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Interdisciplinarity, multiculturalism and non-standard situations in medical simulation

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„Interdisciplinarity, multiculturalism, and work with the patient in a non-standard situation in the context of conducting didactic classes in the field of medical sciences and health sciences in Centres of Medical Simulation”

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Interdisciplinarity, multiculturalism and non-standard situations in medical simulation

Scientific editors

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Introduction

This textbook is the result of international cooperation within a project titled "Interdisciplinarity, multiculturalism and non-standard situations in medical simulation", carried out by the teaching and scientific staff of three centres: University of Opole, the Silesian University in Opava and the Medical University of Plovdiv. The teaching and scientific staff of the University of Opole was both the initiator and the leader of the project. The main aims of the project were: modernisation of their educational offer, improved teaching quality and attractiveness, and the development and strengthening of work and academic professionalism of medical and health sciences students. These were also supplemented with the issues of patients' multiculturalism and interdisciplinarity, considering rare, non-standard situations.

The project authors made every effort to explain multiculturalism to medical students, especially in view of the current migration trends, in particular, taking into account the most important aspects of religious and cultural diversity in view of the processes of diagnostics, treatment, and providing medical support. Nevertheless, the project authors stress that this textbook contains a relatively brief description of selected religions and cultures – in other words, its contents are only an attempt to analyse issues concerning multiculturalism in the context of medical and health sciences. That is why the textbook is not a guide to the religions and cultures of the world.

In medical and health sciences, we are observing an escalation of modern educational technology development. The innovative medical simulation method used in the publication is more and more often used for teaching clinical skills, which translates to specifying priorities, problems, decision making, and, as a result, carrying out selected procedures, including medical treatment. Teaching in simulated conditions perfectly aligns with currently applicable ministerial education standards. This method provides ample opportunity in the process of teaching, learning, acquiring skills, and social competences in the form of effective work in an interdisciplinary team.

The authors agree that the textbook is supposed to respond to the current migration situation in Europe and around the world. These days, it is expected for all barriers for "culturally diverse" patients to be removed in situations related to providing medical care.

This textbook is made up of six chapters.

1. The first chapter ideals with extremely important issues of effective cooperation and communication in an interdisciplinary team.
2. The second chapter discusses selected and important issues related to the perception of health, birth, preventive health care, disease, and death within the context of a selected religion or culture.
3. In the next chapter, the authors discuss issues related with treatment in specific cases in non-standard situations in nursing and obstetrics.
4. Chapter four contains sample simulation scenarios for selected diseases, nonstandard situations in nursing, obstetrics, and physiotherapy, considering aspects of multiculturalism and interdisciplinarity. Scenarios included in the textbook are related to specific areas of medical and health sciences. It should be highlighted that these scenarios may form the basis for creating new scenarios with other or additional teaching effects. The aim of the textbook authors is to establish a database of scenarios with different patterns and technical capabilities. This aim is justified, since it is supposed to capture the imagination of the readers, open them to taking autonomous experimental (empirical) actions in medical simulation conditions, and thus overcome barriers of simulation teaching.
5. Chapter five contains instructional videos concerning multiculturalism, interdisciplinarity, and non-standard situations.
6. Chapter six showcases photos from the Medical Simulation Centre in the Faculty of Health Sciences of the University of Opole.

The authors believe that the textbook will provide practical teaching support for a wide range of readers.

1. Cooperation and communciation in an interdisciplinary team

An interdisciplinary team in health care includes specialists with various areas of expertise. Their shared aim is to improve the patient's health and quality of life. Constant and continuous cooperation between the team members is an important element of treatment. Teamwork helps to broaden knowledge and experience, teaches through problem solving, minimises the risk of errors, and increases performance. It is important for the various members of the team to have high qualifications and technical competences, but there are key features that each of them should have, they should:

- clearly understand the various roles (it is important for all team members to understand who a part of the team at any given moment) is,
- be aware of the common goals (the team is working on setting common goals that reflect the patient's health needs and preferences, considering the impact of the patient's health problems on his or her life and well-being),
- have the ability to work under pressure,
- have the ability to cooperate with others both personally, and professionally,
- be flexible when dealing with whatever comes.

Each health care team is unique and has its own goal, size, surroundings, main members, and communication methods. There are crucial factors, though, that are important for all teams:

- self-motivation of each team member,
- mutual trust,
- effective communication,
- feeling of belonging,
- jointly determined rules,
- ability to compromise – ability to not have differing opinions result in a conflict, but rather a discussion that ends with a common solution,
- openness to change,
- continuous development and self-improvement.

1.1. Effective clinical communication

Clinical communication is the exchange of information on the care over a given person that takes place between the doctors in charge and other members of the therapeutic team and between specialists in various medical areas and patients, their families, and caregivers. A communication process is the way this information is exchanged. It covers several elements: the sender (the person giving the information), the receiver (the person receiving the information), the message (the information being exchanged), and the communication channel. In general, there are two communication channels: oral communication (face to face, over the phone, video chat, e.g., Face Time, Skype) and written communication (e-mail, letters, fax). Communication processes may take place simultaneously, e.g., verbal communication between two doctors or at different times, e.g., written communication in which a nurse documents the care plan and assessment in medical documentation that is read by another nurse later on. The method of delivering information, including structure and non-verbal communication (body language, eye contact and tone of voice), is also an important aspect.

1.1.1. The importance of communication

It is known that effective communication determines improvement in care, decreases health care costs, and leads to greater job satisfaction among health care workers. It has been proven that:

- poor communication leads to failures in teamwork, errors, misdiagnosis and incorrect treatment,
- lack of cooperation and effective communication may account for 70% of adverse events that are currently being reported,
- errors in communication are one of the most reported causes of complaints in health care,
- poor communication and irregularities in exchanging information may lead to a growing number of readmissions, while the lack of effective communication between health care workers is mentioned as the main factor,
- poor and/or delayed exchange of information may affect the quality of care and timeliness of treatment.

For communication in a team to be effective it is necessary to:

- agree on the issues related to the work of the team together,
- build relations in a way that fits each interlocutor,
- look for causes of problems and methods of solving them,
- skilfully provide all the necessary information,
- structure the message in a way that it is clear what we want to say.

1.1.2. Communication of the medical team with the patient

While communicating with a patient, the medical staff must know some groups of patients might have multifaceted communication difficulties. It may be related to how complex information obtained from the patient or given to the patient is, or a language barrier and understanding difficulties, or both.

These groups may include:

- the elderly,
- patients with serious disability,
- homeless people,
- culturally diverse patients – cultural and language differences,
- patients with mental disorders,
- patients during surgery,
- paediatric patients,
- palliative care patients,
- patients in intensive care units,
- patients with multimorbidity.

It may be concluded that, although effective communication was described as one of the important factors affecting cooperation of a medical team, in reality, effective communication is crucial for all the listed determinants of effective teamwork. For example, to set the team common goals, the team members would have to communicate with each other, as well as with the patient and his or her family, effectively. Clear roles and obligations require an open, honest, and continuous discussion on the preparation and ability of each team member to use their skills, knowledge, and resources as best as possible for the purpose of meeting the common goals. That is why communication is a priority within the context of health care. The team should be continuously working on the improvement of its communication skills, since communicativeness is a skill that can be acquired not only through experience, but also through professional training.

Remember!

Effective teamwork and communication are key for safe functioning in complex and dynamic situations, such as in health care. They are necessary for making sure that a given person is provided constant and coordinated care. Good communication makes it possible for interdisciplinary teams to cooperate, to account for different priorities, solve problems related with the human factor and minimise the risk of errors. Most of all, effective communication improves patients' outcomes through improved diagnostic and prognostic capabilities of health care workers.

1.1.3. Acquiring communication skills

In reality, cooperation between medical professionals is not easy. Stress and hectic schedules often lead to misunderstandings and conflict. Studies have been published showing that most of the time doctors and other medical professionals are acting as separate health care workers, not really speaking to each other. Apart from the required medical education, human resources in health care should have other skills as well. The European Union Member States have recognized the ability to use information and communication technology (ICT), entrepreneurship, as well as social skills, such as communicativeness and teamwork, as a priority.

Shared pre-graduate classes for students of the faculties of medicine, nursing, obstetrics, emergency medical services, and physiotherapy would allow the future medical professionals to develop the skill of effective knowledge and experience sharing, as well as learn effective communication in an interdisciplinary team. Building medical simulation centres as part of development programmes for medical universities involved in practical teaching provides new opportunities for practising teamwork. What is more, research shows that education in high-fidelity simulation conditions provides the participants with a realistic opportunity to practice the communication strategies that facilitate teamwork.

Remember!

Education, especially in high-fidelity medical simulation conditions, gives the opportunity to learn cooperation and effective communication in an interdisciplinary team.

1.1.4. Communication strategies and techniques

Lack of structure and standardisation sometimes leads to failures in communication. Below is a list of techniques that may help medical team members in exchanging information.

1.1.4.1. ISBAR

ISBAR – a method of sharing the most important information concerning the patient's complaints that require immediate attention and intervention. The aim of the strategy is the exchange of relevant information between the medical staff, as well as the expression of sufficient urgency. International research shows a decreased number of unexpected deaths, as well as a significant improvement in communication, teamwork and safety since the introduction of ISBAR. It has also been

shown that ISBAR facilitates the exchange of orders by phone, by students participating in a high-fidelity medical simulation.

- INTRODUCTION – state your name and specify your role in the patient's care (in case of a phone conversation, state the name of the department from which you are calling).
- SITUATION (what is happening with the patient?) – state the patient's name and current condition or describe the situation and explain why you are calling.
- BACKGROUND (basic information: what is the clinical situation or context?) – specify the date the patient was admitted, the diagnosis and other important information related with the given situation from the patient's history; quickly describe what has been done so far.
- ASSESSEMENT (what you believe is the problem?) – summarise the patient's condition or situation; explain what you believe to be the problem or say: "I'm not sure what's happening, but I believe the patient's condition is taking a turn for the worse"; describe specific symptoms.
- RECOMMENDATION (what can be done now?) – explain, what it is that you are expecting (e.g., I believe the patient requires immediate assessment. Could you come?) or provide recommendations. If you are unhappy with the response to your asking for immediate consultation, you should ask another person.

1.1.4.2. "Call-out" strategy

The "call-out" strategy (simple and clear messages) – a method for providing important information in urgent situations or when a patient needs specific interventions immediately. Information is passed on in a way that all team members can hear it at the same time. This method makes it possible for other team members to predict the next steps and designate people responsible for specific tasks. The method of communication between team members in urgent situations is very important, since any misunderstandings may delay treatment, and even cause the patient's death. Furthermore, in urgent situations, it is important to designate the team leader that will take over the control and explain the roles of other people to them. Clear and simple provision of information and verification, whether the information has been correctly understood, will prevent errors in communication.

Sample "call-out" exchange of information between the team leader and a resident:

— Team leader: Airways condition?
— Resident: Patent.
— Team leader: Auscultation?
— Resident: Normal respiratory sounds.
— Team leader: Blood pressure?

1.1.4.3. "Check-back" strategy

The "check-back" strategy – this is a closed-loop strategy used for verifying if information was correctly exchanged between two people. The sender initiates the message, the receiver accepts the message, and confirms what is being passed on. Then the sender verifie, whether the information was understood correctly:

1. Step one: the person providing the information starts passing the information on.
2. Step two: the information receiver receives the message and provides feedback.
3. Step three: the person providing the information makes sure that the message was understood correctly.

Sample "check-back" information exchange between a doctor and a nurse:

— Doctor: Administer 100 mg of Propofol bolus intravenously.
— Nurse: 100 mg of Propofol bolus intravenously?
— Doctor: Yes.

1.1.4.4. "I pass the baton" strategy

The "I pass the baton" strategy – involves the exchange of precise information while patients are being transferred, e.g., to another department. It is important for all information to be passed on in an ordered manner. Errors in communication may lead to irregularities, which is why it is necessary to verify the obtained information, e.g., by repeating it or reading it out loud again.

The strategy makes it easier to exchange information concerning a patient's care:

— I Introduction: State your name and specify your role in the patient's care.
— P Patient: State the patient's first and last names (identification – gender, age, department).
— A Assessment: List the patient's current complaints, vital signs, symptoms, and diagnosis.
— S Situation: Discuss the current status / circumstances, the latest changes, and reaction to the administered treatment.
— S Safety concerns: Provide important information – results of diagnostic tests, socio-economic factors, allergies.
— the
— B Background: List comorbidities, earlier episodes, currently used medication and provide information on family history.

— A Actions: Provide information on administered or required treatment.
— T Timing: Determine urgency and provide timing – priority of actions.
— O Ownership: Provide information concerning determining responsible people/teams (considering the patient's and his or her family's preferences).
— N Next: What is going to happen next? Predicted changes? What is the plan? Is there a backup plan?

1.1.5. Communication over the phone

In daily practice, much of the contact between an interdisciplinary team member takes place over the phone. What is specific about this type of communication is that the interlocutors cannot see each other (they can only interpret the tone of voice and the contents of the message). What is more, many phone conversations concern consultations in urgent, difficult, or atypical situations, which may give rise to intense emotions which may hinder effective communication. To make this type of communication more effective, all the necessary information must be prepared ahead, such as the patient's documentation, and the message that we want to convey must be clearly formulated.

1.1.6. The ten commandments of communication in an interdisciplinary team

Below there are some simple tips that may facilitate communication in a team and make it effective (dr Grzegorz Cebula – CM UJ; 2018):

1. "In difficult situations that require quick decision making, use simple and short messages.
2. Use the name of the person you want to address – this will make the communication easier. Remember that *someone* usually means *no one*.
3. Use bidirectional communication. If you want to order someone to do something, this person should repeat the job he or she has been ordered to do (closed-loop communication).
4. Remember – just because you thought of something does not mean it was done. The process could be interrupted somewhere along the way. Thought does not mean said, said does not mean heard, heard does not mean under-

stood, understood does not mean memorized, memorized does not mean accepted, accepted does not mean done.
5. Control the communication process – if two people are speaking at the same time, no one usually knows what is going on.
6. Use the freeze-frame method to summarize the obtained information and make decisions.
7. As the leader give the team members an opportunity to freely speak their minds.
8. As a team member, remember that if you have ideas that you believe are good or you do not agree with the leader's decision, you have the obligation to tell him or her that.
9. If possible, avoid disturbances (noise, tiredness, etc.) or if not possible, remember about their impact on the quality of communication.
10. Encourage sharing experience after working together is concluded. A discussion on what has just happened, concerning things that were successful and things that must be done better next time, provides for the continuous improvement and development of the team."

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1.2. Multiculturalism in health care – specificity of communication with a patient

"Lord, let me […]
understand other languages, other types of suffering."
Zbigniew Herbert 2007: 243

Because of global migration trends, medical staff more and more often encounter patients that differ significantly in terms of their language, beliefs, and practices related to their disease, as well as their expectations regarding health care. This tendency comes with specific problems that need to be solved. The most common difficulties in providing health care include a language barrier and lack of understanding of a different culture or religion. Misunderstandings and incorrect commu-

nication due to not knowing the patients' language – considering patients' rights – may have serious consequences, lead to impaired quality of health care, and even errors in treatment and care. It is important to be aware of potential barriers in cross-cultural communication and acquire skills necessary for solving them.

It is hard to define communication. Some authors say that it is an interaction process that takes place in every environment in which people are exchanging meanings verbally and non-verbally. The communication process is not easy – we are all different and a given message may have completely different meanings for the sender and the receiver. Not only are the words that we speak important, but also the gestures, facial expressions, intonation, and volume of voice and body posture. Differences in cultural background make the communication process that much more difficult. In the case of verbal communication, language and correct understanding of a given phrase play a significant role. Even when the patient is speaking the language of the country of residence in everyday situations, he or she may have trouble understanding specialist vocabulary. To make sure that you have been correctly understood by the patient, your statements must have a simple and clear structure. You should speak slowly and clearly, use short sentences, avoiding medical jargon. It is worth explaining the topic at hand in various manners, for example, using gestures to illustrate what you are saying. You should also keep in mind that you should not address a patient like a child or a person with mental impairment. If the patient does not know the language that the medical practitioner is using, an interpreter is required. It is important to ask the interpreter to keep specific phrases and emotional load. It is worth remembering than you should address the patient, not the interpreter. For the sake of the patient's confidentiality, it is best not use family for interpreting.

It is worth mentioning that the World Health Organization recommends making the so-called communication services (i.e., cultural mediators and interpreters) available and improving them to promote inclusive and culturally sensitive health care in Europe.

Cross-cultural communication reveals problems not only in the linguistic area, but also – if not most importantly – in the non-verbal communication area. Lack of awareness of differences in non-verbal communication may lead to many misunderstandings. Gestures used instead of words, the so-called emblems, present the greatest difficulty. The same gestures may have different meanings depending on the culture. That is why it is best to avoid them when dealing with foreigners.

Important elements of non-verbal communication include spatial relationships, i.e., the preferred distance from the interlocutor. Another one is touch, i.e., haptics, since it is a method of communication that has a lot of cultural requirements. Different countries and regions vary in terms of haptic behaviours towards other peo-

ple. It is important to know what level of touch is acceptable in a given culture, as well as who, where, how, and in what situations is touching appropriate. Eye contact may be another source of misunderstandings. In this case, it is also important to know how it is used. Insufficient eye contact may be perceived as dishonesty or disrespect, while excessive eye contact may be seen as insolence or aggression.

Relation to time may also present difficulty and be a potential source of misunderstandings in contact with foreigners. It is difficult to explain to a foreign patient, who values relations between people more than punctuality, how important it is to respect, e.g., appointment times.

Remember!

The communication process is not easy. Differences arising from different cultural backgrounds make it that much more difficult. The focus on developing cultural competences in recent years makes us more aware of our culture, while discovering other cultures and being more open. This knowledge is extremely useful when solving specific problems arising from ethnic and cultural diversity in health care.

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2. Religion versus medicine

Religion and medicine are two completely different domains. They have different origins and, most importantly, they address different human needs. Yet, despite considerable differences, the two constantly interpenetrate and interact with each other.

Looking at the origins of medicine, it must be emphasised that it has developed from human sensitivity to the suffering of another human being. Religion, on the other hand, is an answer to human desires, vulnerabilities, and needs, including the experience of pain, suffering, disease, or death. Hence, a combination of religion and medicine gives a picture of both - society and humanity. These are the key reasons why one should not ignore the significance of religion in individual decisions and behaviours of patients for whom faith is an important, or the most important, issue.

In the face of the current global migration trends, professionals in medicine and health sciences focus on respect for dignity of every human being, including patients "from different cultures". It is vital that modern medicine people expand their knowledge of religions and cultures because understanding of spiritual needs of patients builds mutual trust which, in turn, facilitates effective cooperation during treatment or medical procedures.

Bearing in mind the relation between religion and medicine, worth noting is that sometimes religious beliefs may contradict medical knowledge. A conflict with medicine as a science occurs particularly when religion forbids using specific therapeutic or preventive procedures, such as transfusion of blood and blood products, vaccinations, or prenatal therapies. The situation becomes even more complicated when it comes to the concept of free will, both in terms of religious and scientific implications. Hence, medicine practitioners face the challenge of having to account for the patient's religious beliefs in delivering the planned treatment. These issues have been the object of dispute for a long time, and not only of medical and ethical nature, but also legal ones. The most common problems involved in delivering medical procedures and therapies include:

- absolute objection of the patient, expressed in person when the patient is fully conscious or via a trustworthy representative,
- absence of an autonomous decision of the patient due to their current health condition (e.g., the patient is unconscious),
- absence of a decision of the patient due to age and development level: newborns, infants, children,
- a parent's refusal to consent to the only effective therapy available to their child due to the parents' religious believes.

Every such dramatic case, as mentioned above, is considered on an individual basis. Medical teams often wonder whether the patient's decisions, particularly when it is a parent who makes them, is based on reasonable arguments or is simply a manifestation of religious fundamentalism and may pose threat to health or even life. Sooner or later, every physician will find themselves in a situation where they have to respect the patient's will based on religious beliefs.

When analysing the above issues, it is worth noting that the refusal to use certain treatment methods for religious reasons has profoundly contributed to the development of medicine. Rejection of therapy by members of certain religious denominations has motivated medical, biochemical, and genetic scientists to seek new treatment methods. The development of blood substitutes used in Jehovah's Witnesses patients may serve as an example here. Such attitudes also initiated implementation of minimally invasive surgical procedures.

It is also worth noting that awareness of the patient's religious denomination can be beneficial. It may facilitate better contact with the patient and help to convince them to undertake certain preventive or other behaviours bringing better health outcomes. Awareness of the patient's religious believes facilitates understanding - particularly in the most dramatic situations, such as administering baptism to a new born baby with a malformation syndrome, giving birth to a stillborn child, the death of a close family member, the need to use blood therapy, the deployment of specialist life-sustaining equipment, and the transplantation of organs.

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2.1. Religions of the world

Religion is a set of beliefs and practices forming a relation between the sphere of sacrum (understood as some supreme force - in Christianity called the Absolute) - and divinity and a human being or community. Religion is the pursuit of holiness.

Religion, as a multifaceted construct, is capable of multiple interpretations and is described with multiple concepts/terms, dating back even to early philosophical theories. In other words, religion can be described as a human being's relationship with some transcendent reality (*transcendence* – going beyond).

Religion also involves a collective experience; therefore, a great number of religious communities have evolved over centuries. Their purpose is to express, define, and teach doctrines or beliefs.

Religion is the highest category of division, comprising several denominations forming smaller groups within the same religion, sharing the same principles of faith. The biggest religions are: Christianity, Islam, Hinduism, Buddhism, Sikhism, Judaism, and the Baha'i Faith.

Academic disciplines studying religion include religious studies, theology, philosophy of religion, sociology of religion, psychology of religion.

2.1.1. Christianity (denominations: Catholicisim, Protestantism, Eastern Orthodox Church)

Christianity is one of the world's major religions. The birth of Jesus Christ of Nazareth (in the 1st century AD) marks the beginning of Christianity that spread around the world. It is sometimes also referred to as "Christianism". Christianity is a monotheistic and prophetic (based on revelation) religion. It originates from Judaism. Jesus Christ was preaching, healing, doing good to other people. He conquered death and rose from the dead. All his doings have become the foundation of the Christian faith. The teachings of Jesus Christ are gathered in the canonical Gospels and in the Bible.

Christianity has a considerable number of followers. It is estimated that Christians account for one third (over 30%) of the world's population. Christianity is the most common religion in Europe, the Americas, Australia, and Africa.

There is no one global classification of Christian churches and communities and other religious groups (to a smaller or greater extent) drawing on the Christian doctrine. One of the most common classifications of Christianity (well-founded in history) is the following:

- Catholicism (including Roman Catholic Church and other catholic denominations) - one billion members,

- Eastern Orthodoxy (orthodox and eastern churches) – 300 million members,
- Protestantism (pre-reformation movements of Waldensians and Hussites, Lutheranism, Anglicanism, Calvinism, Baptists, Adventism, Unitarianism, Methodism, Presbyterianism, Pentecostalism) – 0.5 billion members.

The Christian religion comprises several denominations. To explain and understand the reasons for the development of various Christian denominations, several important historical events must be mentioned here. In 1054, the so-called Great Schism took place, marking the break between the eastern and western church. It was a long-lasting process, spanning over centuries. The ultimate rift occurred in the 13th century, at the initiative of Rome and Constantinople. In 395, Theodosius the Great divided the Roman Empire into Western and Eastern Halves, due to the considerable size of the territory and the already significant cultural differences (the west - Latin language and Roman culture; the East - Greek language and Hellenist culture). Other primary reasons of the Great Schism include major differences in social advancement and culture between the East and the West (the poor versus the rich); the dispute over the origin of the Holy Spirit; rejection by the Patriarch of Constantinople (Constantinople became the other, next to Rome, capital city of the Roman Empire) of the Pope's supremacy; accusations against the Roman Church that it had departed from the purity of faith.

The literature on the subject emphasizes that all disputes concerning the Christian world always engaged both the popes and the secular rulers. They stemmed from rivalry for power and influence in Europe (particularly in the areas occupied by Slavs) and stemmed from individual beliefs concerning the Holy Communion, purgatory, a number of holy sacraments, a number of priests (and what they should look like), days of fasting, and many more.

Differences between religion and denomination:

- religion is the top category in the classification,
- denomination is a group within religion, based on the same foundations of faith.

2.1.1.1. Catholicism

Catholicism is one of the major denominations of Christianity. It is a Christian Church doctrine, similar to the Eastern Orthodox Church. Catholicism is the dominant religion in Poland, but also in many South European and South American countries.

Overview of Catholicism

The word "Catholicism" originates from Greek and means "something universal". The term "Catholic Church" refers to a religious organisation recognising the Pope – the Bishop of Rome - as the supreme authority elected during a conclave.

