesses, these methods eliminate side effects, reduce the incidence of infections and immunosuppression. The achievements of bloodless medicine Jehovah's Witnesses include: open heart surgery, primary and resection of coronary artery bypass, aortic and mitral valve replacement, orthopedic surgery, hip and knee arthroplasty, surgical vertebral immobilization, surgical treatment of scoliosis, transplants (liver, kidneys, heart, lung), oncological surgery, transplantation of peripheral blood stem cells;
VI. the hospital should adopt a strategy for avoiding and controlling haemorrhage
and anemia without blood transfusion. To adopt such a strategy, the medical service should:
1. Use surgical tools to minimize the loss of blood to which we include: electrosurgery, laser surgery, argon coagulation, stereotactic radiosurgery, microwave coagulation knife, ultrasonic knife.
2. Introduce techniques and devices to control bleeding and shock. When using bleeding, use: direct compression, ice coating, elevation of the body above the heart, hemostatic agents, rapid surgical intervention, tourniquet, controlled hypotension. For shock, use: Trendelenburg position, anti-shock pants (M.A.S.T.), appropriate volume replacement after controlling bleeding.
3. Introduce surgical and anesthetic techniques reducing blood loss consisting of: general anesthesia with hypotension, induced hypothermia, hypervolaemic homodylation, laparoscopic surgery, reduction of skin flow, meticulously careful hemostasis, arterial embolization, pre-operative planning, enlargement of the surgical team, shortening the operation time, distribution difficult operations on stages.
4. Use tools and techniques to limit iatrogenic blood loss, i.e. percutaneous oximetry, pulse oximetry, micro-collection equipment, perform only the necessary tests, multiple tests from one sample and smaller samples.
5. Use lotions, such as: crystalloids, Ringer's lactate, physiological saline solution, hypertonic saline solution, colloids, hydroxyethylated starch, gelatin, dextran.
6. Use haemostatic agents for bleeding or clotting disorder, which are divided into local (avitene, gelfoam,

oxycel, surgicel), for injection
(tranexamic acid, aminocaproic acid, desmopressin, vitamin K), other agents (aprotinin, conjugated estrogens, vasopressin).
7. You can also use other techniques and means to treat anemia such as: stopping each bleeding, supply of oxygen, oxygen carbohydrates, maintenance of intravascular volume, hematopoietic drugs (iron, folic acid, vitamin B12), immunosuppressants, if indicated hyperbaric oxygen therapy , toleration of lower Hb values in normovolemic anemia [20].
VII. if in doubt about the treatment of Jehovah's Witnesses, the hospital should use from the help of the Hospital Information Service (HIS), which coordinates the work of an international network for distributing expert information on alternative strategies to blood transfusions. It does this through Communications Communications with Hospitals that operate in cities with larger hospitals. These committees prepare medical personnel for the possible treatment of a patient who refuses blood transfusions, and show on the example of other centers how to deal with them. Members of the Communications Committee are at the patient's or doctor's disposal and help to communicate about the treatment that both parties accept [17,19]. They are also trying to provide the patient with information about his health, diagnosis, proposed and possible diagnostic and therapeutic methods, as well as foreseeable consequences of their use or omission. The patient who is a Jehovah's Witness wanted A Jehovah's Witness who is in a hospital may ask the local Communications Committee to organize a consultation with a specialist who has experience in non-blood treatment. This action allows the doctor to perform the activities that are provided for in art. 37 of the Act on the Medical Profession: "In case of diagnostic or therapeutic doubt, the doctor, on his own initiative or at the request of the patient or his legal representative, if he considers it justified in the light of medical knowledge requirements, should consult the competent specialist doctor or arrange a medical consultation" [21]. If the patient's condition permits and the doctor wants to exercise his right to not receive treatment or withdraw from it, then the Communications Committee may indicate a center or hospital where the patient could be treated taking into account their reservations about the blood transfusion.
Here is a brief outline of how to deal with a Jehovah's Witness located in the hospital, referring to both planned and emergency cases:
1. Analysis of available alternative strategies and selecting them accordingly
to the case.
2. Consultation with a doctor from the same hospital who has experience in the use of alternative methods. Treatment of the patient taking into account the consultant's recommendations.
3. Contact a consultant from another hospital through the Hospital Communications Committee for Jehovah's Witnesses. Treatment taking into account the consultant's recommendations.
4. If necessary, transfer the patient to the care of a doctor or hospital who has experience in treating Jehovah's Witnesses before the patient's condition begins to deteriorate[22,37,93].
As an example of good practice, in the treatment of Jehovah's Witnesses, one can mention the Polish Society of Anaesthesiology and Intensive Care, which set the standard of conduct in the event of admission to a branch of Jehovah's Witnesses. The basis of the procedure is the efficient flow of information between the patient and the team of anaesthesiologists, as well as proper training of the staff. Procedures that have been agreed, as well as those not accepted by the patient, should be recorded in the documentation and signed by the patient.
In summary, the introduction of good practice in the treatment of Jehovah's Witnesses is associated with adequate knowledge of their religion. One should therefore think about the appropriate training of medical staff, during which knowledge about the religious conditions of Jehovah's Witnesses' health behaviors will be conveyed, as well as ways of coping with stress and strategies used to avoid blood transfusions. Medical staff should also be trained in tolerance, ie to learn how to treat a patient as a partner in medical care, fully accepting the patient's right and the right to choose one. Self-education and training as well as developing the ability to establish contacts with representatives who belong to other cultures and tolerance towards patients of different religions and nationalities are necessary here.