Demographic data show an increase in the number of Catholics worldwide, proportional the global growth in population. Southern and Northern Americans (Catholic immigrants) account for a half of all Catholics. The other half is composed of 50% of Europeans, then Africans, and a small representation in Asia and Oceania. The countries with a relatively high Catholic population (above 25%), include: Madagascar, Mozambique, Tanzania, and Ivory Coast. The available data show a considerable decrease in the number of Catholics in many countries, mainly resulting from sexual abuse scandals involving priests (Germany, France, and the Czech Republic). However, there are also areas where the number of Catholics is systematically rising, such as in Africa (as a result of intensive Christianisation) and Asia. Statistical data concerning the number of church members in individual countries are not homogeneous. The figures are nor precise because of considerable difficulties with conducting an in-depth analysis. Statistics include all baptised persons. They do not account for situations where people have abandoned faith or practising faith (meaning they no longer identify with the Church). Obtaining reliable data is even more difficult due to extensive global migrations. Depending on the source, it is estimated that Catholics account for more than 50% of Poland's population. In the Czech Republic, 10% of the population professes Catholicism, but not all of them are practising (the Czech Republic also has a high level of atheism). Bulgaria has its own Bulgarian Greek Catholic Church of the Byzantine Rite (originating from the tradition of the Eastern Catholic Churches), said to have about 10 thousand members.

The Founder

Its Founder is Jesus Christ. It is believed that the source of the Catholic Church is the so-called Primacy of St. Peter, whom Christ addressed with the words: "And I tell you, you are Peter, and on this rock I will build my church, and the gates of hell shall not prevail against it." (Matthew 16:18). [English Standard Version] Peter the Apostle was the head of the first community founded in Jerusalem (AD 33).

Catholics believe in one God in three persons: God the Father (symbol if divinity), God the Son (symbol of humanity), and God the Holy Spirit (symbol of spirituality). A special place is given in Catholicism to the mother of Jesus Christ - Mary. Catholics believe in her virginity and immaculate conception. Mary is believed to be the Mother of God. A part of Catholicism is veneration of Mary (Mariology), founded on the following beliefs:

- virginity of Mary when she conceived Jesus,
- Mary's strong, unwavering faith in God and Jesus Christ from his conception to crucifixion;
- Mary's presence among the Apostles,

- the proclamation by the Church of the dogma of Mary.

The key concepts of Catholicism:

- belief in the existence of one God in three persons, who is the world's Creator and who has revealed himself to humankind,
- belief in the Son of God, who assumed a human form in the person of Jesus Christ, being the true God and human,
- belief in Jesus, the Saviour of humankind,
- belief in Jesus who lived on earth, died for our sins and rose from the dead,
- belief in God who created humankind,belief that every human being is called to faith, hope, and love and to follow God's will expressed in the form of the Ten Commandments, and in particular the commandment to love God and others,
- belief that a human being is destined to live eternally with God, and to rise from the dead when Jesus Christ returns to the earth,
- belief that the Catholic Church is community of people who received the sacrament of baptism,
- belief that the Catholic Church draws its life from the Eucharist,
- belief that a sinner will be punished;
- belief that Catholics are born with original sin,
- belief that every human being has free will,
- belief that God is forgiving,
- belief that every human being can be saved,
- belief in the Final Judgement,
- belief in Mary's immaculate conception.

The goal and the way to achieve it

The basic way to salvation is faith in Jesus Christ, who is the Messiah and the Son of God. Catholics believe in Christ's redemptive death and resurrection. Members of the Catholic Church are those who received the sacrament of baptism and live by God's commandments. According to Catholic Church doctrine, non-Catholics who live a decent life may also attain salvation.

Primary rituals:

- Preaching the Word of God,
- administering the seven holy sacraments:
  - Baptism
  - Confirmation
  - Eucharist
  - Penance (including confession)
  - Anointing of the Sick

- Holy Orders
- Matrimony

The Holy Mass plays a central role in Catholicism. Catholics attend Masses on Sundays and on church holidays, and the most important part of a Mass is the liturgy: the Liturgy of Word – God's teachings, and the Liturgy of the Eucharist - commemoration of the Passion of Christ. Other forms of active Catholicism include the breviary and various church services: the rosary, processions, pilgrimages, funeral rites, baptisms, confirmations. The major holidays of the liturgical year are Christmas, Easter, and Pentecost.

The Holy Book

The Bible is a set of books inspired by God. The Bible is comprised of two parts: The Old Testament and the New Testament. It contains a description of the world, the history of the world, and moral principles to be followed by every Christian to please God. The Bible provides answers to existential questions, shaping one's attitude towards life. The Bible and its individual parts have various importance for various denominations. Individual Christian traditions and branches have their own Canons of Scripture.

Woman and Man

Women and Men are created "in our [God's] image, after our [God's] likeness" (Genesis 1:26) [English Standard Version] No one in the world is created in the image or likeness of the opposite sex. The Bible says that men and women are equal in terms of human dignity, but it sets a clear distinction in how the two sexes experience and express their human nature. The combination of the dissimilarities is of primary importance to human beings. "Womanhood and manhood are complementary not only from the physical and psychological points of view, but also from the ontological. It is only through the duality of the "masculine" and the "feminine" that the "human" finds full realization". (Saint John Paul II).

According to the Holy Bible, a woman is particularly sensitive to the world, other people, relationships, and values. And, most importantly, a woman can be a mother, fully giving herself up to bring a new life to the world. This is the source of the special position held in the Catholic Church by Mary - the woman in whom God chose to dwell. Believers honour and venerate Mary. The primary vocation of a women is to be a mother, take care of herself and others, share God's love and truth. A woman is devoted to raising her children to be decent persons, to care for her husband and family, live by the God's commandments. "Wives, submit to your own husbands, as to the Lord. For the husband is the head of the wife even as Christ is the head of the church, his body, and is himself its Saviour (Ephesians 5:22-24) [English Standard Version].

The Catholic Church recognises the important role of women in all spheres of family and social life, which pertain to relationship and care for other human being. St. John Paul II called this The “genius of women” or “feminine genius”.

On the other hand, only men are called to fatherhood or priesthood. The role of a man in Catholic Church is best described in the words of a biblical scholar, Józef Kudasiewicz: “St. Joseph gave his heart to God, kept his hands busy with work and his mouth shut”.

This mean that a man should find his way to God to realise who he is and what his vocation is. Man is given the power to rule, to serve others seeing God in them, to help and protect the weak (also his children, wife, and mother). And he should speak, when it is necessary, when a reaction is needed to prevent damage, and in this way contribute to building a better tomorrow. Moreover, Catholicism requires that men respect women: “Husbands, love your wives, as Christ loved the church and gave himself up for her […] Husbands ought to love their wives as their own bodies. He who loves his wife loves himself” (Ephesians 5:25-28) [Standard English Version].

Views on sexuality (sexual intercourse, conception, contraception, abortion)

According to the Catholic doctrine, God’s law is natural and invariable; therefore, moral principles are impartial and objective. The most common bans concern:

- abortion (which is absolutely unacceptable) - Catholicism sees abortion as a violation of the commandment “thou shalt not kill”;
- premarital sexual relations,
- fertility regulation (contraception, in vitro fertilisation) – every sexual act should be open to procreation,
- divorce (only in very specific cases does the church permit marriage annulment).

Views on hygiene

Catholicism assumes that whatever God created is good, and a human being is created in the image and likeness of God. God Himself took on a human body. Jesus Christ points to the need to care for one’s body as a gift from God. A human being is obliged to care for the cleanliness of the body as well as for the purity of their inner self. Jesus also teaches that fasting and renouncing is a way to find a balance between the body and soul. A human being should realise that his or her body, like all material things, belongs only to this world and is not the ultimate goal and sense of living.

“For this reason, man is not allowed to despise his bodily life (...) May this leisure be used properly to relax, to fortify the health of soul and body (...) through sports activity which helps to preserve equilibrium of spirit even in the community”

(Gaudium et spes 14: 61). "(...) man looks on the outward appearance, but the Lord looks on the heart" (1 Samuel 16:7) [Standard English Version].

Catholicism rejects surgeries and procedures serving only the improvement of one's appearance.

Dress code for men and women

Attire is very important in Catholicism. The overriding principle is that one should dress with dignity and modesty; in other words, in a way that arouses respect. A Catholic dresses in line with the rule: "cover more than uncover". Clothes should be the source of pure love between the sexes, and not lust. According to Catholic doctrine, the way parents dress (appropriate clothes worn at home) may have positive or negative effect on the process of raising a child. Women and men should dress appropriately for their nature, where femininity and masculinity are clearly separated.

Women should avoid tight-fitting clothes that excessively highlight the body and figure. They should also avoid wearing trousers which are at variance with their nature, inappropriate, and contradict the femininity given to them by God (wearing trousers is seen as wearing male clothes). "Female trousers" are seen in Catholicism as a departure from the dress code of a Catholic woman, who should follow the example of Mary. In extraordinary circumstances, when wearing trousers is required of women (e.g., for job-related purposes), they should avoid wearing them on other occasions. Also important is to cover shoulders during church services or when visiting churches as a tourist.

Men should avoid tight-fitting clothes and avoid showing their bare chest (being shirtless even at home, particularly in the presence of children).

A bathing suit is controversial for Catholicism, as it is tight-fitting and may provoke sinful thoughts in others. Catholicism recommends that people bathe at secluded places. Both men and women should avoid scanty clothes.

Attitude to health and prophylaxis

Caring for one's health is an obligation of every Catholic. All should be interested in their health condition, using the help and support of healthcare establishments. According to the Catholic doctrine, prophylaxis facilitates recovery and healing; therefore, Catholics should actively participate in prophylactic tests and campaigns.

Nutrition and eating

Moderation is always recommended. Eating meat and meat products is forbidden on specific days: On Ash Wednesday, Good Friday, and all Fridays during Lent. Some Catholics fast every Friday. Fasting is a form of repentance and a reminder of human weakness.

Excessive eating and drinking leads directly to a number of other sins: egoism, sloth, gluttony, unwillingness to pray or help others. Excessive eating and drinking may also be a cause of mental disorders such as anorexia, bulimia, or alcoholism. "Abstinence from meat, or from some other food as determined by the Episcopal Conference, is to be observed on all Fridays, unless a solemnity should fall on a Friday. Abstinence and fasting are to be observed on Ash Wednesday and Good Friday" (Code of Canon Law 1251). According to Catholic doctrine, food waste should be avoided. In his encyclical letter *Caritas in veritate*, Benedictus XVI writes: "purchasing is always a moral - and not simply economic - act". Corporal works of mercy, which should be done by every Christian (Catechism of the Catholic Church), include the following works of love:

- feed the hungry,
- give drink to the thirsty.

Sickness and Death

John Paul II wrote about death: "the world is not capable of making man happy", "the world is not able to free man from suffering; specifically, it is not able to free him from death". In Catholicism, sickness, suffering, and death are inherent in human life. Anxiety or fear of suffering or infirmity is considered a normal reaction. Sickness in Catholicism is a moral challenge for the sick person, for the people around them - the family and friends, for healthcare professionals, and for the Church.

The corporal and spiritual works of mercy which should be done by every Christian (as prescribed in the Catechism of the Catholic Church) include:

- visit the sick,
- bury the dead,
- pray for the living and the dead.

The best one can do in sickness is to pray, as the prayer is a way to unite with God. Although a prayer of a sick person is a selfish prayer (it is a plea for healing), it is morally justified. According to the Catholic doctrine, a suffering person opens themselves to the grace of God, which God always administers. Hence, a prayer of the sick should be not only a supplicatory, but also a thanksgiving prayer.

In the face of death, the most important thing is that the dying person is accompanied by Jesus Christ and the Church through the word, prayer, and sacraments administered to the sick. A special role is assigned to *Viaticum* (a Latin word meaning "provision for a journey"; *via* – "road") - a Holy Communion administered to a sick person in approximate danger of death, seen as a spiritual food for the journey to eternal life. Out of all Christian denominations, *Viaticum* is particularly practised in Catholicism.

The anointing of the sick is a sacrament administered to the living. Its purpose is to heal in the name of Jesus Christ, calling the baptised dying person to unite with the Paschal Mystery. It is "the sacrament of passing over from death to life, from this world to the Father (Catechism of the Catholic Church 1524).

A deceased person should be cleaned and dressed in their finery. A rosary is put in the hands of the deceased, and a prayer book is often put in the coffin. A funeral service is held for the deceased's special intention, and then the coffin is put in the grave and the family of the deceased is offered condolences (although more and more often funeral attendees are asked by the family not to offer their condolences). Frequently, the family of the deceased organises a reception after the funeral.

Upon the request of the family, a service may be held for the deceased on a specific date, e.g., 30 days after death. Family and friends bring flowers and candles to the grave (particularly on Easter, Christmas, All Saints' Day or e.g., on the deceased person's birthday) Cremation is permitted by the Catholic Church.

Communication and information sharing

Both on the universal and local level, the Church recognises four main purposes of religious education: rearing, teaching, initiation, and evangelisation. The process of religious education is perceived as a mission to announce Good News to the people of God. It is also the task given by Jesus Christ: "Go into all the world and proclaim the gospel to the whole creation" (Mark 16:15) or: "Therefore go and make disciples of all nations'' (Matthew 28:19-20).

Every religious education activity should lead to better knowing God and deepening one's faith. Every effort made in this respect is an open act of communication, using the tools offered by teaching methodologies, but also by social communication sciences. All efforts should serve but one purpose: communicate God's revelation in the most effective way.

To be faithful to God and human beings, religious education must constantly seek new forms of dialogue. Therefore, Catholicism permits the use of the state-of-the-art forms of communication, including the Internet.

Information about the death of a person is communicated in the form of obituaries, stating the date and place of holding the funeral ceremony. During church services, both on weekdays and on Sunday and holiday Masses, a priest informs the congregation of any deceased parishioners, stating the age and planned date of funeral. Obituaries are also used by families to thank the funeral attendees who accompanied the deceased person on their last journey.

2.1.1.2. Protestantism

Protestantism is another Christian denomination (along with Catholicism and Eastern Orthodox Church). The name "Protestantism" (Latin: *protestari* – declare publicly, protest) originates from the protests of the Evangelicals (specifically the Lutherans) in 1529, at the Diet of Speyer. A resolution was passed at that time forbidding people to convert to Evangelism.

Overview

Protestantism focuses on the divinity of Jesus Christ as the man born of a virgin, who died for the sins of humankind, rose from the dead, ascended to heaven, and returned to the earth. Adherents of this Christian movement are believed to be the most active. The leading protestant churches include Lutherans, Calvinists, Anglicans, Baptists, Methodists, and Adventists, or Pentecostalists.

According to the statistics, roughly 800 million people worldwide identify with Protestantism, which accounts for 40% of all Christians. There are several Protestant churches in Poland (none dominating):

- The Evangelical Church of the Augsburg Confession in Poland (Lutheran),
- The Evangelical Reformed Church (Calvinism),
- The United Evangelical Church,
- The Seventh-Day Adventist Church,
- The Polish Church of Christian Baptists,
- The Methodist Church.

The Protestant denomination is declared by 146 thousand Poles. In the Czech Republic they account for 0.9%, while in Bulgaria for 1%.

The Founder

On 31st October 1517, Martin Luther nailed his 95 Theses to the doors of the Castle Church in Wittenberg as a protest against abuses of the Catholic Church. The event marked the beginning of the revival of the church called the reformation, which ultimately gave birth to a new Christian movement – Protestantism.

God

Jesus Christ is believed to be the only intermediary between God and humankind. Protestants focus more on humanity of Jesus than his divinity (unlike members of the Catholic and Eastern Orthodox Churches).

Key assumptions

Protestantism opposes certain selected doctrines and elements of the tradition of the Roman Catholic Church, although it shares the same theological thought (the Waldensians – Piotr Waldo; Hussites – Jan Hus).

Key Protestant beliefs

- Supremacy of the Holy Bible over tradition (the principle of *Sola Scriptura*); Jesus Christ is seen as the only intermediary between God and human being (the principle of *Solus Christus*).
- Absolute rejection of apostolic succession (testimony given by Apostles), which is limited to its original concept, narrowed down to the doctrine i.e., the word. In Protestantism, it is understood as the succession of the office. To support their view, Protestants evoke the words from the Gospel of St. John (17:20): "I do not ask for these only, but also for those who will believe in me through their word" [Standard English Version].
- The principle of the universal priesthood of believers;
- A heterodox approach to elements such as: veneration of images, relics, holy figures and sites, veneration of Mary. Protestantism also rejects the doctrine of purgatory, indulgence, celibacy of priests, orders, papal authority, saying Mass in Latin, individual confessions. The number of sacraments is also limited.
- Glory is due only to God. Worshipping anyone or anything but God is idolatry (the principle of *Soli Deo Gloria*);
- Protestantism emphasises that a person needs God's grace (the principle of *Sola Gratia*) and the Holy Spirit to live a holy life. To receive God's grace, one only needs faith. Grace and salvation do not result from goods works or religious practices (the principle of *Sola Fide*).

The goal and the way to salvation

Salvation is based on the principle of *Sola Gratia*. In Protestantism, salvation is a gift from God, an act of God's grace, and it can be achieved only through faith. This is the core Protestant belief concerning salvation.

Key rituals

Protestants pray in autonomous congregations which have no inner hierarchy. This means that every adherent may organise religious life of their community. Holy Mass is said only in the congregation's mother tongue, never in Latin.

Protestants do not venerate the Mother of God, they do not practice individual confession (through a priest) (but they practice examination of conscious, individual conversation with a clergyman, universal confession during church services).

Major holidays: Good Friday, Easter, Pentecost, Reformation Day (to commemorate Martin Luther), Thanksgiving (in the USA and Canada, in Poland only in rural areas).

The most important sacrament is the communion of the God's Word with water, wine, and bread. Therefore, Protestants have only two sacraments - the baptism and Eucharist in the form of bread representing Christ's body and wine representing His blood. Confession comprises of two parts - confession of sins and absolution. "Search me, O God, and know my heart! Try me and know my thoughts! And see if there be any grievous way in me, and lead me in the way everlasting!" (Psalm 139: 23-24) [Standard English Version].

Music plays an important role in Protestantism. It is a special form of worship of Jesus Christ.

Holy rites

Baptism – administered only and exclusively with an informed consent of a catechumen (a person preparing for membership in a church). The sacrament is administered through total immersion in water. The day of baptism is a celebration day for the whole congregation and is usually followed by a communal meal called *agape* (love feast). Evangelist churches do not baptise infants. New borns receive a special blessing, a prayer (also for the parents) for protection and development, but they are never baptised. A child decides on their own whether they want to stay in the congregation.

Confirmation (an equivalent of the first communion and confirmation in the Catholic Church) – laying on of hands to impart the gift of Holy Spirit (The Roman Catholic and Eastern Orthodox Church do not recognise Protestant confirmation).

Ordination (of a presbyter, pastor, deacon) and introduction to the office upon satisfaction of formal requirements (traineeships, exams, vicariate). A candidate faces the congregation. His mentors, who have taught and led him, introduce him to the office also through prayer, and ask the congregation for good works. Ordination of women is also permitted. Protestantism is based on the principle of a universal priesthood of believers. The function of a superior of the congregation is purely formal.

Washing of feet and sealing with the Holy Spirit (practised by some congregations) is a symbol of ongoing redemption through the power of the Holy Spirit, who dwells in man, and of belonging to the saved ones. It is also supposed to protect the person against the temptations of the Satan. It is sealing with the seal of Christ. The one who seals is fully responsible for the one whom he sealed, and the seal is valid until the day of salvation.

A marriage is not a sacrament in a Protestant Church (but a bonding between two people, and thus a manifestation of God's plan), unless it has a relevant contract executed with the state. Here, a marriage of two people (nupturients) is only an act of expression of free will. Where a Church is vested with the rights of the state (conservative churches), then a clergyman also serves as a state officer and the marriage is a legally binding act. Conservative churches oppose to marriages with a non-believer.

Protestant churches permit dissolution of marriage in two cases: adultery and abandonment by a non-believer (the Pauline privilege). The innocent (abandoned) person is granted divorce and the right to remarry (as if the spouse was dead). More liberal churches recognise state decisions granting divorce and the fact of a breakdown of the marriage.

The Holy Book

The Protestant Bible encompasses the Old and New Testament. The New Testament is comprised of the same number of books (27) as the Catholic Bible. It consists mainly of gospel and letters of the saints. The New Testament presents the God's kingdom and salvation preached by Jesus Christ himself and his disciples. The Old Testament is comprised of 39 books (versus 46 in the Catholic Bible).

Woman and Man

Roles and obligations of the spouses are the object of broad debate. In general, based on their views on the marital roles and obligations, Protestants can be divided into two groups:

- complementarians (e.g., Baptists, Calvinists) seeing marriage as a partnership following the example of a model Christian family, where the husband is the head of the family and a woman is subordinate to him (it is specifically emphasised that the woman should not have any superior position, hence these Protestant movements are against ordination of women),
- egalitarians (mainly Quakers, the Seventh Day Adventists, Pentecostalists) – absolute partnership of the spouses, full equality among them. They mutually agree on the roles and obligations within the marriage.

Martin Luther noticed the problem of single women. He engaged in providing them with a place to live and clothing and in satisfaction of their basic needs, including efforts to find them husbands.

Views on sexuality

Sexual ethics is the ethics of the whole family. Having children is not the essence of marriage. The church offers support to childless couples, helping them with adoption and encouraging them to establish foster families, which are seen

as the best way to pursue parental fulfilment. The church recognises the need to have one's own children; therefore, it approves of *in vitro* fertilisation. The Lutheran Church emphasises the respect for human life, postulates absolute protection for human embryos and approves of medical advancement as long as it is not detrimental to humans. It categorically opposes to using humans in research. *In vitro* is acceptable if no (excessive) embryos are frozen for purposes other than implementation in the mother's body.

Sexual ethics: In the Protestant church, sexual intercourse is not perceived as a sin, but a special gift from God. Various forms of sexual intercourse and contraception are permitted - the decision is at the discretion of an individual. Protestantism, however, is against emergency contraception, seeing the use of such medicines as abortion. Prohibited sexual behaviours include acts that disrespect human dignity, e.g., mutilation of sexual organs, extramarital sex, prostitution, and pornography.

Celibacy: abolition of celibacy is the effect of debates of the Roman Curia with the reformers. After all, according to the Protestant doctrine, a pastor is simply one of the believers - he is not an intermediary between God and a human being. Hence, a pastor may have a wedded wife when holding his position.

Views on hygiene

In Protestantism, the world "hygiene" refers to one's consciousness, the inner self. Since the body is a gift from God, one should respect it, care for it, and keep personal hygiene.

Dress code for men and women

Appearance should not dominate people's everyday existence. It belongs to the material world and does not serve the purpose of salvation.

Like in Catholicism, the Bible says about modest, humble clothing covering the body. Clothes should not encourage sexual thoughts in the opposite sex; therefore, excessively tight-fitting clothes are unacceptable. Women are supposed to cover their shoulders during meetings of congregation. Excessive jewellery is perceived as seducing and flirting, and therefore will cause direct divine judgement.

Views on health and prophylaxis

The Protestant Church pays particular attention to:

- strengthening and development of healthcare: development of medical institutes, high-risk pregnancy and foetal therapy centres, paediatrics, geriatrics,
- The state's approach to supervision of genetic research (Protestantism categorically opposes medical experiments that may be detrimental to human beings).

As stated in the Holy Bible, every Christian should care for their health and use available pharmacological and non-pharmacological treatments available to them when necessary. Unlike in the Catholic and Eastern Orthodox Church, Protestants accept the practice of supernatural healing.

Nutrition and eating

Meals should be modest. Wasting food is forbidden. Congregational celebrations involving some kind of feast are rather conventional. Drinking alcohol is an individual issue for Protestants; however, excessive drinking or intoxication is stigmatised.

Fasting, understood as refraining from all food at least for one day, and often for longer periods, is very important for Protestants. "Is not this the fast that I choose: to lose the bonds of wickedness, to undo the straps of the yoke, to let the oppressed go free, and to break every yoke? Is it not to share your bread with the hungry and bring the homeless poor into your house; when you see the naked, to cover him, and not to hide yourself from your own flesh?" (Isaiah 58:6-7).

Sometimes the fasting don't even drink water. There are no rules on the duration of fasting and its form - it is at the discretion of the person concerned. It is worth noting that in the Protestant domination fasting has no traditional or liturgical meaning: it is only a form of prayer. It is believed that fasting is an expression of one's relationship with God.

Views on sickness and death

According to Protestant doctrine, healing grace is available to everyone who has faith and trust in God. Protestantism also accepts as true the gifts of supernatural healing. It does not undermine or challenge the achievements of medicine. The sick are often anointed with oil for healing. This rite is performed by senior members of a congregation. Rules for visiting the sick and dying are laid down in the Agenda [Book of Liturgy] of 1968. Protestantism and Catholicism do not substantially differ as regards their attitudes to death.

In the biggest Protestant church in Poland - the Evangelical Church of the Augsburg Confession – the funeral ceremony is governed in Agenda Pogrzebowa [Agenda of Funerals] of 1955. The ceremony is similar to that of the Catholic Church. Protestantism permits cremation.

Communication and information sharing

Like in Catholicism, every person should seek their own individual form of dialogue with God. Importance is attached to broadening one's knowledge (of the religion), individual discussions with the pastor of the congregation, seeking answers to existential questions, and making use of state-of-the-art technologies (e.g., the Internet). Protestants actively engage in missionary, educational and social work.

Additional information

- Some claim that Martin Luther was a pioneer of Nazism, author of anti-Jewish writings, extorting others to burn down synagogues and Jewish dwellings. This was supposed to be a revenge taken on Jews rejecting his views.
- Despite numerous similarities between the Catholic and Protestant Church, from its very beginnings until the present-day, Protestantism has been continuously condemned by the Popes of the Roman Catholic Church.

2.1.1.3. Eastern Orthodox Church

The Greek word *orthodoxia* generally refers to Christianity and has two meanings: glory and true faith. The Eastern Orthodox Church has an autocephalous status, which means the autonomy of a local church as a separate entity, forming a part of the universal Church. In other words, all Eastern Orthodox Churches exist in a communion of faith, canon law, and liturgy (common understanding of the spirit and church services).

Overview

The largest number of members of the Eastern Orthodox Church live in Eastern Europe. Orthodox Christians dominate the population (> 80%) of the following countries: Moldova, Greece, Romania, Ukraine, Serbia, Bulgaria, Georgia, Montenegro, Cyprus, Belarus, Russia.

A characteristic feature of the Eastern Orthodox Church is the conciliarity (synodality) of church administration and equality of all bishops - they are *primus inter pares* (Latin phrase meaning “the first among equals”).

The Eastern Orthodox Church is comprised of autocephalous churches and local (autonomous) churches (which are not fully independent).

The Orthodox denomination has its special place in Polish history, related to the Slavic ritual of 863. It was the early stage of the Polish state and the time of evangelisation by Saints Cyril and Methodius (the only successor of their tradition is Polish Orthodox Church). The appearance of the Eastern Orthodox Church in Poland - or members of this denomination - relates to two events:

- the Christianisation of Ruthenia in 988,
- numerous changes of Polish eastern border.

For historical reasons, the largest Eastern Orthodox Church population in Poland is found in Białystok and the smallest in central Poland.

507 thousand Poles are members of the Eastern Orthodox Church (as at the end of 2018), but the algorithm applied during the census (2011) produced the figure of 156 thousand. In the Czech Republic, the Eastern Orthodox Church has roughly 30

thousand adherents, while in Bulgaria it's nearly 83% of the population (the Eastern Orthodox Church is the largest religious group there).

The Founder

Jesus Christ. The ultimate break-up between the Eastern Orthodox Church and the Catholic Church occurred in 1054 because of disagreement over the origin of the Holy Spirit.

God

According to the Eastern Orthodox Church doctrine, there is one true God of dual nature - both fully divine and fully human. There is one God in three persons: the Father, the Son, and the Holy Spirit. The Holy Spirit is the third Divine Person, proceeding from the Father and the Son through a single breath (this is a major difference in the perception of the 'origin' of the Holy Spirit between the Catholic and the Eastern Orthodox Church).

Mary, seen as the Mother of God and the Mother of all men, has a special place in the Eastern Orthodox Church, which recognises her eternal virginity and the Assumption. The superiority of the Mother of God outshines the figures of all other saints and angels in Heaven. Virgin Mary is the second most important person after God himself. She's an advocate and helper. The veneration of Mary is manifested in the number of holidays connected with her name. The titles of icons depicting her, reflect deep faith in her care - she is often called "Ardent Helper", "Joy of the Sufferers", "Helper of the Sinful".

The goal and the way to achieve it

Members of the Eastern Orthodox Church believe that with the Second Coming of Christ, they will rise from the dead and will live eternally in God's Kingdom. They also believe in the eternal soul and in the Final Judgement (Christ will come to judge the living and the dead).

Key rituals

The major duty of the Eastern Orthodox Church (i.e., of all believers) is to preach the Word of Jesus Christ to the world and administer sacraments which are the visible signs of invisible grace of God, deriving their power from Christ.

The Eastern Orthodox Church recognises seven sacraments divided into three groups:

- the sacraments of Christian initiation: Baptism, Confirmation, and the Eucharist;
- the sacraments of healing: Penance and Reconciliation, Anointing of the Sick;
- the sacraments of service: Holy Orders and Matrimony.

In the Eastern Orthodox Church, communion is administered to infants, after they have been baptised, and when they are able to tell the good from evil (at the age of 6–7), they are admitted to the sacrament of repentance, penance, and confession (Greek: *metanoia* or *exomologisis*; cs. *pokajanije* or *ispoviedanije*). After confession, sins are forgiven, and the sinner becomes reunited with the Church; hence, the sacrament is often referred to as the "second baptism".

Confession and penance used to be performed in front of the whole congregation. In time, confession turned into a private conversation between a clergyman and the confessing person. A clergyman must not disclose what has been confessed to him. In the Eastern Orthodox Church, a confession is not heard in a confessional, but any convenient part of the church, usually just in front of the iconostatis. A clergyman and the confessing person may stand or sit anywhere in the church, if they are facing the cross. Many members of the Eastern Orthodox Church have their "spiritual father". Every sacrament is preceded by a call upon the Holy Spirit.

Many Orthodox Church theologians consider events, such as monk's hair-cutting ceremony, consecration of a church, blessing of the holy water on the Epiphany Day, liturgical blessing, and a funeral to be sacraments. They see the source of disagreement as to the actual number of sacraments in the absence of the established definition of a sacrament. Although the Eastern Orthodox Church has not officially recognised any specific number, it is customarily agreed that there are seven sacraments: Baptism, Confirmation, Eucharist, Penance, Holy Orders, and Matrimony.

There are twelve great holidays in the Orthodox Church. The celebration is meant to be actual "living through" and not commemorating specific events:

- The Nativity of the Theotokos (Virgin Mary), 8 September [O.S. 21 September]
- The Exaltation of the Cross, 14 September [O.S. 27 September]
- The Presentation of the Theotokos, 21 November [O.S. 4 December]
- The Nativity of Christ (Christmas), 25 December [O.S. 7 January]
- The Baptism of Christ (Theophany, also called Epiphany), 6 January [O.S. 19 January]
- The Presentation of Jesus at the Temple (Candlemas), 2 February [O.S. 15 February]
- The Annunciation, 25 March [O.S. 7 April]
- The Entry into Jerusalem - Palm Sunday (the Sunday before Easter)
- The Ascension of Christ (Thursday, forty days after Easter)
- Pentecost (Sunday, fifty days after Easter)
- The Transfiguration of Jesus, 6 August [O.S. 19 August]
- The Dormition of the Theotokos, 15 August [O.S. 28 August]

The Holy Book

The communion of the Bible and the Tradition. The Bible is the basic and central book for adherents. It is seen as the authoritative material deposit of faith. Tradition is understood as preaching the words of the Bible, doctrines, teaching, and writings of the Fathers of the Church, Symbols of Faith, and rites. Iconography is permitted in the Eastern Orthodox Church (unlike in Protestantism).

Woman and Man

Woman and man have been created to form a unity. Although the Apostles preached that a man is the head of a family, and not woman, the Eastern Orthodox Church emphasises that "priority" does not mean inequality. The power of man is only the power of love.

Both men and women should care for the family, relatives, and friends. Particular attention is given to the care and support for the sick, dying, and lonely. Orthodox Christians should take good care of the education and rearing of their children. Ordination of women in the Eastern Orthodox Church is not permitted. Key functions are performed by men.

Views on sexuality (sexual intercourse, conception, contraception, abortion)

According to the Eastern Orthodox Church doctrine, chastity as a foundation of love is a priority for marriage. Sexual acts are permitted in sacramental marriages and should be an expression of faithful love. Procreation is not a necessary requirement for a sexual act. It is only one of the goals of marriage. The most important is the act of becoming one.

Contraception is permitted, if one obtains a blessing from a spiritual father. Abortion as such and any form of inducing miscarriage is forbidden.

The Eastern Orthodox Church calls upon its members to respect homosexuals. A different sexual orientation is not viewed as a sin. However, sexual acts between people of the same sex are sinful.

Views on hygiene

Every man should care for their body by keeping proper hygiene, out of respect for God and life given to them by God.

Dress code for men and women

Everyday clothing should be clean, and clothes worn at feasts should be elegant and formal. It is forbidden to expose the naked body. Women should cover their shoulders and neckline and wear dresses or skirts of proper length. When entering a church, women should also cover their heads. Men (particularly during church services) should wear long-sleeved shirts and long trousers.

Views on health and prophylaxis

According to the Eastern Orthodox Church doctrine, God is the ultimate physician and healer, and believers should pray to Him entrusting their pleas, supplications, and thankfulness. The overriding goal of medicine is broadly understood prophylaxis, covering not only the prevention of diseases, but also the forecasting and promotion of cultural patterns concerning protection of social and natural environment. The purpose of prophylaxis is to deter pathogens directly affecting human body. According to Eastern Orthodox Church doctrine, medicine is an interdisciplinary science making use of the achievements of all other sciences. Medical care has a liturgical meaning. It combines four basic dimensions: therapeia (treatment), epimeleia (care), diaconia (serving others), leitourgia (serving God).

Nutrition and eating

In accordance with the Bible, no food should be wasted. A characteristic feature of the Eastern Orthodox Church is keeping very strict fasting rules. Eating meat, fish, and other animal products (including dairy products) is forbidden during Lent and the Holy Week. There are one-day or multi-day fasts in the Eastern Orthodox Church tradition:

- one-day fasting is always strict: Wednesday (the day when Jesus was betrayed and captured), Friday (the day of suffering and death of Jesus).
- multi-day fasting: Nativity Fast (40 days), Lent and the Holy Week (50 days), Dormition fast (14 days).

One should share their food with the needy and bring blessed food to persons who are sick or dying.

Views on sickness and death

As regards sickness and death, the Eastern Orthodox Church follows the words from the Gospel of St. Matthew (Mt. 25: 31-46), saying that we will not be judged for breaking the Commandments but for our attitude towards the others.

Help and assistance to the sick is a basic duty of an Orthodox Christian on their way to salvation.

The Eastern Orthodox Church permits medical assistance and application of all known methods of treatment, as long as no harm is done to another person (e.g., transplantation of a kidney from a live donor).

Sick persons pray in a hospital chapel or to an icon, cross, holy water, blessed Easter bread (Artos), or prosphoron (a small leaf of leavened bread used to administer the Holy Communion), which they may keep by their bed.

Family members of a sick person pray individually and, in a church, where the sick person is mentioned during the liturgy. A popular form of prayer is Moleben –

a service held after the Holy Liturgy for a special intention of the sick person (food is blessed during the service, which is consumed by the attendees and brought to the sick person to help in recovery).

The sick receives the following sacraments: the Confession, Eucharist, Anointing of the Sick (so called *soborowanije*) as a supplication for recovery from sickness (of body and soul). The sacraments are administered by a clergyman. In his absence, the nearest parish is notified.

When a sick person dies in hospital, the family brings a holy cross (placed on the deceased person's neck) or an icon (put in the hands of the deceased person). When a sick person dies at home, the family holds a wake, praying before lit candles. The family is offered condolences. The casket is kept open. Before the funeral, the body of the deceased is washed and dressed in an elegant attire. The funeral ceremony is held on the second day after death.

In the case of a first degree relative (a spouse, a parent, a sibling) the mourning lasts one year - the mourning person is supposed to wear only black. "Light" mourning is observed in the case of more remote relatives - men are supposed to wear black armband and women a black scarf or head scarf for forty days.

Cremation is avoided by the Orthodox Church members (unless necessary). The care for the soul of the deceased does not end with the funeral. According to tradition, a human soul needs help on the way to heaven, as the journey consists of several stages - passing through aerial toll houses (on the 3rd, 9th, 20th and 40th day after death). Special memorial services are held on those days for the soul of the deceased, during which special food is blessed (koliva). The most important is the liturgy of the 40th day after death. It is believed that on this day the soul ultimately parts with the world and moves to where it will stay forever. Until the 40th day, the grave is visited every day. Olive lamp and candles are lit, and the family says prayers (traditional families also pour wine over the grave during the 40 days, making the sign of the cross). After that period, the grave is visited as the family chooses, most often on Fridays - on the day of Passion of Christ.

Communication and information sharing

All information is communicated orally, in direct conversation with a clergyman, and in written form. Like in the case of two other denominations discussed above, the Eastern Orthodox Church uses the Internet and has its websites.

Information about funerals is provided in written form (obituaries usually include a photo of the deceased), orally or via phone – both, just directly after death as well on the 9th, 20th and 40th day after death, when the memorial services for the deceased are held.

Summary – major issues relevant for providing medical care to Christian patients (Catholics, Protestants, or members of the Eastern Orthodox Church)

- One should be aware of major differences among Christian denominations in the context of providing medical care. However, all denominations of Christianity have a lot in common.
- It is worth to become acquainted with the basics of Christian religion to be able to attend the patient with awareness and professionalism.
- When staying in hospital, Catholics, Protestants, and Orthodox Christians all pray (often with the assistance of the Bible), receive sacraments, contact with a clergyman of their denomination, go to confession, observe fast, celebrate selected holidays.
- All Christian denominations appreciate the advancement and resources of medicine as regards medical treatment. They all strongly oppose abortion and related procedures.
- In the context of medical (and hospital) treatment, major differences occur in the number of recognised sacraments, contents of prayers, and symbols of faith accompanying the patient, different dates of holidays and fasts.
- Every patient should be given the opportunity to pray. Prayers should not be interrupted. Patients should be granted privacy while praying.
- Patients' need to pray should be addressed by ensuring availability of religious symbols of a given denomination (e.g., a rosary, holy picture, prayer book, icon, etc.) on a bedside table.
- Patients should have access to a clergyman of their denomination.
- Patients should be given an opportunity to receive sacraments (e.g., the Eucharist, Anointing of the Sick) in their place of stay.
- If the patient's health condition allows, the patient should be given the opportunity to participate in the liturgy.
- Patients should be able to read the Bible.
- Family and friends should be able to visit the patients (if the patients' health condition allows) or at least contact them on the phone.
- The rules of fasting should be observed, depending on the denomination.
- Patients of all three denominations recognise the benefits of prophylaxis to care for one's health. They willingly participate in such programmes.
- Hygiene and clean clothing are important for all denominations.
- No denominations accept procedures aimed only at improving one's appearance.
- All denominations object to wasting food and are taught by the Bible to share food with the needy.

- A disease is a moral challenge for a Christian. Sickness, suffering, and death are perceived as an inherent element of life.
- Family and friends show interest in a sick person: helping and supporting them. They often want to accompany them at the time of death.
- The power of prayer and absolute trust in God, both on the part of the patient and their family, is extremely helpful.
- Various religious practices are observed in the face of death, including a visit of a clergyman and receipt of relevant sacraments.
- A deceased person is washed and dressed in clean formal clothes. The hands of a deceased person are often put together on the chest.
- Christian denominations prefer direct conversation as the most desired form of communication.

Major differences between Protestants, Catholics, and Orthodox Christians (relevant in the context of hospital treatment)

- Protestants do not venerate the Mother of God;
- They are the only Christians permitting *in vitro* fertilisation as a method of treatment of infertility in married couples.
- They recognise as true the gift of supernatural healing.
- Baptism requires the informed consent of a catechumen.

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2.1.2. Jehovah's Witnesses

Jehovah's Witnesses are a Christian denomination with 8,579,909 members in 240 countries. According to 2018 data, Jehovah's Witnesses are the third largest denomination in Poland, with 116 299 members. In the Czech Republic, there are 15,442 adherents, and in Bulgaria – 2,530.

Overview

Jehovah's Witnesses are the most numerous group within the Bible Student movement initiated by Charls Taze Russell (1852–1916). His successor, Joseph Franklin Rutherford (1868–1942), an American lawyer and preacher, the second president of the Watch Tower Bible and Tract Society, transformed the loosely connected communities of Bible Student movement into a well-organised and active theocratic organisation, following the directions of the superiors appointed by the authorities of the Society. In 1931, the most numerous group of Rutheford's adherents adopted the name of Jehovah's Witnesses.

Their doctrine is based on the Old and New Testament. It is a religious group recognising Jehovah as the only God. Adherents pay particular attention to using God's own name, in appropriate situations and with due respect. Jehovah's Witnesses members are called Bible Students, and the Bible is the foundation of their beliefs. They recognise the so-called Protestant Canon of Scripture (they reject the so-called deuterocanonical books of the Old Testament as apocrypha) and 27 books of the New Testament (Christian Greek Scriptures). They also reject all other non-biblical traditions, including the so-called Sacred Tradition. They believe in one-person God - Jesus and Holy Spirit do not have divine nature.

The main task of the Jehovah Witnesses is literary detailed analysis of the Bible verse and preaching (also at one's own home), engaging in discussion, and publishing papers. Following the evangelic principle "thou shalt not kill"; they are pacifists, they refuse to participate in military service, carry arms, or salute the flag, and they do not participate in political life, seeing all these actions as being in contravention with the commandment of love. Its adherents do not celebrate Christmas, birthdays, or any rituals and holidays other than Baptism. The only feast recognised by them is the commemoration of Christ's Passion (however, their celebration has little in common with Easter).

There's a lot of controversy over the way former adherents are treated - persons who voluntarily decided to abandon the group or were expelled become the objects of severe ostracism. Even more controversial is abandoning children when doctors, against the parents' will, decide to give a child a blood transfusion.

The Jehovah's Witnesses movement is made up of local congregations having several dozen members, organised in circuits and districts in order to facilitate the work of publishers and their overseers. Every preacher/publisher provides monthly reports on their preaching activities.

Basic religious practices of Jehovah's Witnesses include:

- prayer to God (Phillipians 4:6);
- reading and studying the Bible (Psalm 1:1-3);
- meditation on the verse of the Bible (Psalm 77:12);

- attend meetings to pray, study the Bible, sing songs, manifest one's faith and encourage one another (Colossians 3:16; Hebrews 10:23-25);
- preach the "Good News of the Kingdom" (Matthew 24:14);
- prayer to God (Phillipians 4:6);
- reading and studying the Bible (Psalm 1:1-3);
- attend meetings to pray, study the Bible, sing songs, manifest one's faith, and encourage one another (Colossians 3:16; Hebrews 10:23-25);
- help the needy (James 2:14-17);
- build and keep the Kingdom Halls and other objects used for the purpose of worldwide biblical education activities (Psalm 127:1);
- help the victims of natural disasters (Chronicles 11:27-30).

Woman and Man

St Paul wrote: "I do not permit a woman (...) to exercise authority over a man; rather, she is to remain quiet. For Adam was formed first, then Eve" (1 Timothy 2:12, 13) [Standard English Version].

Similar rules are observed in by the Jehovah's Witnesses. This does not mean that during the meetings of the congregation women have no right to speak at all. They are supposed to keep silent in a sense that they do not argue with men. They do not try to undermine their position or preach. The role of women is to enrich the meetings in various ways; however, the oversight and preaching is the domain of men.

Psalm 68:11 reads: "The Lord gives the word; the women who announce the news are a great host." [Standard English Version] Those who bore the tidings deserve respect. It is their skilful home teaching of the Bible that helps many people acquire knowledge that pleases God. Christian wives too should be "praised" for they help their children in gaining knowledge and their husbands in fulfilling their duties towards congregation (Proverbs 31:10-12, 28). And lone sisters have an important role to play in the God's plan. Men should "(...) encourage (...) older women as mothers, younger women as sisters, in all purity" (1 Timothy 5:1, 2) [Standard English Version]. According to the Jehovah's Witnesses' doctrine, God assigned specific roles to men - duties towards the congregation which they should duly fulfil. The role of women, on the other hand, is to show respect to men and support them.

The doctrine also provides for strict rules governing family life. Jehovah's Witnesses oppose that which affects the traditional model of marriage. They reject cohabitation. They believe in happy family life even today, in times of crisis of the modern family model. Family life should be based on love and respect for God. Following God's rules found in the Bible in the family life helps to reach spiritual closeness with Him. The Bible is the source of norms governing the marriage, sexual life, assigning roles within a family, providing guidelines on bringing up children, and

on divorces and separation. Marriages of Jehovah Witnesses are monogamous in all cultures and societies. They believe that every marriage or family needs guidance to avoid disorder and turmoil. And it is the man who should be the head of the family, because of his natural traits and predispositions enabling him to duly perform this role. This does not mean, however, that men are considered superior to women. Men should be kind and understanding to women, because in this way they follow the example of Christ in his attitude towards the Apostles. Guidebooks for Jehovah's Witnesses emphasise that men must not abuse their position in the family to tyrannise their wives. The wife more easily respects the authority of the husband, when he is modest and humble, and not proud and stubborn. Domestic violence is a sin. The man's obligation is to ensure an appropriate financial status for the children and family; however, not at the expense of the time that should be devoted to the family. Professional work does not release the husband from his domestic duties. Family leadership also involves planning activities and not refraining from making decisions. Leaving all decisions to the wife is inappropriate and causes harm to the family. The reverse situation, where the husband decides about everything and does not permit the wife to take any initiative, is equally undesirable. The husband should make the wife feel needed not only by giving her presents, but also by devoting time and attention and considering her opinions when making decisions. Jehovah's Witnesses adherents believe that teamwork proves the most effective. In their religious ethics, the husband and wife do not compete but complement each other. This approach is derived from the belief that God created Eve to accompany Adam in his solitary life. The role of a woman in a marriage of Jehovah's Witnesses is based on two principles: subordination to the husband and showing him respect. The wife should be helpful and support the decisions of the husband. She should not humiliate or criticise him. The same rules also apply when the husband professes another religion. Respect for and subordination to the husband as the head of the family is required whether or not the husband is a Jehova's Witness. The only exception is a situation when the husband demands from the wife that she violates the religious norms.

Views on sexuality (sexual intercourse, conception, contraception, abortion)

According to Jehovah's Witnesses, extramarital sex is immoral. It always has negative consequences, evokes a sense of guilt, and causes marital problems. It may also lead to unwanted pregnancy, disease, or even death. Publications of Jehovah's Witnesses providing moral guidelines and tips for teenagers and adults are available in 700 languages. Sexual acts between the same sex and homosexual relations are strongly condemned as are sexual acts between people and animals (this covers sexual intercourse, oral and anal sex, and touching sexual organs).

The Bible does not prohibit birth control and the use of birth control by married couples. Jehovah's Witnesses disapprove of the motherhood of unmarried women. They also reject contraception inducing miscarriage. They believe that *in vitro* fertilisation, when the egg and sperm belong to persons who are not a married couple, is an act of adultery and is unacceptable.

Prenatal care in the case of Jehovah's Witnesses includes a discussion on acceptable blood products and available alternative methods. The members should be provided with adequate information, including a form where they can refuse to be given transfusion, a power of attorney form for appointing a healthcare proxy, and a medical care plan which can be discussed with the family. It is important that at least one visit is held without the participation of family members or friends to give the patient an opportunity to express their own views freely and openly. Preparation for birth should include decisions concerning the possibility of death. Appointment of a healthcare proxy and relatives who should take care of the child may significantly affect the decisions of the woman and make her realise the consequences of a refusal to be given blood transfusion. Moreover, this step reverses earlier withdrawal of such consent ordered by court. Labour should be planned in a tertiary referral level hospital, adequately equipped for a massive bleeding which may pose threat to the woman's life. When delivering a baby, the medical staff should focus on prevention of massive bleeding.

Abortion is prohibited under the doctrine of Jehovah's Witnesses. When, during the labour, a choice must be made whether to save the life of the child or the mother, the decision is made by the parents or legal guardians.

Views on hygiene

"Cleanliness is next to godliness". Keeping hygiene is closely related to the religious beliefs of the Jehovah Witnesses adherents - "by cleanliness we glorify God".

Dress code for men and women

Seeing themselves as Jehovah's servants, Jehovah's Witnesses pay great care to moral purity and with their modest appearance they are supposed to help others (brothers and sisters) feel comfortable in their company. They want to follow the biblical advice "that the women should adorn themselves in respectable apparel, with modesty and self-control (...) with what is proper for women who profess godliness (1 Timothy 2:9, 10) [Standard English Version].

Although Paul the Apostle wrote these words about women, the principle also applies to men. It is clear from God's word that He does not like men resembling women and the other way round, or clothing which makes it difficult to recognise the sex of the person. Hence, following the principles laid down in the Bible, Jehovah's Witnesses avoid tight-fitting, transparent or otherwise provoking clothes

(which uncover or expose intimate parts of the body). Clothing should be appropriate for the occasion.

Views on health and prophylaxis

Life, as a gift from God, is very precious to Jehovah's Witnesses. They believe that no one has full control over their health but taking reasonable precautions may mitigate the risk of developing many serious diseases. They care for their body, avoid extreme sport and entertainment activities. Their publications contain many reliable and practical tips on health prophylaxis. Jehovah's Witnesses members observe the principle "don't poison your body". They do not smoke, abuse alcohol, or use drugs. Since excessive eating and drinking is bad for the health, they postulate moderation in one's habits. Since body and mind are closely related with each other, they recommend controlling bad emotions and focusing on positive things. In accordance with the principle "better prevention than cure", Jehovah's Witnesses members emphasise that by keeping personal hygiene (e.g., regularly washing one's hands), using clean water, an appropriate well-balanced diet, physical activity, and sufficient amount of sleep, one can prevent many diseases.

Nutrition and eating

Jehovah's Witnesses do not consume blood and unbled meat (Chronicles 15:20, 28, 29). Apart from that biblical rule, they have no other restrictions as to food products.

Sickness and Death

Jehovah's Witnesses do not practice healing through faith. They love living and do everything they reasonably can to make it last as long as possible. They are open to medical treatment and advancement. They seek the best possible care and approve of most available treatment procedures and methods. When they feel they need a doctor, they go and see one. Many jurisdictions recognise the basic patient's right to decide about one's own body when it comes to medical treatment, and hence they safeguard patient's autonomy in making informed decisions about the therapy to be used. In some countries, young adults also enjoy this right. A patient (or parents/guardians of an underaged patient) should be informed in detail about the diagnosis, prognosis, and recommended treatment to be able to make informed decisions. Parents have a statutory right to make such decisions for their underaged children.