Aim and subject of research

The purpose of this work is to justify the need to train health care about foreign cultures, spiritual needs, as well as knowledge of the religion that patients profess.

The subject of my research is the health care community, i.e. doctors, nurses, midwives and paramedics.

Methods, techniques and research tools

In my research I used one of the most popular methods of social research, so-called by means of a diagnostic survey. Determining the research problems and setting hypotheses, gave rise to the analysis of research methods, with the help of which I got answers to the research problems posed by me.

I chose the questionnaire as the most suitable and useful research technique. The research technique is implemented using appropriate research tools. As a tool for my work, I used the author's questionnaire, which was written under the supervision of the promoter. In this case, 118 employees were asked about this question through the questionnaire, ie doctors, nurses, midwives, medical rescuers in two facilities: a Multispecialty Municipal Hospital in various departments and the Non-Public Healthcare Center "Mątwy - Med." In Inowrocław.

Analysis of research results

The research was carried out mainly among nurses and doctors working
in various hospital departments and clinics. A total of 118 people randomly selected were examined. Each respondent differs in terms of age, education, type of work, place of residence and work as well as religious confession. Their opinions on multiculturalism in health care are varied
and they are presented in the tables and graphs along with the analysis of the given question.

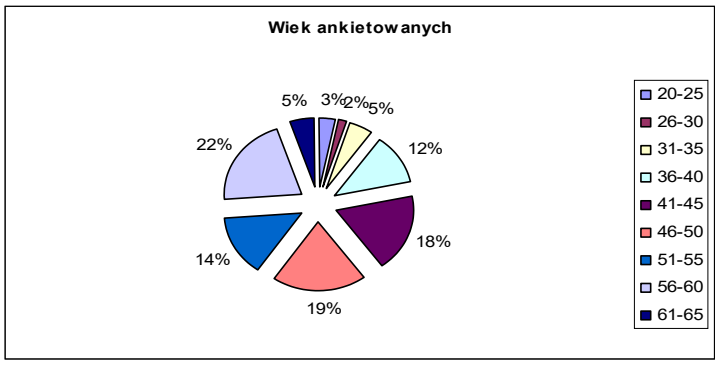

Chart No. 1 - the age range of the studied population.

The age structure of the studied population is as follows: the most numerous group are respondents between the age of 56 and 60, which is 22%. In the second place are people between 46 and 50 years of age, which accounts for 19% of the surveyed group. A slightly smaller group of respondents in the age group 41-45 gives 18%. The least numerous is the age group covering people between 26 and 30 years constituting only 2% of respondents. The average age for all subjects is 44 years, which indicates that the respondents are professionally experienced people and there is a very high probability of contacting these pe ople with multiculturalism in health care. The surveyed people are mostly a group with a secondary medical education with a work experience of 31-35 years of work. The research group is a reliable and experienced medical staff that is in contact with various patients in their everyday work. However, whether many years of experience has translated into intercultural competence of contemporary nursing staff has been shown in the analysis of answers to questions posed in the survey. One percent of the population surveyed is Protestants, 8% of those surveyed are non-believers, but as many as 91% of respondents are Catholics. Perhaps it was faith that led the study population to incline to a response that puts the respect and dignity of another in the foreground regardless of origin. The study analyzed the knowledge of intercultural competence in nursing among 118 respondents. Only 47% of respondents came across the concept under study. 62 people or 53% do not know or do not remember if they have ever met intercultural competence