In many countries, all Jehovah's Witnesses may decide, depending on legal provisions and their individual situation, to appoint their healthcare proxy in case of an inability to make decisions for themselves. If the patient has appointed a healthcare

proxy in a document prepared in advance in case of losing consciousness, the proxy's right to make decisions on behalf of the unconscious patient must be respected.

Jehovah's Witnesses care for their fellow believers who are sick or in hospital, giving them spiritual and practical support. In big cities, there are Patient Visitation Groups, composed of experienced preachers.

In accordance with Bible principles, Jehovah's Witnesses do not accept blood transfusion of whole blood, red and white cells, platelets, and plasma. They choose alternative treatment methods. To avoid blood transfusion, other methods are used in the treatment of bleeding and anaemia. Alternative strategies include the use of applicable combinations of medications, devices, and techniques in order to minimise or avoid blood loss or stimulate blood forming. This approach, based on deployment of various methods, is called bloodless medicine (or bloodless surgery). It also involves procedures on the "economical" use of and special handling of patient's blood. Hospital Liaison Committees help Jehovah's Witnesses find a doctor who will treat them in accordance with their beliefs concerning blood. Since the Bible does not say anything about blood fractions, the doctrine leaves the decision as to their use in treatment to the discretion of a patient. Opinions of the Jehovah's Witnesses members on the use of fractions obtained from basic blood components differ significantly. Doctors should make sure in advance what the decision of their patient is. The Bible makes a differentiation between blood and marrow; hence, the patient makes a personal decision concerning marrow transplantation. Religious beliefs of the Jehovah's Witnesses members do not categorically reject fractionated blood products. Every member decides for themselves whether to take immunoglobulins or a serum containing blood fractions. Jehovah's Witnesses dot not agree to the pre-operative donation and storage of their own blood for subsequent transfusion.

A Jehovah's Witnesses may accept treatment with plasmapheresis (which is a personal decision), provided that a replacement solution (e.g., coloid) is used during the procedure. The Jehovah's Witnesses doctrine rejects the use of allogeneic plasma.

Although the Bible clearly forbids eating blood, there is no direct prohibition on using other human tissue. Hence, the decision concerning transplantation or donation of an organ is a personal one.

Obtaining stem cells at the cost of life of embryos is unacceptable for Jehovah's Witnesses. But every patient decides for themselves whether to take stem cells obtained from their own blood or someone else's blood, provided that the procedure does not involve the purposeful collection, storage, and transfusion of blood components.

Life is sacred. Therefore, all reasonable and humanitarian efforts should be made to prolong and sustain it. However, the Bible does not require undertak-

ing extraordinary, complicated, desperate, and costly efforts to sustain life of a dying person. In some cases, doctors may agree that using specific methods only prolongs the process of dying and sustaining the life of the patient is futile. Patients' express decisions in this respect, whether written or oral, should be respected.

The Jehovah's Witnesses do not have any special rituals to be observed as regards the sick or dying. All reasonable efforts should be made to give the sick person spiritual comfort and medical help.

As for autopsy, the patient makes this decision during life. Sometimes law may require an autopsy to establish the cause of death.

Hospital Liaison Committees

Hospital Liaison Committees have been established to support the Jehovah's Witnesses members in their strong objection against blood transfusion, help medical staff to get an objective view on their beliefs, and better cooperate with healthcare institutions. They are composed of elders (experienced preachers) who communicate with the doctors and other medical staff, social workers, and representatives of the judiciary. The Committees are supervised by the Hospital Information Services, having its international office in Brooklyn, New York. The Committees, upon request of a patient or a doctor, provide free resources (in electronic or printed form) on saving blood and on bloodless treatment methods in various specialist and medical situations. An internet library with such resources is available at: https://www.jw.org/en/medical-library/strategies-downloads/hospital-liaison-committees-jehovahs-witnesses/

Contact with representatives of the Hospital Liaison Committee for healthcare professionals taking care of Jehovah's Witnesses patients:

- International Office: +1 718 560 4700; HIS@jw.org.
- Poland Hospital Information Service (Poland) +48 538 970 000.
- Bulgaria: Hospital Information Service (Bulgaria) +359 879 990 409.
- The Czech Republic: Hospital Information Service (Czech Republic) +421 948 910 065.

Summary – major issues relevant for providing medical care to a Jehovah's Witnesses

- When the patient is a Jehovah's Witnesses, this fact must be documented.
- Jehovah's Witnesses pay special attention to healthcare and in the event of an illness or accident expect the best available care and accept most of the available treatments and procedures.

- Jehovah's Witnesses refuse blood products and do not accept blood transfusions. The patient should be consulted on what blood products are acceptable to them and what alternative treatment methods are available.
- Blood transfusion alternatives should be used (appropriate combinations of medication, devices, and techniques to reduce or avoid blood loss and stimulate blood forming).
- Attitudes of Jehovah's Witnesses on the use of fractions obtained from basic blood components differ significantly. Doctors should make sure in advance what the decision of their patient is.
- The use of uniform procedures, such as informed consent specifying various alternative methods, will help doctors better understand the specific needs of a Jehovah's Witnesses and ensure that their will is respected, and the best possible health outcome is achieved.
- A Jehovah's Witness should be informed in detail about the diagnosis, prognosis, and recommended treatment to be able to make informed decisions.
- Jehovah's Witnesses draw up and carry on them a special document - a medical directive and healthcare power of attorney (proxy), containing personal decisions of the patient as to medical care and naming a healthcare proxy authorised to act on their behalf when the patient is incapable to act for themselves. Doctors and other healthcare professionals must respect the patient's decisions to refuse to accept blood transfusions and the right of the proxy to make decisions on behalf on the unconscious patient.
- A refusal to accept blood transfusions, a healthcare power of attorney (proxy) form and healthcare plan should be discussed, signed, and appended to the patient's medical record.
- Parents have a statutory and natural right to make healthcare decisions for their underaged children.
- A pregnant Jehovah's Witness should be consulted at least once without any accompanying person, to be able to openly express their own wishes as to medical care to be provided.
- Jehovah's Witnesses require special obstetric procedure due to their refusal to accept blood products.
- When, during the labour, a choice must be made whether to save the life of the child or the mother, the decision is made by the parents or legal guardians.
- Jehovah's Witnesses care for their fellow believers who are sick or in hospital, giving them spiritual and practical support. They should be given the possibility to receive such visitors.
- All persons providing medical care to Jehovah's Witnesses should accept the healthcare plan and refrain from administering blood transfusions against their will.

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2.1.3. Islam

Islam is the world's second largest (in terms of the number of adherents) monotheistic religion. Its adherents are called Muslims. According to statistics, in 2020, the number of Muslims will exceed 1.9 billion, as opposed to 1.6 billion in 2010 (23% of worldwide population). The Polish Muslim population in 2010 amounted to < 10 thousand; in 2020, it is expected to reach 20 thousand, and in 2030 - 40 thousand. In the Czech Republic, there were roughly 10 thousand Muslims (mainly foreigners) in 2010, and their number is expected to increase to 20 thousand in 2020, and to 40 thousand in 2030. In 2010, Bulgaria had a one million population of Muslims; in 2020, it is expected to be 980 thousand, and in 2030 - 920 thousand.

Overview

Muslims believe that Islam is a prophetic religion. They believe that the verses of Quran where gradually revealed to Muhammad (prophet and the founder of Islam) by the Archangel Gabriel. The first revelation occurred around AD 610, during Muhammad's prayers in Mecca. The holy book of Islam is the Quran, and the revelations contained there from the message from God (Allah) to humankind. The Quran is the source of knowledge for all Muslims. Equally important are the hadiths (together forming *sunnah*) - a set of accounts quoting Muhhamad's words, referring to all aspects of life.

The dogmas of Islam:

- belief in one God,
- belief in angels created by God,
- belief in holy books: the Torah, Gospels, Quran, treated as revelations of the same God;
- belief in messengers and prophets, who delivered God's message to the humankind;
- belief in the Judgement Day and eternal life in paradise or hell that will happen afterwards.

The foundation of Islam is the five acts of worship:

1. The declaration of faith (Shahada). In Islam; there is only one God. Accepting Allah as the only God means rejection of other religions, lifestyles, or ideologies. "I testify that there is no deity except God and I testify that Muhammad is the messenger of God" - to become a member of the Islam community one must say these words in Arabic. Declaration of faith is a declaration of being one of the adherents of Islam and of submission to the will of God.
2. Everyday prayer (*as-salah* or *as-salat*). Prayer is an obligation imposed by God. It has a prescribed form and is performed five times a day. The times of prayer are not fixed but related to the position of the sun. Another obligatory

prayer is a Friday prayer - the so called *Jum'ah*. Its purpose is to strengthen the Muslim community. It is also an opportunity for delivering religious teaching. There are also supererogatory prayers accompanying the compulsory ones or practised during great feasts. A prayer should be recited in Arabic, in a state of ritual purity, which involves ablution (ritual wash). A state of ritual purity is lost as a result of sleep, loss of consciousness, touching of a person of the opposite sex (other than the spouse), using a bathroom, touching one's intimate body parts. A requirement necessary for a prayer to be valid is the appropriate preparation of the place, which should be clean and tidy. Muslims pray with bare feet, on a special mat or rug. Prayers must not be said at impure places, such as a cemetery, slaughterhouse, dumpsite or bath house. Muslim pray facing the direction of Mecca.

3. Fasting (Saum/Ramadan). Fasting is obligatory for every Muslim for one full calendar month per year (Ramadan). It is a movable fast, related to the lunar calendar. Ramadan is one of the most important Muslim holidays. Fasting begins at dawn and ends at dusk. All food and drink as well as other forms of consumption (such as tobacco) and corporal contacts are forbidden. Exempted from fasting are children, the pregnant, breast-feeding and menstruating women, the elderly, the sick and people on journey.
4. Charity (Zakat). Islam emphasises the importance of charity and caring for the poor. Every adherent is obliged to donate a certain portion of their property to the needy. From the religious perspective, *zakat* may be interpreted as a purification from greed and meanness. In practical terms, *zakat* is simply a form of tax payable annually, and the funds are used to address social needs. *Zakat* is donated at least once a year, during Ramadan. It can have a form of cash donations, clothes, food, or even a good word or smile. The value depends on the wealth of a given person.
5. Pilgrimage to Mecca (Hajj). The pilgrimage is to be done at least once in a lifetime by every Muslim who can afford it financially and physically. The pilgrimage starts in the 12th month of the Muslim calendar year. On their way to the sacred city, all men should wear similar clothing, comprised of two unstitched pieces of white cloth. The simple clothing is a sign of equality of all men in the eyes of God.

Woman and Man

Muslin women at home in their private lives may only meet with other women and their unmarriageable male relatives (*Mahram*), namely father, grandfather, son, grandson, brother, uncle, father-in-law, son-in-law, foster son or a milk brother. Only those people can see the parts of the body that are uncovered during household

work, apart from the hands or face. Islam forbids an unmarried man and woman from staying in the same room. Hence, the private lives of Muslim women are limited to the company of other women and relatives. This rule applies in contacts both with Muslim and non-Muslim women, which is important in the case of contacts of healthcare professionals with Muslim women. It is much easier when the healthcare professional is a woman, even if she's not a Muslim. Other rules to be followed by Muslim women include guarding their chastity, modest lowering of their eyes, wearing a headgear covering both the neck and chest. In Muslim countries, a menstruating woman is not allowed to enter a mosque, pray, or touch the Quran. After menstruation, she must take a ritual purifying bath.

In the Islamic tradition, the duties of a women depend on her role. The primary roles of a woman include being a mother, aunt, grandmother, sister, wife, niece, unrelated woman, and wet nurse. Muslims believe that the mother deserves greater respect and obedience from her children than the father.

The main vocation of a married woman is to be the wife and mother. Muslim women also have voting rights and can hold various offices, but not ones involving any form of directing or managing.

Muslims believe that women and men have different roles to fulfil. They are equal, but not identical. In a situation where the different nature of men and women is of relevance, different rules apply to them, e.g., during menstruation women are exempt from the obligation to pray and are exempt from fasting during pregnancy.

Islam clearly differentiates between female and male obligations. A man is responsible for supporting the family, and a woman should bear children, raise them, and take care of the home.

In the Islamic tradition, a man can perform various roles, depending on his relations with the surrounding world. As the father, he must provide his children with food, a place to live, and clothing, until they will be able to support themselves. Any help from the father afterwards is viewed as charity. As a son, he must obey his mother and father unless the parents demand from him something that would be an act of disobedience to God. Should this be the case, a man must not obey the parents. It is forbidden to look at an unrelated woman.

Women and men are equal before God in Islam. However, according to Quran, the rights of women equal their obligations, and men are one step higher than women. In practice, this means authority over women, absolute power at home and in society, legal and economic advantage, and subordination of women to men. According to the Quran, men are strong, decisive, and resolute, while women are affectionate, vulnerable, requiring the care, and support of men. A Muslim woman does not have to work, but she can. The rights and obligations of spouses are equal but not identical.

Views on sexuality (sexual intercourse, conception, pregnancy, contraception, abortion)

Islam has a positive attitude towards sex. It is perceived as something good. However, Muslim rules concerning sexual relations are very strict. Sex is permitted only in marriage. Premarital and extramarital sex is forbidden. Adultery is punishable by stoning or whipping. Islam encourages spouses to sexual intercourse which, on the one hand, is a marital duty and, on the other - an act praised by Allah. In the Muslim world, sex within marriage has its social aspect - it helps to successfully resits temptations, thus saving men from adultery and condemnation. A satisfied man will more eagerly fulfil their family, religious, and social duties. Sexual contacts between spouses are forbidden during menstruation and for 40 days after giving birth to a child. Spouses are not allowed to kiss in public. Islam prohibits anal sex and all other forms of deviant behaviours (which, according to the Muslim doctrine, include homosexuality).

In the Islamic tradition, from the moment of conception, a guardian angel watches over a new life. A pregnant woman prays to God for help and care during the pregnancy and confinement. Women wear special amulets with appropriate quotations from Quran protecting them from evil. They have a form of small bags tied to wrists, neck, or waist. From the fourth month of pregnancy, sex is not permitted. A violation of this ban is viewed as infanticide.

Strict bans apply during labour. A Muslim patient should be attended by female medical staff, if possible. Special hospital clothing covers the whole body. Exposure should be limited to the absolute minimum - sex organs can only be uncovered to examine the birthing woman. The labour position is chosen by the birthing women in advance. Whether the man is present at birth giving or not is a personal decision. During labour, Muslim women repeat the words addressed to Muhhamad: “O! the messenger of God”, and the accompanying women respond: “O! Merciful God, O Merciful God”.

According to the Islamic tradition, the crying of a newborn is proof that the baby has been just touched by Satan. When the child is born, the family may want to whisper a special prayer - a call for prayer to one ear and the declaration of faith to the other. After cutting the umbilical cord, the first word spoken to the child should be “God”. When a newborn does not require immediate medical assistance, the family should be given time to perform the rituals (usually taking a few minutes). To protect the child against the forces of evil, an amulet with verses from Quran is put on the child’s neck. The child is also bathed four times - the last time in water which has been boiled with flowers. Confinement is a period of “impurity” for a woman.

Islam encourages its adherents to enlarge their families. It is prohibited to limit the number of children unless there is an important reason for doing so. Situations

justifying contraception include concern for the life of the mother, care for health and appropriate bringing up of children, short breast-feeding period (according to Quran breastfeeding should last two years), but also a man's concern that he will not be able to support his family (fear of poverty), and the woman's wish to remain attractive if she's afraid that her husband may divorce her. All birth planning methods are permitted, provided that they do not pose any hazard to the woman or man and do not result in permanent infertility. Usually, family planning is the responsibility of a woman.

One of the primary principles of Quran is protection of new life. Hence, abortion is prohibited from the moment a foetus is given its soul, which happens approximately 120 days from fertilisation. Islam permits abortion in the following cases: rape, incest, possibility that the father is mentally ill, defects and deformations of the embryo. Abortion due to difficult financial situation or sex of the child is not permitted. Presently, Tunisia has the most liberal law in this respect, allowing abortion for any reasons, both for married and unmarried women, without the need present consent of the husband. In Algeria, Egypt, Iran, and Pakistan, on the other hand, abortion is allowed only when the woman's life is threatened.

Views on hygiene

Hygiene, both in the physical and spiritual sense, is very important in Islam. Muslims wash their hands before and after every meal. The most important obligation towards God is prayer, and prayer may be performed only in the state of purity of the body, clothing, and place of prayer. Ablution (ritual washing) is required before every prayer (which must be performed at least five times a day) and before recitation or reading of Quran. Bathing should be taken before Friday prayer and holiday prayers. Muslims must wash their genitals after urinating/defecating and take a bath after sexual intercourse. They must use water and not paper or any other material for cleaning. There are also rules concerning going to the toilet. A Muslim must enter the toilet with their left foot and, before entering the toilet, they must say the words: "Oh God, I seek refuge in You from that which is evil and dirty". They leave the toilet with the right foot, saying the words: "Forgive me".

In contacts with Muslims one must avoid yawning (Islam sees yawning as a sign of Satan); while sneezing (like in the European culture) one should cover the mouth with a hand and try to keep the sound of sneezing as low as possible. Stomach rumbling should be avoided too.

Dress code for men and women

Awrah is the term indicating the areas of the body of a man or woman which must be covered in the presence of other people. The purpose of it is to preserve

modesty and dignity of those who abide by the rule. There are different types of *awrah*, and the extent to which they must be covered depends on the relationship with the people around.

Dress code for women. Women must not dress and behave like man (or the other way round). Religion determines fashion. The rules on female clothing are provided in the Quran. The basic rule is to wear outer clothing which should not expose the figure. The *awrah* of the woman is divided into *Awrah Ghalida* (hard *awrah*) - the area between the chest (including the breast) and the knee, and *Awrah Khafifa* (soft *awrah*) – whole body except the face and hands. The soft *awrah* must be covered when the woman is in the public areas or when an unrelated man may be able to see her, e.g., on the street or the marketplace. An unrelated man must not see a single hair on a woman's head - this would mean seeing her *awrah* and committing a sin (unless there is an important reason for it - e.g., providing medical care). In private, e.g., at woman's home, but in the presence of her male *mahram*, a Muslim woman must cover her hard *awrah*, but may show her soft *awrah*. The only person allowed to see the whole body of a woman, including her hard *awrah*, is her husband.

Al-Tabarruj (the adornment). *Shariah* contains certain dress code rules that a woman must conform to in public places. She must cover her *awrah*. This also applies to adornment. She must wear outer garment, consisting of a *Khimar* – a headgear covering hair and reaching down to the chest – and a *Jilbab* – an outer garment which covers the whole body, hiding its shape. It may be made of a single piece or two pieces of fabric. Women must not wear bright colours or any clothing that would attract attention. This applies to jewellery, make-up, or anything that would produce sound while walking. Women are not allowed to wear perfume that can be noticed in public. However, when the make-up or clothes do not attract unnecessary attention, they may be worn in public.

In private, in the presence of other women or a woman's *mahram* (but not in the presence of unrelated men), a woman may wear any clothes and make-up she wants, as long as they conform to the Islamic tradition (e.g., the clothes must cover the hard *awrah* and must not imitate the garment of disbelievers, etc.). There is some controversy about the Muslim scarf or vail covering the head. Several different terms are used in Polish to refer to that piece of female clothing. The most common include hijab, chador, burqa or niqab. A popular misconception is that Quran requires women to cover their faces, while it is only prescribed that women dress modestly and do not show their adornment in public. The custom of covering the face was introduced in the 8th century by the Abbasid Caliphate. Hence, Muslim theologians and lawyers are not unanimous about that. In modern times, many women see a scarf as a symbol of their Muslim identity.

Dress code for men. The *awrah* of the man is divided into *Awrah Ghalida* (hard *awrah*) - the private parts and the bac side, and *Awrah Khafifa* (soft *awrah*) - the areas between the navel and the knee. Men are not allowed to uncover any area of their their hard or soft *awrah* in public, or in private - in the presence of other men. The same applies when a man is in the presence of a woman (including his relatives). A Muslim man may show any part of his *awrah* to his wife.

Views on health and prophylaxis

Islam is a religion caring for mental and physical balance. According to the Quran, a Muslim is healthy (both physically and spiritually) when he or she believes in God and follows the rules of God. Universal and practical rules of Islam permit good and beneficial things and forbid harmful ones. The main purpose of Islam is to prevent diseases by keeping daily hygiene and moderation in every aspect of life. According to Islamic tradition, prophylaxis includes fasting, regular prayers which, being an act of remembering God, calms the heart and engages the joints, muscles, and the spine of the praying person (physical exercising), ritual washing of the body, and pilgrimage which is supposed to free a person from daily anxieties and problems.

Nutrition and eating

Muslims divide food products to permitted (*halal*) and forbidden (*haram*). They do not eat pork (and pork products, e.g., porcine gelatine), meat of draught and domestic animals (horse, donkey, cat, dog), of predatory animals and of animals that died as a result of strangulation or have been otherwise brutally slaughtered. An animal to be eaten must be killed in accordance with ritual slaughter principles, through the draining of blood, by a Muslim saying the *Bismillah* formula. Islam sees blood as an element of life; therefore, it is forbidden to consume it in any form. Permitted meats include fish, camel, sheep, poultry, and seafood. Ritual slaughter does not apply to sea animals.

A Muslim diet is very diverse. A lot of spices are used, such as curry, cinnamon, cardamom, saffron, oregano, thyme and turmeric. Stewed vegetables with sauces, pastes, and salads are prepared from cucumbers, tomatoes, aubergines, peppers, courgette, green peas, onions, parsley, and chickpeas.

Manners of eating are very important in the Muslim tradition. Food is eaten using three fingers of the rights hand, which are licked afterwards. Using a fork and knife is not forbidden. When they are used, the fork is held in the right hand. Muslims must not eat with their left hand, as it is used for hygienic acts. When the right hand is not fit or is immovable, a Muslim must be fed by another person, using the right hand. Another rule is taking from the plate the food that is the closest to one's hand, and not from the middle of the plate. This rule stems from the belief

that blessing is sent to the middle of the plate and, therefore, this part of the food should be eaten at the end of the meal. This is an important rule that should be respected when feeding a person who cannot eat on their own. One should not be lying when eating; therefore, a Muslim patient will try to sit up during meals. Muslims must not waste food or eat too much. Muslim patients may request permission to be brought meals by the family or friends from home or a Muslim restaurant.

Fasting is viewed as a way to purify the body and soul. During Ramadan, Muslims do not eat or drink from dawn to dusk. According to this tradition, a meal should be eaten before dawn. Sick persons as well as pregnant and breastfeeding women are exempt from fasting (they should fast later). Medications absorbed through the skin, rinsing/gargling, injections, and blood collection are not considered as breaking the fast, but taking ear or nose drops, rectal and vaginal suppositories, and inhaled medications are.

Sickness and Death

A disease is viewed in Islam as an opportunity to repent for one's sins and, thus, to achieve eternal life. Islam recommends patience in enduring life's difficulties and illnesses. According to Muslim ethics, whoever has found themselves in a difficult situation because of age, illness, or accident, will receive support. The Quran calls upon adherents to care for the sick and disabled members of their families.

When staying in hospital, a Muslim patient will have many visitors from the closest family, relatives, friends, and acquaintances. Praying five times a day is an obligation of every Muslim. During sickness, they expect to be able to have a Quran and Misbahah (praying beads) with them, to have access to running water to wash before praying (if their condition allows), and a place to put their praying rug to be facing the direction of Mecca while praying. They will also expect that they are granted peace and quiet for praying (which usually takes 10–15 minutes). When a Muslim patient is not able to pray, the family may bring them an electronic device, playing the recorded verses from Quran or read the verses aloud to them.

Although it is not mandatory, for religious reasons many Muslim families prefer that women are treated and attended to by women and men are treated and attended to by men. Muslims (particularly women) avoid unnecessary uncovering of their body during a medical examination. Like with any other patient, doctors and nurses should always obtain a patient's consent to any medical and care procedure and inform the patient in detail on the nature and scope of the planned procedures. Particularly, when a forbidden area of the body is involved - whole body (except face and hands) for women, and the area between navel and knees for men. It is recommended that during examination or treatment of a Muslim woman, she is accompanied by a family member or, if this is not possible, by some other woman.

Healthcare professionals should avoid physical contact or limit it to the necessary minimum, and when such contact is necessary, the patient must be informed why.

Although suffering and pain in Islam are viewed as the will of God and should be endured, painkillers (including those based on narcotics) are permitted, if the patient's condition so requires. Consumption of alcohol in a medication is forbidden, but it can be used for disinfection.

Muslims are not allowed to reject medical treatment. All life-saving treatments and procedures are permitted, although futile medical care should be avoided. Euthanasia is prohibited.

Treatment with the use of blood and blood products is permitted. Muslims accept blood transfusion and organ transplantation. Blood and organ donation is seen as an honourable act because it is done to save life, although it is permitted only when there are no alternatives. A decision concerning transplantation is a personal one; however, certain medical conditions must be met.