in health care. The vast majority, as many as 78% of the surveyed population is of the opinion that knowledge of other cultures is needed when performing nursing activities in everyday work with a patient who it is not always our nationality. Due to the significant increase in the scale of spatial movements of people from other countries and regions of the world, medical personnel recognize the need to know other cultures to professionally help the patient, respecting their needs, dignity and cultural and spiritual customs. In the next stage of the research, an assessment was made of which skills and attitudes of the respondents are most desirable to facilitate the contact with the patient of another culture. The question addressed to the respondents gave the opportunity to choose three characteristics, in their opinion, the most important. Without much astonishment, it should be said that knowledge of the language is the answer that dominates this question and that's how 78 people responded. Fewer fewer, as many as 72 people surveyed correctly said that respecting and recognizing cultural differences is a very useful feature in contact with the patient. Almost equally, understandably speaking without medical jargon (42 people) with the ability to recognize problems resulting from cultural differences (41 people). You can see that perfect contact and getting to know a person who is provided with medical help is extremely necessary for comfortable work and patient satisfaction.

Tab. 1 Please indicate the 3 most important, in your opinion, the attitudes and skills that help the nurse to get in touch with a person presenting a different culture?

1	Overcoming ethnocentric attitudes and stereotypes	31
2	**Knowledge of language**	78
3	**Speaking slowly, clearly, without medical jargon**	42
4	Knowledge in the differences between the culture of the nurse and the culture of the patient	25
5	Knowledge about the impact of culture on health and disease	27
6	Ability to overcome fear of cultural otherness	22
7	**Respect and recognition of cultural differences**	72
8	Ability to recognize problems resulting from cultural differences	41
9	Knowledge about social policy regarding, for example, treatment of ethnic minorities	2
10	Other, what? 0	0

Next, an assessment was made of which abilities and attitudes according to the respondents are most desirable to facilitate the nurse's contact with a patient of other cultures. The question addressed to the respondents gave the opportunity to choose three characteristics, in their opinion, the most important. Without much astonishment, it should be said that knowledge of the language is the answer that dominates this question and that's how 78 people responded. Fewer or less as many as 72 surveyed people correctly stated that respect and recognition of cultural differences is a very useful feature in contact with the patient. Almost equally, understandably speaking without medical jargon (42 people) with the ability to recognize problems resulting from cultural differences (41 people). You can see that perfect contact and getting to know a person who is provided with medical help is extremely necessary for comfortable work and patient satisfaction.
An attempt was also made in the research to assess the number of patients met by nurses in their daily work. Taking into account the fact that a large group of respondents are people with a long professional experience, mostly working in hospitals, it is not a surprise to have a very large contact with people of other cultures in their careers by those people. As can be seen from the data collected in the table and chart No. 11, 54 people replied that they did not encounter a person with cultural differences on their professional path. While 64 respondents had contact with people of other religions. These data are not necessarily accurate because it is often the case that patients do not inform health professionals about their denomination or sexual orientation. If the foreigner

can be recognized by the appearance or linguistic accent, then religion and sexual orientation are unknown until the patient himself says so. The respondents had the most contact with Jehovah's Witnesses. Faith to refuse, for example, a blood transfusion somehow forces the patient to inform medical staff about his religious beliefs to refuse the procedure. Jehovah's Witnesses are therefore the most common and the contact of a nurse with such a patient is known to her. The Roma were indicated by the population in question as a large group with which medics have contact. Certainly their characteristic appearance and behavior of clans accompanying a sick person allows for 100% recognition of this nationality without unnecessary questions. In fact, without the trust and honesty of the person being treated, we will never know the real answer to this question.

Tab. 2 Did you have contact with a person presenting a different culture in your work (eg different nationality, religion, sexual orientation)?

No	**Yes / what culture, religion ...**	
54	Jehovah's Witnesses	46
	Roma	18
	Buddhists	1
	Muslims	6
	Protesters	2

According to 44% of respondents, health care workers treat patients of other cultures as well as other patients. However, 31% of respondents noticed that people presenting a different culture benefiting from health care in hospitals and clinics where the respondents work, they need an individual approach. If respondents notice the need for an individual approach to a person presenting a different culture, it is a sign that training should be carried out that the knowledge of the subject matter of other cultures would not be foreign to the medical staff.

Tab. 3 With what attitudes towards a person presenting a different culture while performing professional duties you met?

1	Individual approach	33
2	Treatments the same as other patients	46
3	Curiosity	12
4	Indifference	0
5	Humiliation	0
6	The use of physical violence	0
7	The use of psychological violence	0
8	Deliberate extension of the waiting period for the service	0
9	Treatment concerned	1
10	Intentional non-compliance with the patient's rights card	0
11	I did not meet this situation	13
12	Other what?	0

Respondents who in their professional work did not meet with a person presenting a different culture answered

the questions very much like working with such patients.

Tab. 4 To confirm the similarity of people's responses, the Pearson's linear correlation coefficient formula was used.

I	**Xi**	**Yi**	**Xi * Yi**	**X^2i**	**Y^2i**
1	33	38	1254	1089	1444
2	46	45	2070	2116	2025
3	12	14	168	144	196
4	0	0	0	0	0
5	0	0	0	0	0
6	0	1	0	0	1
7	0	0	0	0	0
8	0	0	0	0	0
9	1	0	0	1	0
10	0	1	0	0	1
11	13	12	156	169	144
12	0	0	0	0	0
Σ	**105**	**111**	**3648**	**3519**	**3811**

n = 12, r = 0,99

The result of 0.99 indicates a very strong dependence, i.e. regardless of whether the subjects had contact with people of other cultures or did they not meet with such a patient they responded almost the same. Over 40% of respondents said that such a patient should be treated in the same way as other patients. Without specialist training on multiculturalism, health professionals will act instinctively, not with learned standards and procedures. The respondents who did not meet with a culturally different patient as well as respondents who met such a patient put on the same treatment as other patients. This will not allow to establish good contact with the patient and will not provide him with the sense of security so necessary in treatment and convalescence. Knowledge of religion and different traditions by nursing staff is essential for showing kindness and respect to a representative of another culture. Respondents were asked if and how they were prepared for effective contact with people presenting a different culture, and here the analysis turned out to be shocking. In the health care system, employees are guided by a more sensitive than professional knowledge about the impact of different cultures in the behavior of medical personnel with a patient, e.g. another religion. There are no training sessions to make the nurse acquire the ability to recognize problems resulting from cultural differences and overcome ethnocentric beliefs, prejudices or stereotypes. Among 102 respondents, 86% did not take any training in this area

Tab. 5 Have you been prepared for effective contact with a person presenting a different culture?

Yes through training	**No**
16	102

The need for education in the specificity of particular cultures has been analyzed and nationality and respect for the racial or religious diversity of the patient in nursing studies. The respondents in 50% tend to make the subject

supporting their knowledge in this field introduced in the studies. 38% of the surveyed population has no opinion on this topic, and 12% of respondents strongly claim that such an object is unnecessary. From the group of 118 people examined 39 indicates that undergraduate studies should be knowledgeable about multiculturalism, 9 respondents believe that such knowledge should be passed on in master's studies, and 11 people see the need for such education only at postgraduate studies. In the sixth table, the respondents presented competences, which possession is necessary in working with a transcultural patient.

Tab. 6 What competences (range of knowledge, skills and behaviors / attitudes) in your opinion are indispensable in the professional work of a nurse in relations with a person presenting a different culture?

Lp.	Knowledge	Scope		
		Large Small	Mediu m	Small
1	Knowledge about different cultures, cultural differences, diversity, stereotypes, prejudices and discrimination	24	64	30
2	The impact of different cultures on health, disease, prevention, diagnosis, treatment of diseases	35	62	21
3	The main determinants of the lifestyle of different cultures	16	71	31
4	Knowledge about rituals and rituals related to birth and death	21	54	43
5	Knowledge about social policy that respects, for example, issues of treatment of national and ethnic minorities	17	54	47

Summary

The accession of Poland to the European Union contributed to the opening of borders, and also increased the migration of people from countries with a different culture. This fact directly affects the phenomenon of multiculturalism, which is becoming more and more popular in the world. Thus, the knowledge of nurses and other health care professionals about the cultural differences of patients is necessary in the contemporary world. Entering into a new cultural space gives rise to various reactions, from positive to very negative, and gaining knowledge about different cultures can prevent these extreme and unwanted emotions. A group of randomly selected people working directly with the sick was asked a question of what behaviors, skills and knowledge are necessary in the professional work of a nurse in direct contact with a person representing a different culture. 48% of respondents claim that having theoretical knowledge, practical skills and the right attitude should be required of middle-level medical personnel. Analyzing the attitude and behavior towards migrants, as many as 42% of respondents said that the behavior, attitude and respect for each other and the other person should be presented by the nursing staff to a very large extent. Respondents tend to expand their knowledge of the cultural background from which a middle-aged patient is born, in addition to medical knowledge. The respondents see the need to learn more about everyday life, traditions and customs, and knowledge of migrants' religions in order to acquire practical skills in their daily work with these patients. Multiculturalism in Poland it is not a very common phenomenon, but it is already appearing.