A dying Muslim tries to lie on their right side, facing the direction of Mecca, and if it's not possible, on their back, with the face and foot soles facing the direction of Mecca. This is a very important tradition for Muslims and their families; therefore, it should be respected. The tradition requires that a dying person be accompanied by the family who is praying for them and reciting the verses from Quran. After death, the body is washed on a special plank by a family member of the same sex. It is a very important religious ritual. Therefore, when the deceased has no family or friends, the hospital should notify the nearest Muslim centre, which will send a person to wash the body of the deceased. If the nature of the disease does not allow washing, the water is poured on the diseased. The body is wrapped up in a plain white linen shroud and carried to the mosque, where funeral services will be performed. If it is not possible, the funeral ceremony takes place at the cemetery. It is believed that a Muslim should be buried within three days of death, but some Islam adherents believe that it should be within 24 hours, preferably before sunset. The deceased is buried with the face directed towards Mecca.

Autopsy is viewed by Islam as an act of disrespect for the deceased (violation of body). However, it is acceptable when needed to establish the cause of death, to protect the public health, or when it is required by law. In such case, it must be performed in a specially designated place inaccessible for unauthorised persons. The prior consent of the family is needed to perform the autopsy. Funeral prayers should be said before the autopsy. After autopsy, all body parts must be collected and duly buried.

Communication and information sharing

Basic knowledge on religious beliefs and information from the patient on daily practices will help to provide them with culture-sensitive and competent care. When communicating with a Muslim patient, one should free oneself from stereotypes and prejudices, which prevent the objective perception of others and discourage dialogue.

A medical interview is an opportunity to gather information about the patient and their health condition, but also about their family and social situation. It is worth asking the patient what the diseases means to them and what, in their opinion, is the cause. Such questions help to gather information useful in diagnosis and selection of treatment. It is also helpful in explaining the available treatments and procedures and in agreeing on the treatment plan acceptable for both sides. It is crucial that the patient understands the questions and instructions of the medical staff; therefore, it is worth using interpreters. For confidentiality reasons, it is better to avoid situations where a family member or a friend of the patient acts as an interpreter. All instructions should be communicated in clear and plain language. The patient may be asked whether they understand the instructions or to repeat the instructions using their own words. When talking to a person from a different culture, it is worth using non-verbal communication and body language. Medical staff should speak slowly and clearly, directly addressing the patient. They should use short sentences and speak in a normal voice. Avoid idiomatic expressions, a raised voice or difficult words. Some patients may nod, even if they don't understand what is being said to them. Out of embarrassment or respect, they may not ask for the information which is important to them. Hence, it is necessary to always make sure that the patient understands the instructions given by medical staff and accepts the proposed treatment. Possible sources of culture conflicts between the patients and medical staff include different understanding of time, personal space, body language, and system of values. Some patients may avoid eye contact with medical staff, particularly those of the opposite sex. This is based upon the principle of modesty that Muslims should confirm to and upon the obligation to show respect to persons having higher social rank. Some Islamic groups forbid touching those of the opposite sex, and this prohibition also applies to a handshake. When the patient and medical staff speak the same language, it is important to be aware of one's own manner of communication, to respect the beliefs and opinions of the patient, and be attentive.

Summary – major issues relevant for providing medical care to a Muslim patient

- Basic knowledge about Islam is important in providing healthcare to a Muslim patient. Detailed information on the patient's daily practices will enable medical staff to respect their spiritual needs, the need for privacy, and to preserve modesty.
- When talking to a person from a different culture, it is worth using non-verbal communication and body language. It is crucial that the patient understands the questions and instructions of the medical staff; therefore, it is worth using interpreters. For confidentiality, it is better to avoid situations where a family member or a friend of the patient acts as an interpreter. All instructions should be communicated in clear and plain language.
- Medical staff should speak slowly and clearly, directly addressing the patient. They should use short sentences and speak in normal voice.
- Avoid idiomatic expressions, a raised voice and difficult words.
- It is necessary to always make sure that the patient understands the instructions given by medical staff and accepts the proposed treatment.
- Possible sources of culture conflicts between the patients and medical staff include different understanding of time, personal space, body language, system of values. Some patients may avoid eye contact with medical staff, particularly those of the opposite sex.
- When the patient and medical staff speak the same language, it is important to be aware of one's own manner of communication, to respect the beliefs and opinions of the patient and be attentive.
- Whenever possible, a Muslim patient should have a single room with no Christian symbols (cross or holy pictures).
- Prayer is very important in the life of a Muslim. Muslim patients should be provided with the appropriate conditions to pray, a place to put their praying rug, and a place to put the Quran.
- To facilitate praying, the patient should be informed of the daily routines; any procedure should be postponed until the patient finishes their prayers.
- Do not remove any ornaments having religious significance from the patient's body unless the procedure to be performed so requires (surgical or diagnostic procedure).
- The obligation to preserve modesty is of utmost importance in Islam. Muslim men and women may not wish to have any physical contact with a person of the opposite sex or uncover their body in the presence of a person of the opposite sex. The best solution will be to ensure medical staff (physician, nurse, physiotherapist) of the same sex and if this is not possible, a conver-

sation with the patient may be helpful, to express one's understanding of and respect for their views concerning the body.

- Healthcare professionals should avoid physical contact or limit it to the necessary minimum, and when the contact is necessary, the patient must be informed why.
- Islam forbids unnecessary touching among unrelated adults. One should avoid touching (with affection) the head of the patient, because the forehead is used in the daily prayers.
- It is a duty of a Muslim to visit the sick in hospital; therefore, they must be provided with such possibility, taking into account, however, the patient's need to rest.
- The Muslim women's right to wear clothes covering the whole body, including the head, neck, shoulders, and legs, must be respected.
- In the case of female Muslim patients, all information concerning nursing care and treatment must be provided to the patients and her father or husband.
- A Muslim patient giving birth to a child should be attended by female medical staff, if possible. Exposure of her body should be limited to the absolute minimum; the labour position is chosen by the birthing woman in advance.
- After cutting the umbilical cord, the family may want to whisper a special prayer to the ears of the child. When a newborn does not require immediate medical assistance, the family should be allowed to perform the rituals (usually taking a few minutes) and bathe the child four times.
- The state of ritual purity is achieved by means of ablution. Muslim patients should be given the possibility to perform ritual washing of the face, hands and feet before the prayer or reading the Quran (including bed-ridden patients).
- Purity is a very important religious concept for the Muslims; therefore, they should be given the possibility to wash their hands before and after every meal and before praying. They should be also able to wash their hands and perineum/rectum after using the toilet, urinal, or bedpan (also the bed-ridden patients).
- Fasting is an integral part of Islam. It purifies the body and soul. This issue should be discussed individually with the patient. When breaking the fast, it is important for successful treatment that the patients and their family should be informed and recommend postponing the fast until recovery.
- It should be remembered that medication absorbed through sthe kin, rinsing/gargling, injections and blood collection are not considered as breaking the fast.
- It should be remembered that taking ear or nose drops, rectal or vaginal suppositories or inhalation medications is considered as breaking the fast.

- It should be remembered that Muslims do not take pills containing gelatine and medications containing alcohol.
- Peripheral venous access in the left arm should be avoided.
- Muslims divide food products between permitted and forbidden. All issues concerning food preferences should be discussed individually with the patient. When it is not possible to prepare the meals complying with Islamic tradition at hospital, the family should be allowed to bring the meals prepared at home.
- The rules on preparing meals are very strict. Meals should be prepared using separate dishes and kitchen utensils. Kitchen staff should be informed that they are preparing food for a Muslim patient and conform to the rules.
- The manner of eating is very important in the Muslim tradition. It is important to enable the patient to take the appropriate position during meals, i.e., sitting position.
- Eating with the left hand is forbidden as it is used for hygienic acts. When the right had is not fit or is immovable, a Muslim patient must be fed by another person, using the right hand.
- Muslims believe that a blessing is sent to the middle of the plate and, therefore, this part of the food should be eaten at the end of the meal. This rule should be respected when feeding a Muslim patient.
- When the patient is unconscious, if possible, their bed should be placed so that they are facing the direction of Mecca. The family should be able to accompany a dying patient to recite the Quran to them.
- Muslims may not wish that their deceased loved ones be touched by persons of another faith or of the opposite sex.
- Family should be given the possibility to wash the body of the deceased.
- A funeral should take place within 24 hours; cremation is forbidden; an autopsy is acceptable in specific situations. APrior consent of the family is needed to perform the autopsy. Funeral prayers should be said before the autopsy.

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2.1.4. Hinduism

Hinduism is the third largest religion in the world. Its various denominations have more than one billion worshippers, most of them living in India and Nepal. It is estimated that in 2020, the number of Hindu adherents will exceed 1.1 billion versus 1 billion in 2010 (15% of the worldwide population). In 2010, the Hindu population in Poland, the Czech Republic and Bulgaria was < 10 thousand and is expected to remain at this level in 2020 and in 2030.

Hinduism is the oldest known religion on the subcontinent. The term encompasses several beliefs and separate religions, so it is not a single uniform religion of India, but a general term denoting a group of related but varied religious systems originating in the territory between Pakistan and Bangladesh. It does not have a founder, dogmas, rituals, or a depository of faith that would be recognised by all inhabitants of India. Every era has left its trace in it, preserved in beliefs and religious practices of the Hindu. It has been shaped by various factors. Its beginnings are closely connected with the arrival of Arya people and their settling on the Hindu land, approximately two thousand years before Christ. The Aryas believed that certain writings contain sacred knowledge (Vedas). These foreign elements were assimilated by the religion of the settlers which, with time, under the influence of other religions, accepted or rejected further beliefs and practices. Additionally, the unique location of the Indian subcontinent, its geographic features, customs and the beliefs of numerous diversified peoples living there and new conquering peoples arriving had an enormous impact on shaping of Hinduism. It evolved from continuous accumulation of elements of different origins and sources.

Overview

Hinduism is a conventional term commonly used by European specialists in religious studies. In India, the term denoting what people in the West understand by religion is *sanatana dharma*, meaning: "eternal order". Hinduism is a set of related beliefs, cults, views, laws, and norms of conduct. Its adherents share:

- respect for the holy books - Vedas,
- belief in reincarnation (a soul, after the death of the body, may be reborn in another living creature),
- belief in karma (law of cause and effect),
- pursuit of liberation.

The Holy Books of Hinduism

The books believed to contain revelations are called Vedas ("sacred knowledge"). They are crucial for today's spirituality of Hinduism. There are four sets of Vedas:

- Rigveda – a collection of hymns recited during sacrifice offering rituals
- Yajurveda – a collection of writings connected with sacrifice rituals
- Samaveda – a collection of chants connected with sacrifice rituals,
- Atharvaveda – a collection of magical prayers and hymns for private cults.

It is worth noting that Hindus do not separate private life from religious life as clearly as, for example, in European culture. A Hindu's life is dominated by rituals. Apart from an extensive calendar of feasts, a Hindu may receive as many as forty religious rites (*sanskara*) at various points of life, from birth to death. Hinduism assumes that every creature has a soul which, after death, is reborn in another living

creature – it can be an insect, animal, human being, etc. The Hindu society is divided into classes (varnas). The highest class is formed by the Brahmins (priests). Then, there are the Kshatriyas (warriors, kings, officials); the Vaishyas (merchants); and the Shudras (labourers). Individual classes are subdivided to castes and subcastes. A caste determines the person's place in society, marriage possibilities, and even the types of food that one may consume. Although the division into castes has been officially banned in India, it is still deeply rooted in the mentality of the Indian people. According to the Law of Karma, our present life is the consequence of our earlier incarnations. On the journey of soul, the perspective of moving between the castes is possible, but only as a result of Dharma - the rules and duties that differ from one caste to another. The belief in some supreme order imposed on people, which must be observed to have a chance for future "advancement", results in humble endurance of social constraints. Dharma plays a pivotal role in this religion. It is a set of Karma laws, natural and universal rules leading to happiness and enlightenment. And it is these laws and rules that have an undeniable and decisive influence on the lives of Hindu adherents.

Woman and Man

A woman's position in India depends on her social rank, education, caste, ethnicity, and religion. Apart from the above, it is also to a considerable degree dependent on the man and his open-mindedness in accepting the changes taking place in the world. When the man realises and understands the need to change the social status of women, his wife and daughters will be treated with due respect. But in a traditional family, deeply rooted in patriarchal values, a woman is still perceived as a dependent person, fully subordinated to the will of men and viewed as a burden. Because rural communities are more traditional, the situation of women there is much worse than in the cities. Regrettably, the ancient Law Code of Manu, stating that a female child should be under the care and control of her father and a grown-up woman of her husband and, when widowed, of the eldest son, is still respected. Although presently women in India try to emancipate themselves, still young women are not supposed to be on their own, particularly in male company, as this may cause doubts as to their morality. Therefore, mainly men emigrate from India. It is a common belief that women fulfil themselves best taking care of the house and bringing up children. Although the constitution of India guarantees equal rights to men and women, they are strongly affected by tradition. Patriarchy dominates all spheres of life - work, family, public rights, and even religion. Schools are attended mainly by boys, and girls usually stay at home. Men sit first at the table. A woman can eat only after men have finished their meal. The wife can never eat together with the husband. Moreover, when the food is scarce, only men get it. In

Hinduism, a menstruating woman is impure and should stay in isolation. Women are also prohibited from participating in religious ceremonies during the first four days of the cycle. Menstruating women should also keep a special diet, sleep under warm cover and should not bathe. In India, a woman is first owned by her father, and after marriage by her husband. In accordance with tradition, a young wife moves to the house of her husband, where the head of the family is the mother-in-law, and this is where the nightmare starts for her. She is often treated as a stranger, as a useless person who is a burden for the family pantry, subjected to psychological and often also physical torture. Quite a common form of humiliating of a woman is throwing kerosene on her, which leads to burns and death. Burning is the cause of many unnatural deaths of young women. The situation of a young wife gets even worse when she gives birth to a daughter, particularly in rural areas where the birth of a girl is seen as a considerable burden for the family. In Hinduism, a woman plays an important role in the family because only she can bear children. However, she is often treated as a servant and performs the worst household jobs. The situation of abandoned wives is also difficult - they have to raise abandoned children on their own, are often harassed and humiliated, and often become victims of rapes and extortions.

A man is the head of the family and the most desired descendant. Sons are expected not only due to the inheritance rights (presently daughters also enjoy inheritance rights), but also because in Hinduism only a son, never a daughter, can continue the cult of the ancestors, which is very important for the Hindu. The tradition requires that the eldest son takes care of the parents, so he usually stays in the family house or takes over the family business. Therefore, sons are more valued than daughters. It is also the reason why in India there is a tradition to address a woman with the word “son” instead of a “daughter”. This is how (usually) an old man shows respect to a young woman. Similarly, when the first-born is female, the parents call her “son”.

Views on sexuality (sexual intercourse, conception, pregnancy, contraception, abortion)

There are many different attitudes to sexuality in Hinduism, from acetic, through moderate approval, to affirmation. In the past, sex was seen as a source of pleasure and fertility. Eroticism is strongly present in Hindu mythology. Modern sexual life is constrained by numerous norms and rules. It should be limited to marriage, which must be monogamous and based on mutual fidelity. Public demonstrations of feelings are prohibited and punishable by a fine or imprisonment. Umbrellas and newspapers are not permitted in municipal parks because young couples could hide behind them and kiss.

In 2018, the Supreme Court of India issued a decision that homosexuality is not an offence and is not punishable. However, there are no laws forbidding discrimination of homosexuals. India is not a tolerant country when it comes to sexual minorities. Only heterosexual relationships are accepted by society, while homosexual ones are condemned.

Conception, pregnancy, and birth are parts of the life and death cycle. To beget and raise a descendant is the basic duty of the wife and husband. In the past, women were supposed to prepare for pregnancy by eating special food symbolising fertility. Pregnancy in Hinduism is a special time, which is evidenced by the fact that the age of a person is counted from the moment of conception. Before labour, to help the birthing woman, all knots in the house should be untied. This is supposed to make the childbirth easier and prevent complications. The first religious rite (*Jatakarman*) is performed just after birth. The father of the child cuts the umbilical cord and whispers the words of a special mantra to the child's ear, asking for long life and wisdom for the child. Moreover, as a sign of acknowledging the child, he touches his/her forehead. A newborn's mouth is touched with a mixture of honey and butter, which is to bring the child happiness. Particularly important is the ceremony of the first breastfeeding. There is a lot of controversy among doctors and midwives concerning the traditional Hindu lotus birth, where all the processes related to detachment of the child from the placenta occur naturally and spontaneously. After the birth, the umbilical cord is not cut and clamped, but left until it dries and falls off by itself (usually within three and 10 days). This type of labour is most commonly practised in the case of home births, but may take place in hospital. After the baby is born, one must wait for ejection of the placenta. Ejecting the placenta may help to start breastfeeding, as it stimulates the release of oxytocin which, in turn, stimulates uterine contractions. The placenta is then put in a bowl and placed near the child (even for 24 hours after birth). It is important that the placenta is placed at the same level as the baby or higher as long as the cord is pulsating, which means that the blood is being pumped from the placenta to the baby's organs. Then, the placenta is delicately rinsed with warm water to remove any blood clots, and lightly dried with a towel. Remains of foetal membranes attached to the placenta should also be rinsed and dried. Then, the placenta is placed on a sieve lined with a piece of muslin and left until dripping stops (usually one or two days after birth). The placenta and remains of the foetal membranes may be rubbed with soil to speed up the drying process. When in a sieve, the placenta should be covered with a piece of muslin or other natural fabric. The cover should be replaced at least once every 24 hours or when it becomes soaked. When the dripping stops, the placenta should be put in a bowl filled with Ringer's solution. The mother must be very careful when feeding or hugging the baby. The

baby should be dressed loosely, with clothing that opens at the front. Some children show anxiety or interest when the placenta or the umbilical cord are taken care of. It is worth describing to the baby what is being done. When the child position needs to be changed, the cord may be damped in one place to make it more flexible. It will dry by itself. Another method is to wrap up a fragment of the cord with a damp piece of cloth to keep it flexible and make it easier to take care of the baby. Parents claim that when the babies remain attached to the placenta, they are calmer. After detachment, they become more interested in the world around them. There have been instances of babies leaving the hospital with the attached umbilical cord in Poland. The decision is made by the parents, and there are hospitals which respect their choice. Propagators of the lotus birth emphasise the spiritual aspect of it. They also claim that such children are calmer and more composed, less prone to stress and anxiety, have greater self-esteem, better immunity, and their emotional relationships are characterised by greater stability. Opponents point to the health risks involved in leaving the placenta.

An important element of caring for a child in Hinduism is massage. It is believed to be beneficial for the physical and mental development, to stimulate the baby's immunity and strengthen the bond between the mother and the child. The massage is performed with the use of almond or sesame oil which contain A and E vitamins absorbed by the child through the skin.

The Hindu attitude toward contraception is very complex. The reason for it is the deep heterogeneity of the religion and evolutionary character of many of its beliefs. In the Hindu tradition, family planning meant seeking ways to enhance a woman's fertility, hence the use of contraceptives was stigmatised. In modern times, efforts to limit the number of children and keeping the family rather small have religious value. Contraception, both natural and pharmacological, is, therefore, permitted.

Most Hindu adherents do not accept abortion, even in the case of a rape, deformation of the foetus, etc. Abortion, as an external intervention, is considered a crime in the light of the religious law, although India, as a secular country, does not prohibit it. As a result of the development of medicine, Hindu scientists begin to consider lawfulness and acceptability of some pre-natal diagnostic procedures and tests, including early determination of the unborn baby's sex. The reason for this is discrimination against girls. With common access to ultrasound devices, parents may easily check the baby's sex and sometimes choose abortion. Hindu law forbids revealing the sex of an unborn child to the parents, but the persons performing the procedure know how to evade this rule.

Views on hygiene

The life of Hindu adherents is to a large degree dominated by rituals. They perceive the world around them from the perspective of ritual purity and impurity (being tainted). This division determines even the order of daily activities. After every work which may involve contact with tainting substances, objects, or persons, one must wash. Water has purifying qualities, not only in the physical sense. Hindu wash even several times a day. In the morning the streets are full of people smelling of coconut oil rubbed in their damp hair. But they often wash in ponds or on the streets - in buckets or by a water pump. It is much easier for men, as women have to "wash" in clothes, often before dawn, in a rush, hiding from others. Almost half of India's population have no access to water. There are not enough bathrooms and toilets. Even in the cities, people often have to use water pumps and share toilets. Regrettably, in a society literally obsessed with ritual and physical purity, every fifth Hindu woman has no access to running water, and only 2% of women living in rural areas use menstrual pads. The incidence of diseases caused by lack of hygiene and of easily avoidable infectious diseases is much higher in India than in other underdeveloped countries.

Dress code for men and women

Presently, many India inhabitants wear traditional clothes in everyday life, not only on special occasions.

The traditional Hindu garment is called a *sari*. It is a several meter long stretch of cotton or silk fabric. There are many ways to wear *sari*, but the most popular is wrapping up and draping part of the fabric around the waist to cover the legs and draping the remaining part over the shoulder to cover the breasts. The edges of cotton *sari* often have a decorative stripe. More expensive *saris* worn on special occasions are often made of silk with metal threads. A *sari* is usually worn with a petticoat and a top (*choli*). A *sari* is not worn by women throughout India. In the north, a *sari* is used on special occasions. Young girls normally wear trousers and a knee-long or even ankle-long shirt (*shalwar kameez*) or European-style clothes. A *shalwar kameez* is usually worn with a long scarf or shawl called a *dupatta*. A Hindu women's attire also includes small elements indicative of her social rank. A *bindi* ("holy dot" or "red dot") is a characteristic mark worn on the forehead. It is a sign that the woman is under the protection of the father or husband. It is usually red, made with turmeric or saffron. In northern India, a red dot on the forehead means that the woman is married, while in the south, it is usually worn by young unmarried women. The location of the mark is very important - according to the Hindu tradition, the place between the eyebrows is the location of the most important *chakra* (one of the focal points of energy in human body). A *bindi* is supposed to prevent

the person from losing energy. A traditional mark of a married woman is *sindooram* - a red coloured powder worn along the part of her hairline.

Unlike women who adhere to the tradition, most Hindu men prefer western clothes. Popular traditional male garments are *dhoti* or *lungi*. *Lungi* is a non-formal piece of clothing in the form of a long stretch of fabric wrapped around the waste. *Dhoti* is similar to *lungi*, only it is wrapped around the waist and then between the legs. It is usually made of light-coloured fabrics. The Hindu consider it to be more formal than *lungi*. Pyjamas-like trousers (lenga) are a daily garment, but since they are worn mainly by workers, they are not the right choice when e.g., paying a visit. Wearing a turban is quite popular among men, particularly in rural areas. In India, there are no rules requiring men to take off their headgear when entering a place. Tearing a turban from one's head is a form of humiliation. The way a turban is wrapped, its colour or even pattern is often an indication of the region the person comes from or their caste.

Views on health and prophylaxis

There is no single view on health in Hinduism. For yogis, a healthy and fit body is very important, because any illness could disturb meditation; therefore, they care for their health and body and use various methods to detoxify it. Natural medicine, based mainly on herbs, is very rich in Indian culture. Very popular is Ayurveda healing (recognised by WHO as an equivalent concept of health and therapy), based on the idea of preservation of the balance between the forces of life and components of human body and the surroundings. Unreasonable eating habits, inappropriate activity of the body, sexual habits or strong emotions may cause illness. A therapeutic method based mainly on a diet, called *siddha* is popular in Southern India.

Nutrition and eating

Eating. Hindu differentiate between two types of food - *kacca* and *pakka*. *Pakka* is processed food, the food which was boiled or cooked using fire, fat, or hot water. *Kacca* refers to eating raw products, e.g., fruit, and therefore is eaten only at home. It is believed that *pakka* is safer, hence the risk of tainting another person or even passing one's bad luck on them is smaller. Food that has been touched by the lips of the eating person can only be eaten by that person. It should not be given to another. This is why a Hindu does not touch the dish or bottle with their lips when drinking. The container remains clean, and others can use it. Hindu scriptures recommend a vegetarian diet, but adherents are free to choose their own. Those who eat meat, abstain from pork and beef. Tea and coffee is permitted, although many Hindu believe that coffee dulls the mind. The most orthodox members of the highest caste - Brahmins - do not eat onion and garlic. Hindus don't eat mushrooms, and often also tomatoes and potatoes. Drinking alcohol is strictly forbidden. The

already mentioned division into castes also determines what can be eaten by members of a given caste and in whose company. Persons of the higher caste must not take food and water from lower castes. There is also a special diet for menstruating women. It is composed of dry products, mainly rice and salt. Indian cuisine varies from region to region. In the north, people eat more meat and wheat products, while in the south, vegetarian dishes are more common, based on a great variety of rices. Rice is sticky, because traditionally Hindus eat with their right hands, without using cutlery. India is a kingdom of spices. It would be hard to find an Indian dish with less than ten different spices in it. Hindu cuisine is rather salty. One should remember that serving food and drink to a Hindu with the left hand may be perceived as disrespectful or even ominous.