Due to the fact that the problem in the health service is not massive staff is up to the novelty geared to the average. However, this poses new challenges for nurses. In addition to the biological and health needs of the patient, attention should be paid to its ethnic differentiation, origin, religion and the related differences in the sphere of customs. That is why multiculturalism is gaining more and more importance as respondents see.

Conclusions

Thanks to surveys from among 118 and a diverse group of respondents and the following analysis, the following conclusions were made:

1. The vast majority of respondents are Catholics, who respect and dignity of the other person regardless of origin, put in the foreground. 53% of the studied population do not know or do not remem ber have you ever met with intercultural competences,but instinctively indicate that you need to know other cultures in contact with the patient is indicated.
2. Due to the significant increase in the scale of spatial movements of people from other countries and regions of the world to Poland, 78% of respondents see the need to know other cultures in a professional way to help the patient with respect for his needs, cultural and spiritual customs.
3. Research shows that language skills are the dominant feature facilitating contact with a person presenting a different culture. This is what 78 respondents indicated. Not much less because 72 people correctly recognized that respekt and the recognition of cultural differences is necessary for comfortable work and patient satisfaction.
4. Particular attention was paid to the question whether the studied population had contact with a person presenting a different culture in their work. 64 out of 118 respondents, or 54%, met on a professional path of a person with a different culture. Jehovah's Witnesses are the largest group of patients they meet. Because of their religious beliefs, Jehovah's Witnesses most often inform medical personnel about their faith, for example, to refuse blood transfusions. Nursing staff often do not know that they are dealing with a person of a different religion and until the patient does not say that he is a Buddhist, Protestant or Muslim knowledge of such medicine will not have.
5. The attitudes of the respondents in their professional work towards people culturally different were examined. 46 respondents indicated that a culturally different patient should be treated in the same way as another patient. 33 respondents perceived that an individual approach to a person presenting a different culture is very necessary, which necessitates the need to adequately educate medical personnel in the field of intercultural competences in nursing.
6. A question was asked to the group of respondents whether they accepted a passive or active attitude as a witness of discrimination. 57% of the respondents did not have to deal with it with discrimination, which is a good sign of medications. However, 34% of the respondents met with such a situation and fortunately did not remain passive to such reprehensible behavior. The results of the research indicate that patients with cultural otherness may feel safe in places where they expect help and support.
7. It turned out that there is almost no training in health care at All in the field of acquiring skills, recognizing problems arising from cultural differences by nurses. 102 respondents did not receive any training, although they met on their professional path with multiculturalism. 50% of the surveyed population recognizes the need for education in terms of the specificity of individual cultures and nationalities, and respect for the racial or religious diversity of the patient in nursing studies. The respondents who indicated that the need for training is justified deemed the most accurate form of training courses.
8. A group of randomly selected people working directly with the sick was asked a question of what behaviors, skills and knowledge are necessary in the professional work of a nurse in direct contact with a person representing a different culture. Most of the respondents indicated that the ability to communicate verbally and non-verbal and overcome barriers and non-cultural differences preceded by training on this subject is essential in the proper therapeutic process of these people. The result of Pearson's linear correlation coefficient, confirmed the need for training on a par with practical skills in the nurse's daily work. Linear dependence giving the result of 0.99 provides about a very strong relationship of practical skills resulting from a large professional internship with the need to deepen their theoretical knowledge about different cultures, cultural differences, overcoming stereotypes, prejudices and discrimination. As you can see, two factors connected with each other can only contribute to the success, not only of the Polish nurse, but also of the whole health care service when working

Analyzing the results of research, it can be concluded that cultural differences, as well as religion, become a difficult issue in the functioning of modern health care. What is needed is adequate knowledge of foreign cultures, spiritual needs, as well as knowledge of the religion that patients profess. The result of the research confirms the need for training on an equal footing with practical skills in the daily work of nurses and other health professionals.

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