Sickness and Death

Sickness and treatment. Hindu patients, particularly from lower castes, may be reluctant to accept western methods of treatment out of fear that, if they oppose karma from administering justice, it may return to them in another life with a vengeance. A Hindu male patient would like their family to visit them during the stay in hospital, to help him in making decisions concerning treatment, like consenting or not to a surgery. A Hindu woman is unlikely to have any special requests and would like to consult her husband on all medical decisions. Both private and public hospitals in India allow families of patients to visit them, and a selected member of the family may even stay at night in the same room with the patient. They assist the patient with hygiene and eating and are authorised to make decisions concerning therapy. The role of nurses is limited to administering medications and performing basic medical procedures. For a Hindu patient, meals prepared collectively for numerous patients may be a serious issue. Moreover, if they are enthusiasts of Ayuverdic healing, they believe that an illness is simply a sign of imbalance in the body and requires clearing the energy channels. For that purpose, they perform special massages with the use of coco and almond oils. Also important is restoration of mental balance. This is achieved through *shirodhara* - gentle pouring of warm oils over the forehead, followed by a head massage. A special diet is also required, excluding animal products, coffee, and tea. The rules on eating applicable in the case of specific illnesses are divided into two groups: fruit and vegetable having a chilling and warming effect on the body. Meals are prepared in special tin dishes. Once prepared, the food must not be warmed up.

In Hindu culture, shoes are often taken off when entering a house, place of cult, and some other places. When visiting a patient, Hindu visitors may choose to take their shoes off before they enter the patient's room. If the patient is older than their visitors, the visitors should remain standing unless they are offered a seat by the

patient. Respect for the elderly and close family relations is deeply rooted in Hindu religion. Gesture in very important in communication in India. Many gestures are incomprehensible for the Europeans - they may look similar to what we know but mean something completely different. It should be remembered that in the presence of a Hindu, all actions must be performed with the right hand. The right hand is used to give food and drink, while the left one is used to remove impurities and in the toilet. It is particularly important not to touch food or other people with the left hand. Showing one's foot soles to another person is an act of disrespect, and so is pointing with a finger. To show something to someone or draw their attention to something one should use whole arm or the chin. A clenched fist with a thumb up is a sign of disapproval. A straightened little finger is a sign that the person needs to use the toilet or has just used it, and one should not give them their hand. Many Hindu people greets others in a European style (with a handshake). However, a traditional Hindu greeting showing respect and good manners is a bow with the hands placed on the chest, with the index fingers pointing upwards. The sign of utmost respect is touching someone else's feet (an impure part of the body) and then one's own forehead (the purest part of the body).

While staying in hospital, a Hindu patient's religious practices may take the form of prayers, meditations, or reading holy books. A small picture or figure of a god may be used for praying. Preferably, a praying person should be facing north or east, but it is not mandatory. Attention should be paid to threads on the patient's wrist. They are usually white, orange, or red. They are the sign of a sacrifice made in a Hindu temple or having gone on a pilgrimage. They must not be cut, because they are considered sacred. They may be untied only with the consent of the patient or their family. When taken off, they must not be thrown away, but given to the family. Most of the religious feasts are celebrated in accordance with a specific aspect of divinity worshipped by the patient or their family. A Hindu belief in karma is the source of reluctance to improve one's living and interfere with the suffering resulting from the illness. Intubation, artificial feeding, and other forms of futile medical care may be seen as contrary to Hindu beliefs. Palliative care, however, is accepted in the religious tradition, as it leads to a natural death.

In Hinduism, ethical issues concerning euthanasia are in agreement with classic and folk religious traditions. However, Hinduism does not have a single code of rules of ethical conduct. The rules have always been flexible and freely interpreted by local communities. Two major characteristic concepts have to be considered in the Hindu approach to voluntary and active euthanasia - namely karma i dharma. Karma is the key to understanding the Hindu approach to euthanasia. Dharma is moral and ethical law, which must be abided by to ensure oneself prosperity in the present life and after death. One of the foundations of Hinduism is a belief in rein-

carnation and the journey of souls continuing until ultimate liberation from repetitive existence. Therefore, euthanasia, as any other form of shortening one's life, is prohibited. Dharma assigns duties and obligations, karma binds a person with them. Every person should live a life which will earn them a better incarnation in subsequent life. By taking their life in the present incarnation to escape from suffering, a person deprives themselves of the possibility to achieve a higher spiritual level and brings bad karma. The Hindu tradition does not approve of mercy killing, aided suicide, or suicide. The only form of suicide permitted by Hinduism is self-starvation or self-suffocation by withholding one's breath, practised by Brahmins to achieve nirvana. Hinduism also objects to the artificial prolongation of life as it only prolongs suffering inherent in every existence. A human being should be allowed to die in peace.

Hinduism lacks affirmation of physical life which is not perceived as valuable. Instead of celebrating the joys of present life, which are not worthwhile, one should focus on development of the spirit of goodness. Hinduism has no clear views forbidding transplantations of organs taken from dead donors. However, knowledge about the nature of transplantology is very low in India. Frequently, families of the deceased do not consent to taking organs for religious reasons.

A Hindu would prefer dying at home. However, death in hospital is acceptable if cannot be avoided. A dying patient may prefer to be alone, with his family, priest, or Guru (if possible). In religious terms, death may be either good or bad. A death is good, both for the dying person and their family, when the dying person has had the time to prepare themselves for death, when it occurs at the right astrological moment, and when it is accompanied by appropriate rituals. A bad death will have permanent ramifications in future lives and unfortunate consequences for the family (such as bad lack, nightmares, infertility). It will take them years to offset bad death with retributive rituals. A bad death is sudden death, death with excessive bodily fluids, or death accompanied by poorly performed rituals. The place of death also matters. The most preferable is death in the holy city of Benares near the Ganges River, but if that is not possible, a dying person will be lowered to the floor to avoid the area between the ceiling and floor. Family members place a light near the head of their loved one. Interrupting the process may have eternal consequences because it will affect all future births. Just before death, religious Hindu put a leaf of tulsi (holy basil) and a few drops of water from the holy river of Ganges in the mouth of the dying person, believing that it will help them to pass to another incarnation. For the Hindu death is a part of life. This is why the ritual of passing is so important for them. After death, the body is cremated in a temple. Before cremation, it is anointed with oils, wrapped up in sheets and flowers, and then placed on a funeral pyre. Burning the body is accompanied by mantras. Artificial prolon-

gation of life is an individual decision. However, it is common in the Hindu tradition to allow nature to take its natural course.

In Hinduism, every organ is an integral part of the body, which should be cremated immediately after death to accelerate the process of leaving the body by the soul. For this reason, families are very reluctant to consent to autopsy. An autopsy is performed upon court order.

Summary – major issues relevant for providing medical care to a Hindu patient

- Basic knowledge about Hinduism is important in providing healthcare to a Hindu patient. Detailed information on Hindu daily practices and customs will enable medical staff to provide professional healthcare while respecting their spiritual needs and the need for privacy.
- One must be aware of the religious beliefs and practices (rituals and rites) of patients to enable them to perform their religious activities while in hospital (lighting a lamp, saying prayers, chanting mantras).
- When performing religious activities, patients should be granted privacy and should not be disturbed until they complete their rituals/prayers (unless absolutely necessary).
- A Hindu patient would like their family to visit them during the stay in hospital, to help them in making decisions concerning treatment. A patient should be given such possibility, taking into account, however, the patient's need to rest.
- Do not remove any ornaments having religious significance from the patient's body unless the procedure to be performed so requires (surgical or diagnostic procedure).
- Moreover, attention should be paid to the threads on a patient's wrist. They are the sign of a sacrifice made in a Hindu temple or having gone on a pilgrimage. They must not be cut, because they are considered sacred. They may be untied only with the consent of the patient or their family. When taken off, they must not be thrown away, but given to the family.
- Gesture in very important in communication in India:
  - It should be remembered that in the presence of a Hindu, all actions must be performed with the right hand (one should not touch other people with the left hand);
  - Showing others one's feet soles, pointing with a finger and clenching fists with a thumb up are gestures carrying a negative message; in order to draw one's attention to something, one should use the whole arm or a chin;

  - A straightened little finger is a sign that the person needs to use the toilet or has just used it – and one should not give them your hand;
  - A bow with the hands placed on the chest, with index fingers pointing upwards, is a sign of respect and good manners in the Hindu tradition;
  - A sign of utmost respect is touching someone else's feet, and then one's own forehead;
- A Hindu female patient would like to ask her husband for advice on all medical decisions. It is vital that she is given this opportunity;
- Women's right to wear elements indicating their social rank should be respected (*bindi* – red dot, *sindur* – red powder in hair).
- Hinduism, a menstruating woman is impure and should stay in isolation during menstruation. Menstruating women should also keep a special diet, sleep under warm cover and should not bathe.
- In India, the first religious ritual is performed just after birth. All Hindu rites, whether stemming from tradition or religion, should be allowed, unless the mother's or child's life is threatened.
- In such case, the family should be able to stay with the patient and all their rituals should be allowed and respected. Medical staff should avoid entering the patient's room and interrupting the prayers.
- The right to umbilical non-severance birth should be respected. The decision is made by the parents (there are hospitals which respect their choice).
- An important element of care for a child in Hinduism is massage with an almond or sesame oil. If possible, the mother should be allowed to do it while still in hospital.
- For patients believing in Ayuverdic healing, an important issue will be to be able to perform in hospital a special massage with a coco and almond oil and *sirodhara*. They also have a special diet - this issue should be discussed with a patient individually.
- Most Hindu adherents have great respect for food. Meals prepared collectively in the hospital may be a problem for them. All issues concerning food preferences should be discussed individually with the patient. When it is not possible to prepare appropriate meals in the hospital, the family should be allowed to bring the meals prepared at home.
- All Hindu dos and don'ts should be respected, including those concerning prohibited food products. When the patient's condition allows that they abstain from certain products, a hospital dietitian should compose their diet in such a way as to ensure that they do not get any food products which they cannot eat for religious or traditional reasons.

- One should remember that serving food and drink to a Hindu with the left hand may be perceived as disrespectful or even ominous.
- A Hindu belief in karma is the source of reluctance to improve one's living and interfere with the suffering resulting from the illness. Intubation, artificial feeding or other forms of futile medical care may be seen as contrary to Hindu beliefs. Palliative care, however, is accepted in the religious tradition, as it leads to a natural death.
- In extraordinary situations, particularly when the life of a Hindu patient is threatened, all Hindu rites, whether stemming from tradition or religion, should be respected. In such case, if possible, the family should be able to stay with the patient and the medical staff should respect and allow the performance of all rituals, avoid entering the patient's room, and interrupting prayers.
- A Hindu would prefer dying at home. However, death in hospital is acceptable, if it cannot be avoided. A dying patient may prefer to be alone, with his family, priest, or Guru (if possible).
- Death and funeral rituals are among the key Hindu ceremonies. A death is good, both for the dying person and their family, when the dying person has had the time to prepare themselves for death, when it occurs at the right astrological moment, and when it is accompanied by appropriate rituals. A bad death will have permanent ramifications in future lives and unfortunate consequences for the family (such as bad lack, nightmares, infertility). The family should be allowed to perform all rituals preparing their dying loved one for death, and as they are being performed - medical staff should avoid entering the patient's room and interrupting them.
- The place of death matters in Hinduism. To avoid the area between the ceiling and floor, a dying person will be lowered to the floor by the family.
- Just before death, a religious Hindu put a leaf of tulsi (holy basil) and a few drops of water from the holy river of Ganges in the mouth of the dying person believing that it will help them to pass to another incarnation.
- In Hinduism, every organ is an integral part of the body which should be cremated immediately after death to accelerate the process of leaving the body by the soul. For this reason, families are very reluctant to consent to autopsy. An autopsy is performed after a court order.

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2.2. Cultures of the world

Faith that does not become culture is not wholly embraced,
fully thought, or faithfully lived.
John Paul II

There is a strict connection between religion and culture:
"(...) no culture of the past or present, and it seems no culture in the future,
can be considered as not having religion."
E. Fromm

The concept of faith and culture are not equivalent. However, their disintegration would be deeply unreasonable, as culture encompasses everything that has been consciously created by a human being. Hence, culture is every act of a human being performed in accordance with their thoughts, certain ideas, intentions concerning the world (nature and civilisation). In other words, culture is humanisation.

Broadly understood culture can be divided into "material" culture (physical and biological values), culture of "civilisation", (social values), "spiritual" culture (value of knowledge, pursuing the truth), "moral" culture (pursuing goodness).

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2.2.1. Vietnamese culture

Characteristics of the Vietnamese culture

Vietnam has a long history with the first surviving archaeological evidence of settlement in the current territory of Vietnam originating more than 5000 years ago. For a long time with only short breaks inbetween, Vietnam was under the dominance of another country. From the 1st century AD, South Vietnam was part of the Cambodian kingdom of Funan, from the 2nd century it was governed by China who continues to exert influence on Vietnam both in terms of culture, and the development of the country.

Vietnam flourished economically and politically under the Ly dynasty from the 11th to 13th century. In the 15th century, Vietnam was re-conquered by the Chi-

nese. In the 16th century, the first Portuguese sailors reached Vietnam, creating a commercial colony there. In 1887, Vietnam was colonized by the French and incorporated into the Indochinese Union. The Indochinese Union ceased to exist during World War II. According to the Geneva Accords, Vietnam was divided into two republics - the Communist Democratic Republic of Vietnam and the Republic of Vietnam. The founder of modern Vietnam and of the Communist party was Ho Chi Minh, civil name Nquyen Tat Than, who was the president until his death in 1969. At the turn of 1960 – 1961, the National Front for the Liberation of Vietnam and the Vietcong strike forces were established and supported by the Communist regime of Ho Chi Minh. These units began carrying out anti-government operations in order to merge the country with the Democratic Republic. Initially, it was a partisan war that turned into the Vietnam War in 1965, with about 40 states officially participating in support of South Vietnam while the Communist regime was sided by the Soviet Union and the People's Republic of China. Thus, an open American-Vietnamese war broke out during which more bombs were dropped over Vietnam than during the Second World War. After numerous world protests, American forces left Vietnam in 1973 and in 1976, the united Socialist Republic of Vietnam was declared which was admitted to the UN a few years later.

The Socialist Republic of Vietnam is located on the east coast of the Indochinese Peninsula, bordering with China in the north, Cambodia and Laos in the west and washed by South China Sea along the east coast. The weather differs in the north where there are the four seasons from the south where only two seasons alternate. Agriculture has a prominent standing in Vietnam with the basic, widely exported produce being rice.

Current Vietnam is situated on a territory of 331,114 km^2 with a very diverse landscape, dominated by the important elements of the Red River (Song Hong) which springs in China, and the Mekong River. Both rivers are sources of water and livelihood for the Vietnamese. The entire country is divided into 63 provinces and 5 cities that fall under central management. These includes Hanoi, Hai Phong, Ho Chi Minh City, Da Nang and Can Tho. The provinces are further divided into counties and municipalities. The population fluctuates around 84 million people.

There are 54 ethnics living on the territory of Vietnam. As many as 86% of the total population identify as the Viet, making them the most important ethnic. There are also the Tho, Chut, Muong, Hmong, Khmer, Chai and Chinese. The capital of Vietnam is Hanoi with approximately 7 million inhabitants. Founded in the mid-10th century AD, the city is situated in the north with the Red River flowing through it.

The official language isVietnamese which is spoken by the majority of the varying population in different regions. The written form of language is common to the whole of Vietnam.

The Vietnamese as Migrants. 60 745 Vietnamese live in the Czech Republic. In Poland, the number of Vietnamese is between 20 and 30000. According to available sources, 2,600 Vietnamese live in Bulgaria.

Important personages

- Ho Chi Minh
  - By original name Nguyen Tat Thanh, Nguyen Ai Quoc and Nguyen Sinh Cung, 1890–1969. Revolutionary, communist, thinker and linguist also known as the Father of the Nation.
- Thich Quang Duc
  - The Vietnamese monk in Saigon ho has self-immolated in protest against the persecution of the monks in June 1963.
- Vo Nguyen Giap
  - A Vietnamese general who participated in the creation of the Viet Minh (organization campaigning for the independence of the country). In 1946, he was appointed commander-in-chief of the army. He is listed as one of the top 20 strategists of the 20th century.

Traditional Vietnamese Natural Healing

The Vietnamese traditional medicine is built on centuries of historical experience. A name firmly inscribed in the history of Vietnamese medicine is Tue Tinh nicknamed "God of South Medicine." Distinguished among traditional lay healers of the 18th century were also Le Huu Trac and Nguyen-gia-Phan, the latter being considered to be the first epidemiologist, lauded for having laid the basis for the fight against infectious diseases. Traditional Vietnamese medicine is based on two fundamental opposite principles, Ying and Yang. Ying controls the inside of the body. It is the negative, cold principle that stands for the female characteristics, the Earth, the Moon, darkness and death. The positive Yang principle controls the body surface and is characterized by male attributes, the Sun, the sky, light and life.

In their natural treatments, the Vietnamese use drugs and substances of vegetable basis. They use flowers of plants for upper body and root medicine for the bottom half of the body. The choice of drugs is determined by the shape and colour of the affected organ. Determination of the disease and diagnosis are carried out by inspection of the tongue when the tongue root (underbelly), centre (organs above the diaphragm) and the tip of the tongue (chest organs) are examined. Features of the tongue such as colour, coating and size are observed. Widely used therapeutic methods include acupuncture, acupressure and cupping therapy.

The Role of Men and Women in the Vietnamese Culture

Vietnamese women have always cooperated when working in the family, selling on the market to convert family production into money, taking care of children, elderly relatives and the sick. The standing of current Vietnamese women in the family is very important due to the high division of labour in the family. They are very active and communicative, independent and hard-working. In the countryside, the position of women may vary and be more submissive. The formal head of the family is always a man. A woman may give her opinion but the final decision is always made by a man. Vietnamese women seek to have the lightest colour of skin possible. For this reason, they protect themselves from the sun with parasols or umbrellas to keep the skin alabaster white. The standard of female beauty in Vietnam is to be slim. Slenderness is universally observed in the whole family, particularly by women. Men have the duty to perform hard work and be strong in crises. Currently, second generation Vietnamese live outside Vietnam who were born in their new countries, studied and founded family there. These generations are more active and proficient in the language of the country they live in. Their partner status changes. During hospitalization of a woman at the hospital, her main partner is the husband or father who is customarily present to receive the diagnosis. The man often speaks for the woman. In the event of hospitalization, men are accompanied by men as well. When treatment is to be introduced or a surgery is suggested, the whole family consult together.

For the Vietnamese, family comes first and plays a significant role in resolving even the situation of specific couples who confer among themselves on housing, mortgages or loans. Everything is especially consulted with the parents. Most of the Vietnamese living outside Vietnam financially supports a broad family in Vietnam. The Vietnamese are accustomed to helping each other and contributing to the poor and they also expect the same from others. For the family, social events, such as weddings, anniversaries, birth of a child or death of a family member, are of utmost importance and will be attended by all the members of the family, including those who currently do not live in their homeland. Special emphasis is put on weddings. A rich wedding is prepared for the bride even if the family has to be indebted for several years. There are sometimes several hundred wedding guests. The wedding is a time of poem recitals, speeches to the newly-weds, abundance of singing and photographing. After marrying, women retain their surname while children are named after the father.

Due to the relation to the family, they live together with several generations at once. They help and support each other and care for the sick or the elderly. The father or the eldest son is the one who makes decisions while the wives are subordinate.

Parenting

The relationship of the Vietnamese to children is just as strong and tight-knit as to the entire family. It is expected that the children will listen to and honour their parents and have respect for the elderly. They are taught to be honest, quiet and decent. Rules for good behaviour teach them not to make the situation of their loved ones more difficult by constant complaints about their own problems. In Vietnam, maternity leave lasts four months, then the child is put into nursery or the parents hire a nanny. The child may be at the nanny's for the whole week or the nanny may be staying with the family even overnight.

Parents put particular emphasis on the education of their children and their children achieve average or above-average results. Children born in another country can speak the language of majority population very well and focus on learning other foreign languages.

Vietnamese children have less free time, they do not participate on organized and leisure group activities with the majority population, they study intensively and children from well-to-do families frequent prestigious individual clubs - language, tennis, golf. The Vietnamese care for their children's health very much as well, attending preventive examinations almost regularly. 84% of parents regularly visit Child Counselling Centres and 69% of parents attends preventive examinations with their older children.

Relationship to Human Sexuality

Taking care of reproductive health is very important for the Vietnamese. The Vietnamese prefer to use the condom in the first place and hormonal contraception in the second place, while not avoiding abortion in unwanted pregnancy.

Vietnamese women approach pregnancy with great responsibility, but if their midwife / nurse or doctor do not stress the importance of preventive examinations to them, they do not seek them on their own. If the prospective parents attend prenatal course together, the father of a child will want to be present at the birth. A very sensitive issue for the Vietnamese is revealing the child's gender. It is therefore necessary to take care not to communicate this fact in the possible presence of an interpreter. Pregnancy is granted great attention. Arduous activity is not recommended in pregnancy and emphasis is put on relaxation and sleep. A pregnant Vietnamese woman is taken care of by the entire family. Sufficient amount of meat, vitamins and eggs is recommended - all for the child's health.

Most of the Vietnamese would liked to have a first-born baby boy. Privacy and shame are important points to the hospitalization of Vietnamese women. Vietnamese women are very shy, especially before unknown men. Vietnamese women never blow their noses in public - to them, it would be an expression of incivility

and ludicrousness. If a Vietnamese woman has difficulties, such as vomiting, it is often the case that she will let the nurse know of these difficulties only after she has tidied up the vomit herself. She will accept medication against vomiting only in case of repeated and long-lasting vomiting when no self-medication using natural methods has been successful. Vietnamese women do not complain of fatigue, they prefer enough sleep. In the event of difficulties evacuating, they will not make this fact known to the nurse unless they cannot manage it themselves or unless the nurse asks them. Vietnamese women will first try to use their domestic treatment methods, such as increased consumption of liquids and leaf vegetables. Vietnamese women use cleansing enemas only as a last resort. Vietnamese women would prefer to give birth in the domestic environment among their close ones but they do realize the disadvantages and give birth in hospitals instead. Just before birth, Vietnamese women perform a cleansing ritual. They like to take a bath before the birth, either in the presence of the child's father or alone. In labour, Vietnamese women show minimal facial expressions and give a calm impression, behaving quietly - they want to deal with pain on their own. They will not voluntarily opt for painkillers due to fear of habituation or possibility of side-effects. Vietnamese women refuse any "aggressive surgery" and prefer vaginal birth to C-section. They consult their husband in all matters.

A woman in first stage of labour may refuse to walk but when warned of the need to walk, she will listens. It is appropriate at the time of labour to offer adequate pain relieve and other non-pharmacological means. They remain quiet during childbirth. Crying is not usual for Vietnamese women. Vaginal birth is preferred to C-section. Eating habits of Vietnamese women remain even in hospital in accordance with their philosophy of yin-yang balance, attributed to the power of heat and cold. If there are problems with the child, it is more appropriate to consult the issue with the father or another member of the family. This person will decide who is to let the mother know. When bad news is being announced to her, it is appropriate that a doctor is present. If necessary, an interpreter is to be ensured as well. Healthcare workers must realize that if necropsy of the child is to be performed, the issue needs to be discussed with the Vietnamese family. It is not just the parents' matter but the whole family's matter.

Relationship to Physical Hygiene and Clothing Characteristics

Personal hygiene is very important to the Vietnamese and Vietnamese patients prefer to tend to it themselves. If they cannot, they prefer the assistance of a family member of the same sex. It is important to know that privacy and shame are important points in hospitalization of the Vietnamese. From the point of view of hygiene rules, the Vietnamese do not differ significantly from the European popu-

lation. They follow the normal rules of hygiene. Pregnant Vietnamese women observe special hygiene (e.g. Cleaning their teeth with salt water).

If they cannot, they want a family member of the same sex to help them. If possible, they prefer to shower in the morning and every day. According to their culture, Vietnamese women should not bathe at all in the first days of the post-natal period, however, as Vietnamese women are aware that they would not be met with understanding of Vietnamese cultural traditions in European healthcare facilities, they will subject themselves to the hygiene requirements of their maternity ward.

Clothing Characteristics. The Vietnamese living in Europe clothe the same way as other citizens. To them, clean and decent clothing is one of the signs of good behaviour. They clothe their children the same way. Vietnamese women take good care of themselves. They almost never wear skirts. Women and girls wear folk costumes only on festive occasions and rather in closed groups.

Relationship to Health and Prevention

Health is symbolized by the balance between Yin and Yang, a disease occurs as a result of a disturbance to this mutual harmony. Each principle affects its bodily organs. Yin controls the abdomen, the stomach, the intestines and the urinary bladder. The organs controlled by the yang principle include the kidney, the heart, the lungs, the spleen and the liver. The Vietnamese differ from the majority population in Europe by their somatotype, belonging to the mongoloid (Asian-American) race by skin and hair colour, smaller stature and the shape of their eyes and nose. The Vietnamese take active care of their health, eating healthy diet, being less prone to overweight and exercising. They also list different forms of relaxation as prevention and seek cultural events relevant to their minority. They are respectful of medical authority. In case of medical examinations, they prefer that a member of the family be present. As a nation, the Vietnamese are fond of heat. If a Vietnamese is depressed, another member of the family or their friend will try to cheer them up by telling stories or make them take their mind off things.

The Vietnamese Healthcare System. The current healthcare system in Vietnam is both public and private. Health insurance is divided into two categories: for civil servants and for employees of private companies.

Dietary Characteristics

Vietnamese cuisine is very diverse, varied and differs regionally. It is very close to the Chinese cuisine. One of the fundamental differences is that Vietnamese cuisine works with fresh uncooked vegetables more and uses more herbs. The basic ingredients are rice and noodles. Noodles are prepared in various forms - dry, in

soups, in various shapes and made from either rice, or wheat. They may be eaten for breakfast, lunch and dinner. Rice is used to produce pasta, rice vinegar, rice starch, rice paper or rice alcohol. Vietnamese cooks process all meats - rabbit, beef, chicken, pork, turkey, duck, venison, fish, seafood, frog, hen talons. They can also prepare meats like dog, cat, mouse, or snake. The Vietnamese eat a lot of raw vegetables and fruit. The Vietnamese drink different types of drinks - mineral water, juices, tea, coffee, beer, wine and also liquor. Vietnamese dining has its rules. The Vietnamese can eat at the table, but also cross-legged. Food is eaten with chopsticks directly from the served bowls. When eating, they are usually strident and fail to observe European etiquette.

Warm dishes of the yang principle include eggs, poultry meat and rice. Cold dishes of the Yin principle include carrots and bean sprouts. Vietnamese dining philosophy rests in the balanced composition of foodstuffs which leads to health. The Vietnamese eat three times per day, lunch and dinner are understood as the main dishes. They do not want a "good taste". The Vietnamese are accustomed to eating together and slowly. Soiling the tablecloth or chewing loudly are not expression of bad manners, but rather expression satisfaction. They like warm, soft food (e.g. pure broth with vegetables and rice). Little salt. They will not accept anything cold into the mouth. They drink a lot, especially tea or water at room temperature - tea without lemon or sugar, diluted with water. They do not drink beverages with ice. Majority of the Vietnamese are lactose intolerant. If the Vietnamese are ill, they eat rice porridge and a lot of fruit and vegetables. Acclimatisation to a different diet is not easy for the Vietnamese and may take adults several months. They are not accustomed to e.g. milk and cheese from their homeland.

During hospitalization in hospitals, they have no problem adopting to the diet served there. We may often encounter the family bringing the patient their favourite treats. The Vietnamese understand food as medicine and chose specific diet in connection to somatic problems, e.g. for stomach-ache, they eat white meat, celery and apples. Concerning dietary habits, the research among 4 684 Vietnamese living in the Czech Republic found that the majority of respondents eat regularly and in accordance with recommendations for healthy diet. They prefer meat, rice, vegetables and fruit. Their preference for milk products (milk, yoghurt, cheese) is low. Their fat intake mostly consists of vegetable oils while use of butter was indicated only by a minimum of respondents.

Relationship to Illness and Death

In principle, the Vietnamese favour home care before visiting medical facilities or being admitted. They seek medical assistance in necessary cases only when the health problem has advanced and pain is intolerable.

Disease. In accordance with traditional Chinese medicine are people alive and well because their bodies are in a state of inner balance and harmony. The balance between Yin and Yang is constantly distorted by everyday actions and effects of external influences. If a person is healthy, disharmony will be adjusted swiftly and they achieve balance again. If the balance is disturbed and is not restored, it can lead to a feeling of sickness and up to the onset of an illness. Health and disease outbreaks are affected by six external factors - the common climatic elements: wind, heat / fire, summer / heat, humidity, dryness and cold. Each of these elements is associated with a certain season when the element is most frequently active. During the illness, these pathogenic factors may interact and transform one into the other. There are five basic causes of disease. which include internal wind, internal heat / fire, internal humidity, internal dryness and internal coldness. Diseases caused by external wind include fever and chills while diseases caused by internal wind include cramping, numbness, impaired liver function.

An ill member of a Vietnamese family is most often taken care of by women who are responsible for care of the ill. They provide main care around the patient's bed regardless of the patient's gender. They are expected to provide the patient daily bath and food. A pastor or monk may visit the ill as part of spiritual care of them. Vietnamese patients require privacy and quiet as they believe that sleep has healing power. All examination results and planned interventions must be explained slowly and clearly. Some Vietnamese patients and relatives may want to discuss the need for transfusion with another doctor. If transfusion is necessary, family members are willing to donate blood. If under certain conditions it is important to perform an autopsy, the family decides as a whole. It is appropriate to invite a family member and an interpreter to medical examination. The family member can be used as an interpreter but attention has to be paid to the sensitivity of the subject to be discussed with the patient or interpreter. Especially on topics related to sex.

In the course of hospitalization or visits to doctors' offices, increased attention needs to be paid to explaining the results of examination and various tests or procedures thoroughly and verifying that correct understanding has been achieved. It is common for the Vietnamese to nod during the talk which can make one believe that they listen and agree with what is said. For the Vietnamese, it is customary not to disclose a serious diagnosis to the patient without prior consultation with the family, especially with their husband or father. The family decides whether and when to tell a patient about the diagnosis so that they are not exposed to more stress and worry.

In the case of outpatient treatment of chronic diseases, they cooperate with the physician and adhere to the treatment regimen. Doctors and nurses play an indispensable role in health-preserving care of the ethnic group in all primary, secondary and tertiary level prevention. There, a host of ethical, cultural and religious

particularities of individuals can be revealed which affect the course of treatment. When taking treatment history, the Giger and Davidhizar's Transcultural Assessment Model (2002) may be used. This model is based on the evaluation of six cultural phenomena - biological diversity, the environment, the individual, time, social integration, interpersonal space and communication. The goal of professional nursing care is to provide culturally equal nursing care. As patients, the Vietnamese are known not to voluntarily ask for painkillers due to fears of habituation; they will also rather clean up vomit themselves and then report having vomited due to shame. In short, Vietnamese patients seek help only when advanced problems or severe pain occur. First, they try to apply "home remedy". If such treatment does not work, they seek medical attention.

Dying, Death. Since the family is clearly a priority for the Vietnamese, they put emphasis on two traditional family responsibilities: caring for their elderly parents and mourning their deaths. These obligations are considered sacred. The Vietnamese pay attention to dignified dying which lies in the quality of nursing care for the dying. They remember the good deeds of the dying person, talking to them and spending most of their time at their bedside. An important role is played by the family and the nurse who takes care of the dying person. At this stage of life, the patient needs peace, sense of security and assurance that they are not alone. In terms of nursing care, this means supplying all needs. These may be somatic needs - being clean, not being hungry or thirsty, not being in pain. Such care may feel undignified to the dying person and may summon deep feeling of shame in them. Here, the family or the family nurse may play an important role, as they fully respects the autonomy of shame of the dying person. Other needs include psychological and social needs - a sense of belonging to the family, self-perception, safety and preparation for departure from life. When dying, the Vietnamese prefer to be at home with their family members. Individuality and dignity must be always preserved. Religion also plays a role of great importance, as it approaches dying and death in their own way and the patient can be expected to behave in a way that corresponds to their faith.

Dying is inextricably connected with a mourning period that begins even before death when it is obvious that it is inevitable. When death finally comes, the whole family gathers around the dying relative. The eldest son or daughter will propose a name for the dying person, as it is considered bad luck to continue having the same name one used in life after death. It is a customary ritual for the eldest son or daughter to take the deceased person's shirt which they wore when alive and wave it in the air, asking the spirit of the deceased to come back. The funeral itself is an elaborate ceremony, comprising traditional preparation of the dead body: it is washed and shrouded in cloth or mat, the hair is combed and the nails cut. Money, gold and rice are placed into the deceased one's mouth as a sign that they left this world without poverty or starvation. The body is then placed in a coffin. Family

members then stand guard of honour until a favourable time for the funeral has been chosen. Day of the funeral is determined in advance as an appropriate date according to the lunar calendar. The family organize a procession the structure of which is subject to precise and strict order of hierarchy. The funeral colour is white - the closest relatives dress in white robes. In Vietnam, death is seen as the passing away of the body and also as the departure of the soul that goes to another world to find peace, if it is properly venerated on earth.

Communication and Methods of Information Exchange

Both verbal and non-verbal communication play as important roles in Vietnam as in other cultures. In a meeting, the traditional Vietnamese greeting is shaking right hands with a distinct grip of the other person's hand. The way the greeting is performed is by holding hands and leaning forward slightly. It is not advisable to bow so as to touch the other person, especially the head. This part of the human body is considered to be special and any contact on this level is completely inadmissible. The Vietnamese are a nation of touch. Touching and hugging are quite normal and common, but only in friendly relations. In Vietnam, it is unacceptable for lovers to hold hands in public or manifest their affection for each other in any other way. The Vietnamese are taught chastity and mutual restraint from early age. Similarly, it is inappropriate that a stranger should stroke a child's head or a man touch another woman. It is a gesture expressing a close relationship which may only be shown by family members. If a Vietnamese person wishes to pay respect to another person, he or she squeezes their hand for a short while in both of his or her palms. In connection with the traditions of the Far East, it is customary in a meeting to first greet the man and then the woman. The talk is usually initiated by questions on the family and health to express one's interest. Questions about age during a conversation are not considered disrespectful, on the contrary, they are very important to place a person in the social hierarchy which is strictly respected. The Vietnamese often smile and laugh out loud even in situations Europeans may not find ludicrous. Laughter is often an expression of uncertainty which in inter-cultural communication may result in misunderstandings. Direct eye contact is considered as rude. Likewise, crossing one's legs expresses superiority and crossing arms over the chest is a sign of irritation. It is totally inadmissible to open criticism of an individual in public. Disputes are customarily addressed in private and without witnesses. It is customary to hand over objects with both hands which is the Vietnamese way to express appreciation of the other. Vietnamese does not distinguish polite form of addressing the other, only verbal expressions that result from the situation. Some men allow a few centimetres of fingernail to grow on one or both little fingers as a sign that they do not need to work physically. When com-

municating with a Vietnamese patient, health professionals should look for similarities on which to build. Every professional should carefully handle the sensitive issues and remember that even within the same culture, there may be differences between social classes and between men and women. Although the Vietnamese themselves belong among the most polite patients, when they do not yet speak the language of the country they may not use the formal ways of addressing others in communication - this is in no case a sign of disrespect. During their presence at healthcare facilities, they are calm, patient and cooperative. The amount of time a Vietnamese patient has spent in the country plays a significant role in medical environment communications. The longer the stay, the more they have mastered the language of the majority and the more effective the communication is. We can also often encounter teenagers who function as their parents' translators.

Cultural Peculiarities

Historically, the people of Vietnam believed in spirit and mental strength and the belief persists to the present. An important feature of Vietnamese culture is the cult of ancestors and belief in psychical existence of the individual. People believe that after death, souls remain in the world to be able to continue to intervene in family affairs. The central point of the cult of the ancestors is the altar of ancestors which can be found in almost every family. Especially on holidays, home altars are set with gifts - rice, fruits and other items which serve to win the favour of the spirits.

Vietnamese religion is based on other religious currents - Buddhism, Confucianism and Taoism. Most of the Vietnamese are Buddhists. This religious-philosophical belief system has its roots in antiquity. It is a major world religion professed by people around the globe. The essence of this religion is awareness of the meaning of life and the suffering it brings and the effort to end the continuously repeated cycle by reaching the Nirvana (eternal peace, liberation). Buddhism greatly influenced the development of Vietnamese culture and traditions.

Confucianism and its main objective is to influence the moral values of people. This belief system is associated with the Chinese sage Confucius (551–479 BC), who preached the path to a better human life and the proper functioning of society through respect, education, wisdom and the pursuit of self-improvement.

Taoism deals with the doctrine of harmony, liberty and freedom. Taoists emphasize the natural balance and the importance of physical and mental health.

Due to the great tolerance of the Vietnamese, we may also encounter Hinduism, Islam and Christianity in Vietnam.

Buddhism understands disease as subject to negative emotions and deeds of the past. Caring for the sick and healing practices focus on achieving harmony of the hu-

man body which has been disturbed and warding off demons. Nursing practice which arises from religious attitudes is not as obvious as in the Christian environment.

Traditions and Customs. Traditional Vietnamese culture is influenced by the historical development and influence of China. Typical traditions include various feasts. Interestingly, the Vietnamese do not celebrate birthdays. The Vietnamese are very superstitious and for that reason, one can encounter a number of superstitions that they respect.

Traditional Vietnamese Holidays. Traditional Vietnamese holidays include a celebration of the arrival of the Lunar New Year which is governed by the Vietnamese lunar calendar and is similar to the Chinese calendar. Each lunar month has 29 or 30 days and each year has 355 days as a result. The arrival of the Lunar New Year is one of the major celebrations in Vietnam when the whole family meet, exchanging gifts, celebrating and debating vividly. Major holidays include Feast of the Dead (Thanh Minh) on the fifth day of the third month, when the Vietnamese visit the graves of their ancestors. Another feast day is the Summer Solstice which falls on the fifth day of the fifth month and is associated with burning human statues and figurines. Important holidays also include the Wandering Souls Day, which is celebrated on the fifteenth day of the seventh month. Food and other gifts are sacrificed to the wandering souls in order for them to reach peace and forget about death. A Children's holiday is Trung Thu when children meet in processions with lanterns, eating special sweets. The Vietnamese celebrate Christmas on December 25th.

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2.2.2. Arab culture

Characteristics of the Arab culture

The Arab world is geographically situated in North Africa (Algeria, Egypt, Libya, Morocco, Tunisia) and in Southwest Asia (Afghanistan, Bahrain, Yemen, Iraq, Israel, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Saudi Arabia, United UAE, Syria). The countries of the Arab world are inhabited by about 300 million people. There are differences in affluence among Arab countries. In recent years, attempts to unite the Arab countries have occurred but due to significant cultural differences have not yet been materialized. Arab states have a common standard language, especially written. There are, however, many dialects in oral communication which are difficult to understand among each other. Arabic requires a rich vocabulary. The cultural differences are also tremendous. Due to economic and political problems of the poor Arab countries, there has been long-lasting migration to the West and to Europe. These are mainly young men, unfortunately often illiterate.

The number of Arabs in the Czech Republic, Poland and Bulgaria

It is not easy to present the numbers of Arabs, as the census last took place in the Czech Republic in 2011. In the case of the Czech Republic and Poland it is drawn from the sources, which show the numbers professing Islam.

In the Czech Republic, there are approximately 4,200 Arabs professing Islam.

There are some 2,500 Arabs professing Islam in Poland.

In Bulgaria - this information was not traced

The Role of Men and Women in the Arab Culture

A woman's status is greatly influenced by her place of birth - whether she comes from a big, modern city, or from a rural area. Of course, whether she is from a poor or rich family and whether her parents are educated and whether her family is rather traditional, or rather modern and progressive, plays a significant role as well. Like elsewhere in the world, there are women who are happy and live happily in abundance, as well as women who live in poverty and for whom claiming their rights is difficult. In recent years, modern attitudes of women have attacked the conservative way of life and come into conflict with conservative traditions. This model of upbringing already begins in childhood. Girls tend to stay at home to help with the household and prepare for their future role as mothers and wives. For this reason,

girls have not been sent to school for centuries as all they would need in life was good housekeeping which could be learn at home from their mothers. As soon as the girls would grow up, they would marry and leave for their husband's homes. Currently, girls who can be educated come from high society. In some cases, certain areas are divided to be occupied by men and women separately. In public (i.e. even in meetings), even foreign women have to wear the basic local garment called abaya, a thin black coat from neck to ankles, over their regular clothes, and have their hair covered with a black scarf. In some countries, there is habitual tolerance of European women not to have their head covered by a scarf, for instance when shopping in large shopping centres or on the street. In the Arab world men have exclusive status. In childhood, boys are sent outside to play and gain experience so as to build courage in street brawls and learn the dangerous ways of the world. Boys' education is supported and it pays off to the families as Arab culture obliges children to take care of their parents in adulthood. In this system with almost no public social security, the parents depend on the care of their children. The responsibility falls on the boys as the girls leave their parents behind and go to live with their husbands. The parents know that, which is why they pay the boys' schooling: the better the education, the greater the possibility of a better job and higher salary and, of course, better provision for the parents. Arabs pay great attention to their appearance. Clothing is of informational value and signals status. Both in society and on the street, it is necessary to be properly groomed.

Relationship to Human Sexuality

In Arab societies, problems related to sexual and reproductive health are rarely discussed and are considered as a very sensitive topic. Many Arab women have little knowledge about hormonal contraception. They often have negative attitude. The use of contraceptives is also affected by religious faith, family and community. Premarital sexual relations are taboo and often punished. In many Arab countries, polygamy is permitted. A man may have several wives under the condition that he can sustain them.

Relationship to Physical Hygiene and Clothing Characteristics

As a general rule, Arabs become "unclean" by discharge, contact with bodily secretions and excretions, touching people of the opposite sex and contact with genitals. They are gravely "unclean" during intercourse, ejaculation, menses, or the puerperium. For individuals who are unclean, touching the Quran, its recitation, presence in the mosque and prayer is forbidden. Light uncleanliness can be removed by washing the hands and forearms, the feet up to ankles and by wiping the head. Grave uncleanliness must be removed by complete bath or washing of the whole body and also rinsing the nostrils and the mouth. A minimal re-

moval of uncleanliness in addition to the prescribed washing before every prayer includes also taking a shower at least once a week, always on Friday. It is also very important to Arabs to take proper care of their hair. Axillary hair must be removed three times a week, pubic hair once a fortnight. All this is done with reference to the Prophet Muhammad. Arabs also ascribe great importance to oral hygiene. Ideally, teeth should be cleaned before each prayer. Arabs also demand absolute respect for their right of intimacy. These patients usually insist on hygienic care in the presence of their relatives and refuse to receive any care of this kind from medical staff. If hygienic care is provided to an Arab client by medical staff, it is very important to respect the principle that a man washes a man and a woman washes a woman. To an Arab patient, excrements, blood and bodily fluids are unclean. If the Arab patient is soiled by them, a complete wash under running water must follow. Arabs wash daily before prayers (face, ears, hands, feet). Classic hygienic care can never replace the washing ritual, which needs to be done under running water, keeping the proper order and washing with the intent to be cleansed, which is why it is possible that a Muslim patient may want to wash again after hygienic care has been given, but this time ritually. A full bath and shower is performed every Friday. Women take a complete bath after menstruation, after the postpartum period and after gynaecological examination. As regards compliance with oral hygiene - the sick people of the Islamic faith brush their teeth more than once a day. In the case of a lying patient, it is important to take care that there is enough boiled water because it has the purifying effect of running water.

Method of dressing – it is individual and corresponds to a particular faith practised by the laws of the respective Arab countries and the Quran. We may encounter the burqa and a hijab as headwear on the one hand, and jeans and modern clothing brands on the other. Some Arab women's clothing must not emphasize their bodily curves and female physical beauty. A woman can only uncover herself in front of her husband or her family.

Relationship to Health and Prevention

In Arabic countries, healthcare facilities provide primary, secondary and tertiary treatment. There are independent governmental organizations which bear responsibility for the provision and financing of health care for students. The Red Crescent is the largest "provider" of pre-hospital care. This organization is also responsible for providing health care during major Muslim holidays, such as Ramadan, when population grows by up to 2 million pilgrims who set out to Mecca and Medina. Health ministries of individual countries are the main guarantor of the healthcare system and health care is affected by the wealth of the country. Great emphasis has recently been placed on access to primary care and prevention. Part

of the poor population live in primitive conditions and without access to pharmacies and information sources. Many people are not educated in the area of prevention at all, or there is nowhere to obtain such education, resulting in a dismal situation regarding disease detection and early treatment. Government regulations pertaining to and training of healthcare workers is usually carried out strictly in the public sector, but salaries in private hospitals are higher and working there thus becomes more attractive to medical staff. The main task is to guide healthcare workers to behave so as not to endanger the safety of patients which should become a top priority and includes the need for further education, teamwork, open communication, feedback and sharing of cultural perception which is based on the importance of patient safety in all areas of care.

Dietary Characteristics

To the Arab client, regulations concerning food are as important as any other. For Arabs with an Islamic faith, alcohol is forbidden on the grounds that alcohol reduces awareness of Muslims and their enthusiasm. According to the Quran, pork must not be consumed in any form, however, they can consume other meats, e.g. beef and poultry. Arabs are also opposed to the consumption of raw or half-raw meat. Recommended meals for Muslims include vegetables, mutton, rice, pulses and spices. (health.euro.cz, 2007) Muslim and non-Muslim food is often not significantly different. Drinks are basic, such as Moroccan tea, water, juice or milk. Among Arabs, three major taboos are known. The first is a strict prohibition of drinking alcohol which is not written in the Quran but rather came from tradition. The second is a complete prohibition of smoking. This taboo is not recorded directly in the Quran either and is observed the least. The final and most vital is the prohibition of the consumption of pork. From marine organisms, they can eat fish that have scales. Dietary habits of Arab patient in the hospital – they don't consume pork, including food prepared on pork lard. The orthodox Arab Muslim religious will not even use a knife that has been used to cut pork. It is appropriate to serve the patient poultry or beef, avoiding minced meat. It is also appropriate to offer the ill person the possibility of a balanced vegetarian diet. In case of need to respect a specific diet, the patient and their family should be made aware of the relevance of the dietary prescription and potential consequences of failure to observe it. It is appropriate to have food served and medicine administered to an Arab woman by another woman. (zdravi.euro.cz) Fasting is one of the five pillars of Islam. Dealing with patients of the Muslim faith, one also needs to deal with fasting. One of the significant fasting seasons is the Ramadan (9th month of the Islamic year, lasting 28–30 days). During this month, it is prohibited to eat and drink from dawn to dusk. Great emphasis is also placed on inner balance and a prayer. In the evening after sunset, banquets are of-

ten organized by the richer families for the poorer population. Children, pregnant and nursing women, the elderly, travellers and the faithful who serve in the army or carry out tough work are exempted from the fasting obligation.

Relationship to Illness and Death

Misunderstandings may occur during provision of care to Arab patients, particularly for religious reasons. It is necessary to know the religion of the patient and his family. For Arab patients professing the Islamic faith, religious prescripts are very strict and they guide them throughout their lives. General awareness of this religion from the perspective of health professionals is often superficial and is associated with world extremism and terrorism. A very important factor in the provision of healthcare, not only with Arabs, is the first contact established between the patient and healthcare professional. In case of improper first contact, the Arab population is very quick in losing trust. Knowledge of basic attributes of faith, customs and traditions is, therefore, essential with Arab patients in accordance with the rules of professional relationship and tolerance. They do not understand illness as punishment for sin, but as a test and opportunity to gain awareness of oneself. Along with the body, the faithful are thus curing their heart as well. Arab patients also believe that illness gives them opportunity to be purified of sin, saying that the greater the illness, the greater the reward.

Arabs have always believed that healing itself is in the hands of God, but they also recognize that it is good to entrust a human, an expert, with the whole process of healing, as well. As confirmed by their interest in study both at European and American medical faculties, medicine is a very popular field with Arabs. Many attributes of these issues lead Arabs to a very different perception of accepting medical care, especially in women. The problems that may occur during examination, treatment or therapeutic regime can be divided into four categories: examination of an Arab woman by an Arab physician, examination of juvenile Arab girls (boys), interventions outside the internal or external genitalia, and interventions on internal or external genitalia. Doctors and healthcare workers of other faiths who find themselves in a situation where they are treating an Arab patient, may often experience great deal of mistrust. Arabs are aware of the necessity of an examination, of course, but when an Arab woman arrives and the examination is not urgent, the physician (male) has to always insist on the presence of another man from the woman's family. If the patient is married, she must be accompanied by her husband, if not, she must be accompanied by a representative of her family. Even if an Arab nurse or other healthcare professional were present, their presence alone is not considered to be adequate.

Arab countries vary in their degree of orthodoxy, which means that they differ in degrees of liberal approach to the process of exposing some parts of the female

body as may be necessary during examination by a physician. In some countries, for example, auscultation, percussion and palpation examination of the abdomen and chest must be carried out through the garment. This then does not allow for any visual examination which has to be replaced by a good and complex history taking. X-ray examination is quite normal, however, in case of ultrasound diagnosing of a woman, it is necessary for it to be performed by another woman. However, the presence of a representative of the family or spouse does not mean that everything is perfect. It is necessary to view the examination from the Arab woman's perspective. The refusing, shy attitude may in conjunction with stress from the disease eventually even lead to the development of psychological trauma. Sometimes it is better to call for cooperation a consulting female physician, as an Arab woman may be fully examined without any male presence by her. Arabs mostly respect the seriousness of the whole situation where the health or even her life are in danger and they also understand that the procedure they would like best is the one to be applied at all times. Nevertheless, if it is possible, it is good to have some female staff present around the Arab woman so that her family can remain at peace. It is very important to deal seriously with all the relatives of the patient. Care should be taken to sufficiently inform them and to emphatically explain the severity of the entire situation so that the close ones can understand the healthcare professionals. If this communication fails or the healthcare professionals use arguments by European standards, liberalism or democratic principles, the family of the Arab woman could decide to terminate her treatment or examination, which could in some cases unfortunately also lead to fatal consequences.

The specificities of the examination of an Arab child are quite similar to the rules of examining an Arab woman. The central figure in the family is of course a man. The child belongs first and foremost under his authority and his decisions. The presence of the mother during examination of a child is only possible in the most liberal Arab countries. Once a young man reaches the age of maturity, he may decide according to his own free will. Another specific fact is that, for instance, amputation is rarely allowed by the family at all.

Death. The traditions and customs in dying and death are significantly influenced by the religion of the dying person and their entire family as a whole. Arabs prefer to die at home surrounded by their family and often believe in the afterlife. In the Islamic religion, the body of the deceased is buried into the ground only.

Communication and Methods of Information Exchange

Arabs use very lively gesticulation. Touches are common even among men in public. Contrarily, they are forbidden between a man and a woman. In communication, it is recommended to use the title earned as part of education. Communi-

cation with the patient at the hospital has its own specific characteristics. A large number of visits (relatives and friends wishing to participate in the illness and healing) need to be taken into account. If the patient does not know the language, a professional interpreter needs to be provided. The presence of their own interpretation services at the hospital is largely infeasible, mostly due to financial reasons. When talking to a member of the opposite sex, one does not ask about family or intimate problems. These patients are reluctant to talk about biological functions (urination, stool, vomiting, etc.). In case of providing care to a pregnant Arab woman, one does not talk about pregnancy with the man. It is inappropriate to ask a single women whether she has children (extra-marital intercourse is prohibited).

Cultural Peculiarities

The Arab culture is influenced by historical roots and religion. Most Arabs are Muslims, divided into the Sunni majority and Shiite minority. Part of Arabs practice Christianity (e.g. in Lebanon, Syria, Egypt, Iraq). Due to the wide range of Arab countries, an Arab culture cannot be specified as it differs by positions of the country, national economy, and wealth of the country. The Quran and the Sunnah of the Prophet Mohammed can contribute to the understanding of health.

Recently, there has been an integration of the influence of religion on health with some research activities to investigate the influence of religious practices on health and health promotion. Religion also begins to prevail in medical studies, in particular in medical psychology where religion and spirituality are used in the field of illness management and resilience, in social-psychological studies that examined the effect of religion on health, and in studies of public health aimed at inequalities in healthcare. The increase of studies covering religion and spirituality as influences on health and well-being means a shift away from biomedical and rather negative perception of health where health is merely the absence of illness toward a broader and more positive understanding. This is linked to the concept of salutogenesis which is a more holistic approach to health that focuses on the factors that encourage human health and well-being rather than the factors that cause illness. A term often used to describe how religious a person is rather than describing the ways they are religious - with regard to the practice of rituals, narration of certain stories and the adoption of some doctrines of life and death - is religiosity. Even though it can be said that religiosity is multidimensional, it is often considered as a protective factor for health. In regard to resilience and health, this implies that religiosity contributed to a number of positive results in the area of health, particularly in the field of social relations.

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2.2.3. Jewish Culture

Characteristics of the Jewish Culture

Israel, which is called Medinat Yisrael in Hebrew, was founded on May 14, 1948. It is found in the Middle East and stretches along the eastern coast of the Mediterranean Sea. Its neighbouring countries are Lebanon, Syria, Jordan and Egypt. Israel also borders on the Jordanian West Bank and the Gaza Strip which are controlled by the Palestinian Authority. The population density is 324 people per km^2. The capital of Israel and the seat of the Government, the Parliament, the President and the Supreme Court is Jerusalem. The capital city of Jerusalem is founded by an act which forms the constitution of Israel and is included in the legal code since August 5, 1980. Jerusalem is also considered as capital city by the Palestine who did not agree with the division of the territory in 1947. Since then, dispute has been going on between the Israelis and the Palestinians who along with Arabs consider the creation of a Jewish state as a tragedy and who use Jewish holidays and celebrations as opportunities for terrorist attacks. There are about 7,303,000 people living in Israel. The official language is Hebrew and Arabic for the Arab minority**.** Other languages commonly used in this area are English and Russian. The state guarantees religious freedom. On its territory, there are three religions: Judaism, Islam and Christianity.

The Jewish religion is Judaism. There are 14 million believers worldwide, mostly living in Israel and the USA. There are more than 5 million people in both of these countries who adhere to Judaism. The founder of Judaism is Abraham who lived around 2000 BC in Mesopotamia and led his tribe to Egypt. Five centuries later, the Jews were led out of Egypt and conquered Palestine. The resulting kingdom was divided into the northern Kingdom of Israel and southern Kingdom of Judah.

Healthcare in Israel. Since 1995, a healthcare reform has been carried out. Every citizen of Israel is legally insured. The insurance is paid according to one's income level and everyone has equal healthcare. Furthermore, a system of individual health insurance schemes is also available from the health insurances, which is used by about 80% of the population. The third option is based entirely on commercial, individually negotiated and paid insurance.

Hospitals are specialized in urgent and catastrophic medicine, conducting international training for crisis management during collective admission of wounded patients. The ambulance service is connected to the military information system. The rescue service Magen David Adom literally translates as Red Star of David. The National Emergency Medical Service also provides transfusion and training of both professionals and laity.

Judaism in the Czech Republic

Permanent residence of Jews in Bohemia is supposed since the 10th century A.D. An important personage is Rabbi Judah Loew ben Bezalel (1512–1609), the legendary creator of the Golem of Prague, also known as Rabi Löw. In the 17th century, the number of Jews in Bohemia rose due to the influx of refugees from the East, fleeing persecution. Rulers tried to regulate the number of Jewish inhabitants by the so-called familiant laws which were adopted in 1724. They stipulate that only the eldest son is allowed to start a family. The law remained in effect until the second half of the 19th century when new constitution was adopted in 1867, granting Jews equality. This event led to the emancipation of Jewish inhabitants. However, their liberation also led to their assimilation and subsequent loss of culture and religion. In 1906, the Jewish Museum in Prague was established in the effort to capture the withering Jewish culture. Jews played a significant role in the economy and culture of Czechoslovakia. Their numbers grew fast and at this point in time, there were about 118,000 of them. This development was ended by Nazi ideology and German occupation. Jews were always restricted due to this domination up until 1941 when their systematic mass murdering started. 80,000 Czechoslovak Jews were killed. Another wave of anti-Semitism occurred in 1952 under the Communist rule. In times of political loosening political tensions in 1968, many Jews emigrated and only a fraction of the members of the Jewish religion were able to live to see religious freedom in 1989 thanks to state-recognized Federation of Jewish Communities in Prague.

Contemporary Judaism in the Czech Republic. Jewish groups are associated in the Federation of Jewish Communities (FJC), which unites 10 legally independent Czech and Moravian communities. After 1989, the FJC reported 3,000 members. To date, the number is about 1,600. Their services are held at the Old-New and the Jubilee Synagogue in Prague. The activities of FJC include for example the provision of religious, cultural and educational events. They run the Sefer publishing house and in cooperation with the Jewish Community in Prague, they established the Jewish Museum in Prague. Furthermore, they are the Hagibor Social Care Facility. Last but not least, they secure the reconstruction of Jewish monuments.

In Bulgaria, there are about 1,360 and in Poland about 3,500 Jews.

The Role of Men and Women in the Jewish Culture

During greetings and introductions, orthodox Jewish men never shake hands with women, not even Jewish ones, apart from their wives and women in the family. This principle is rooted in biblical prescripts whereby a man could be ritually contaminated e.g. by inadvertent contact with a menstruating woman. Restraint is therefore appropriate during introduction, as well as waiting for a signal or bowing slightly. Persons of same sex shake hands routinely. The rule to avoid touch-

ing the opposite sex influences treatment greatly. In Israel, orthodox clients have the right to require treatment or examination by a same-sex person. The same rule should apply in the European healthcare. In case a woman is examined and no female physician is available, her husband or another family member is present. Exception is made in situation when the patient's life is at risk. Worships in synagogues are conducted separately, i.e. women sit either behind a wall or a screen, or on a higher floor of the gallery so that men cannot see them and are not unnecessarily distracted during prayer. According to their strict rules, they observe the Shabbat and eat kosher food strictly. Home plays even greater role than the synagogue in Jewish life and the family forms the basic unit of Judaism. Home and family secure the future. A sign of a Jewish home is a mezuza (small oblong box) attached to the upper third of the door. This is commanded by the Torah and the mezuza contains a scroll with passages from the book of Deuteronomy. Mezuza is a sign of the family's piety. If an orthodox Jew is entering the house, they will always kiss their fingertips and touch the mezuza with them. This way, they demonstrate their love of God and Torah. The most important value is "enthuse shalom" - Hebrew for "peace of the home". Children are required to respect their parents under all circumstances. Parents, on the other hand, must fulfil their parental duty to take care of their children, ensure their education and their financial support for the necessary period of time. At home, the table that represents the altar found in the Temple is the most important place.

Relationship to Human Sexuality

Judaism views sex as a gift in case people use it responsibly. Jews understand sex as an intimate relationship, not as a biological process. Intercourse is allowed but only after marriage as part of procreation. Homosexuality is viewed very badly. The Old Testament curses and punishes it. God allowed that man should use sex to reproduce which means gay people are committing sin. Lesbian love is somehow forgotten in the Old Testament, but in real life, it is not in accordance with the Jewish prescripts. Jews overlook these people, if they have no special demands, but they also talk about whether homosexuals should be allowed to go to synagogues. There are two kinds of Jews and each of them views contraception differently. Orthodox Jews do not use contraceptives very often and discuss this issue with the rabbi. Modern Jews do not address this question at all.

Childbirth, circumcision. The birth of a child by C-section is not considered to be the "opening of the womb" and the child does not have the privileges and duties of the first-born. Immediately after childbirth, the time period of special regard to the safety of the child begins. The Talmud remembers the protection of the new-born through practical provisions, such as the fact that the baby must be breast-fed for

two years. Immediately after the birth, the child undergoes a ritual by which he or she is accepted into the community. When a boy is born, his admission to the community is carried out by means of a complex ceremony. This ritual is based in the Torah and the new-born boy is circumcised as the Scripture dictates: "Cut the flesh of your skin, and it will be a sign of the covenant between me and you. Let every man who is eight days old be circumcised among you." Circumcision, "brit mila" in Hebrew, literally "a covenant of circumcision", is carried out on the eighth day after giving birth at home or in the synagogue and is considered as an important event. It is performed by a mohel who has medical and religious knowledge. During the procedure, the boy is being held by the godfather, the so-called "sandak", and besides the parents, many guests are present. After blessings, the boy receives a Hebrew name, which traditionally includes the name of the father. Circumcision expresses the idea that physicality and instincts should be subordinated to a higher moral law. Other religious duties associated with birth include a ceremony called the "redemption of the first-born". It takes place on 31st day after birth and the first-born son is symbolically redeemed from the God. The ceremony is to remind the Jews that the tenth plague of Egypt spared the first-born Israelites because they became consecrated to God.

Abortions. According to official statistics, Israel has 99 abortions per 1,000 births. In the country, there are abortion commissions consisting of a social worker and two doctors. The Commission does not aim to decide for the woman what is best for her and does not do so. Rather, it seeks to capture the difficult social situation. Nevertheless, it often acts as a cold administrative body who basically approves every request more or less automatically. About 19,000 abortion requests are received annually by the Commission and around 17 to 18,000 a year are performed. The most common reason is pregnancy outside of marriage which in a very traditional community can unfortunately equate to life threats. In ultra-orthodox communities, abortion of a healthy child by a healthy woman is an exception. In secular and more liberal religious groups, the abortion of an unexpected child in wedlock may be also encountered. According to halacha, the embryo does not have a human soul until the fortieth day, so abortion is allowed from a religious point of view until then. The same approach can be found in Islam. Religious Jewish women still rarely have an abortions. On the contrary, secular Jews originally from the former Soviet Union, have brought with them the approach that abortion is a form of contraception. Generally, birth rate is rising and abortions are on the decline, except in vulnerable groups of foreign workers (guest workers) from Asia and Jewish immigrants from Ethiopia. Gynaecologists in Israel are not obliged to perform abortions in order to be able to work in the field and obtain certification.

Relationship to Physical Hygiene and Clothing Characteristics

It is normal to wash one's hands before prayer or other religious act. Ritual cleanliness at mikveh - Friday afternoon, after illness, after menstruation, or of a bride. For cleanliness after menstruation, a pool with a prescribed height of natural water - rain, river, or sea water is used. It can be replaced with tap water or a bath in the river. A shower is required before entering the mikveh. They do not touch their genitalia (not even men - when urinating, they use strings). Washing hands is mandatory after waking up from sleep or after using the toilet (they must also take off their rings). It is also necessary **to**wash your hands before prayer or any other religious act.

In the period of menstruation and after menstruation, the woman is "unclean" (nida). Menstruating women are strictly forbidden to have sexual intercourse 12 hours before menstruation and 7 days after it. They sleeps separately. Adherence to hygiene principles which are part of religious customs includes performing a general bath and body hygiene, cleaning one's nails and shaving before the Shabbat starts. During the Passover holiday and the Seder dinner, there is a ritual washing of the hands. During Yom Kippur, it is forbidden for Jews to wash, men are not allowed to shave, women to use make-up or otherwise beautify themselves, use perfumes or any deodorants. On Judgement Day, a human must stand before his or her Judge without any useless thing. Leather shoes must not be worn and sexual intercourse is prohibited. An important piece of information for healthcare professionals in connection with hygiene: Preparation of the surgical site. An adult pious Jew adheres to a beard and hair grooming prescript: "You shall not round off the hair on your temples or mar the edges of your beard." Ultra-orthodox Jews let their beards and hair grow freely and never touch them with a razor or razor blade. It is allowed to trim the beard and hair with scissors. Nowadays, Orthodox Jews routinely use electric razors.

Clothing Characteristics. Typical features: Headwear: men - yarmulke, hat and side curls, shtreimel; women - hat, scarf, wig. Jews uncover themselves as little as possible - even in hot weather. The appearance of men and women in Judaism, has its own specifics. Women should dress in a way that adheres to the Torah. The greatest emphasis is placed on modesty. Generally, the rules of women's clothing were formulated by rabbis. Women should dress morally, so that their clothes do not provoke and they are not uncovering themselves. Of course, this depends on their time and customs. Some Orthodox Jewish women cover everything but their face. There are also differences in hair styling, as unmarried women may walk with their hair loosened, while married women should use headwear. This is because hair is the only feature women may use to seduce men. In this case, the headwear may include various scarfs, nets or hats. Male clothing is connected with observing another Jewish prescript, namely fastening beam fringes, the "tzitzit" in four

corners of their garment, the "arba kanfot", so that looking at these fringes, they are reminded of the commandments of the Lord. The number of tassels is also exactly determined to equal the number of commandments, 613.

A specific part of the Jewish male outfit is called the kipa, a piece of headwear. Jews began to wear this headwear as a sign of their awareness that higher divine power rules over them. A kipa or yarmulke is worn during every prayer and exists in various materials and colours. The important thing is the opportunity for which kipa is worn. Clothing of Orthodox men is black in most cases. Many of them wear a long black coat called a "kaftan" and a white shirt. On holidays, they prefer other colours, such as gold and white. During morning prayer, men wear the tallit, a prayer cloak that is worn over the shoulders or over your head. Examples of a white garment is the so-called kilt which is a simple white suit symbolizing purity and transience of human life. There is another rule of beard and hair grooming for priests. This rule is formulated in the Scripture and interpreted in various ways. The general interpretation, however, maintains the argument that they cannot remove the chops or the curl of their temples called the "payot". Orthodox Jews observe this rule without reservation. Others use scissors or electric razors which are not prohibited by the halakha.

The Jewish family as the basic element of the Jewish people is the primary environment where Jewish individuals live their faith on a day-to-day basis. It is in the family that they receive basic awareness about Jewish rituals, acquire knowledge of Scripture and become introduced to the commandments and prohibitions of faith.

Relationship to Health and Prevention

Jews themselves assess their level of health as good. The ultra-orthodox Jews place great emphasis on health and use medical services at a high rate. In Judaism, care of one's soul and body is connected to health while at the same time, the Torah commands Jews to choose life and live it. One may say that Jews tend to trust health professionals more and have a positive attitude to issues concerning health, however, a large portion of Jews still consult health issues with rabbis. Rabbis have the power to decide medical interventions in patients, including cosmetic surgery decisions which may be taken as violation of the integrity of the body in the context of breach of traditional Jewish values. Consultations on healthcare are conducted especially in order to ensure that care is received in accordance with Jewish law and the will of God. The patient expects the rabbi to provide emotional support, listen, and strengthen hope and comfort. Compassion and dignified treatment of severe illness are indispensable. Jews believe therapy but also the rabbis who give them spiritual support. From the perspective of most Jews, both physicians and rabbis are messengers of God, but unlike the physicians, the rabbis have

the power to see into the future, which is why situations arise when they prefer the recommendations of rabbis to those of medical staff.

Treating a rabbi. Rabbis pray in the morning, afternoon and evening. Medical staff should know that they utter their prayers in a low voice in the Hebrew language, using prayer aids such as cloaks and straps, and cover their heads with a yarmulke. It is necessary to respect the fact that during prayer, they do not wish to be disturbed. In this case, the nurse will ensure a quiet, solitary place, ensuring quiet for the other patients as well. There are also significant dietary particularities. If the medical condition allows it, it is possible to have food prepared at home and brought to the patient. When the day of rest (Shabbat) comes, the rabbi may have more visits. Also, it is good not to schedule any diagnostic or therapeutic procedures during this special day and other Jewish holidays, unless their life is in danger. The spiritual community leaders are addressed by their surname or title.

Dietary Characteristics

In Hebrew, the term "kosher" means "clean", "pure", "capable". There are well-defined rules ("kashrut" in Hebrew) which determine the appropriate and inappropriate food. The first rule comprises the suitable and unsuitable foodstuffs for the preparation of food. It is forbidden to eat pork, camel, camel milk, seafood, especially crustaceans, clams, snails, oysters, lobsters, eels, rays, insects, snakes or caviar. All products derived from non-kosher animals are also prohibited. The allowed kosher meat must come from toed ungulates who are also ruminants. These are sheep, cattle, goats, deer, etc. Fish are also permitted as food but only those that have scales and fins. Poultry is also considered as kosher, especially domesticated animals such as chicken, turkey, goose, duck and pigeon.

Kosher diets also include neutral foods ("parave" in Hebrew), which are eggs, fruits, vegetables, salad and potatoes. These foods can be side dishes to meat or dairy products. The second rule determines the suitability of the specific food. The animal must come from ritual slaughter ("shechita" in Hebrew). It is not enough to divide the food, but it is necessary to have different set of dishes for each type of food. Each household therefore has two sets of dishes, plates and cutlery. One is designed for meats and the other for dairies. Dishes must not be mixed even during washing. Meat pans are used exclusively for the preparation of meat dishes and no dairy product may touch their surface. The dishes should be kept separately and most families have the dishes colour-coded. Neutral foods can be combined with both types of food. The fourth and last rule includes catering orders for the holidays. For example, on the feast of Passover, it is forbidden to eat fermented food (chametz). Compliance with the rules of kosher food often differs. A pious orthodox Jew tries to eat strictly kosher without exceptions. Other Jews are milder in their

adherence to kashrut. A lot of Jewish families have a kosher household, but sometimes they go to restaurants where they only eat fish which, however, is not on a kosher plate. As modern times progressed, Jews were forced to compromise and Judaism relaxed the rules and traditions. Currently, it is possible to buy kosher food on websites where there is a very varied menu from ready-made passover maces to vegetables, fruits, over soft drink and biscuits to sets of knives.

Relationship to Illness and Death

Jewish understanding of illness is based on the principle that illness is punishment for sins or that illness has a purpose that is only known to God. Jews believe that a necessary step towards healing is changing one's relationship with God. Care provided to an ultra-orthodox Jewish ethnicity, also called Hasidim (Hasidic Jews), includes an understanding of the spiritual beliefs of Jews and their code of respect for religious customs. Jews are afraid of stigmatization in connection with physical or psychological illness.

Nutrition and hydration should be ensured to the patient, provided that such procedure does not cause them unnecessary pain. Decisions on interventions should include an assessment of the quality of life of a dying patient. According to the rabbi, the life of a suffering person should not be extended. However, it is imperative to provide the patient with oxygen, artificial nutrition and a drinking regime. If the patient themselves refuses to be treated but the treatment could be beneficial for the patient, they should be persuaded to change their decision. Rabbis consult Jewish patients questions about the end of life. The sick ask about the cessation of treatment which is based on maintaining life at a poor prognosis. The orthodox view insists on preserving life even with a high probability of failure of life-sustaining interventions. Some prominent rabbis argue that treatment, however aggressive, should continue with a very poor prognosis, while other rabbis argue that in the event of a disease that also entails considerable suffering, the patient may refuse treatment. For Jewish patients, rabbis are a mainstay in their faith and hope. If the patient has a bad prognosis and knows that they will die soon, the family brings the rabbi to give blessing to the ill person. Jews consider dying as a natural situation on the way through life. Dying should take place with dignity and compassion of the family members, loved ones or medical staff present. As a rule, a dying patient is visited by a rabbi who should be introduced by a medical professional to the attending physician. Through the rabbi, questions of the end of life and cessation of health care are discussed. Jewish patients and their families have the right to insist on disconnecting ventilators, interrupting artificial nutrition and hydration. Spiritual care is part of holistic patient care. An interview with the patient helps to understand how faith influences their decisions on care. At the time of death and death,

a person must not be left alone, they needs to have their closest, usually family, with them. The dying person should confess their sins ("viddui" in Hebrew) and leave the world with the words "Shema Israel" (Hear, O Israel). The Jew is to prepare for death in full consciousness. The spiritual needs of the dying are taken care of by the funeral fraternity ("chevra kadisha" in Hebrew) - a group of pious, honourable men and women. Jews always demand a funeral by burial, they refuse cremation. The burial is to take place on the day of death or the day after. An exception is Shabbat or another holiday. Before being buried in the grave, a ritual cleansing of the body of the deceased ("tohora" in Hebrew) is carried out. The body is washed with lukewarm water, sometimes with a mixed egg white. The deceased person' nails, ears, nostrils and hair are cleaned with the help of a funeral fraternity's cleaning kit. During the cleaning process, the body lies on a wooden board which contains numerous grooves that allow the outflow of water. The clean body is dressed in a white shroud ("kittel" in Hebrew). If the deceased is a man, the body is wrapped in his prayer cloak (tallit) the fringes of which (tzitzit) are cut off. The body of the deceased is buried in a simple coffin. The body must be buried whole and no part must be missing from it. For this reason, autopsies are also prohibited. Jews believe in the coming of the Messiah when all of them will be risen from the dead. After the death of a family member, the relatives tear a part of their clothing as a sign of mourning. They then wear the torn clothes for thirty days, men do not shave or cut their hair. The nearest family member, usually a son, prays for the deceased. The Prayer (Kaddish) is then pronounced during every morning prayer time. The mourning period is divided into three parts. The first period ("shiva" in Hebrew) begins immediately after death and lasts until the funeral and usually seven more days. At this time, the survivors do not leave home. They sit on low stools with their shoes off. Friends or members of the Jewish community are taking care of the grieving family, bringing them food; instead of visiting the synagogue, men go to pray to the house of the family of the deceased, where they prayed together. This is followed by a second period of mourning ("sheloshim" in Hebrew), which lasts thirty days. The survivors return to their work, the son prays the Kaddish at the synagogue. The torn clothing is worn over clean clothing, shoes are on. After thirty days, men can shave and cut their hair again. Torn clothing can be taken off and the survivors engage in normal life.

Care for the deceased. In nursing care of a deceased patient, it is advisable to open a window so that their soul can symbolically leave the body more easily. After death, feathers should be laid over the lips and nose to detect breath. The patient's body should not be washed, this is done before the funeral, and ideally it should not even be stripped of the clothes it is wearing. Nursing staff must always wear gloves during such care. Dentures should be removed from the mouth. The patient's eyes must be closed, their body should lie straight with their arms at the sides and their legs straight next to each together. The body should be covered

with a white sheet and the family should be informed as soon as possible. If the patient had no loved ones, the rabbi will be informed. In the room, the body of the deceased should be placed with its feet towards the door. An autopsy is inadmissible from a Jewish point of view. It is considered as disfigurement of the body and abuse of the deceased person. As God created man, He is also to receive him back in the same form. Therefore, the deceased person must be buried with all the tissues, organs and bodily fluids in order for a ritual burial to take place properly. Jews believe that their soul is immortal, death is not the final stage of life, only a transition to another form.

Communication and Methods of Information Exchange

Spiritual care is part of holistic patient care. Talking to a patient helps understand how faith affects their decisions in receiving care. Experts make some of the recommendations for practice, such as finding out the importance of religion for an individual, their degree of religious affiliation, their religious habits, customs, traditions and principles. In providing care to a Jewish ill person, the problem of language barrier may also arise. Jewish patients speak a language called Yiddish, they may be reluctant to ask for an interpreter or to admit that they do not understand the information given. This creates a cultural divide between the patient and the nursing team.

Communication with the opposite sex can also be difficult for a Jewish patient from their point of view. Since religious customs do not allow this, informal conversation between a man and a woman is not welcome, which is why Jews of different sexes are often in separate rooms at social events and education is also divided by gender. Therefore, in practice, it is possible to encounter a situation where the patient refuses to leave the room and thus meet with other patients. Such behaviour can indicate a culturally appropriate reaction of the patient to the social environment, but it can also indicate a pathology whereby the patient develops anxiety. An unmarried Jew is also not allowed to stay alone in the same room with anyone of the opposite sex, which also applies to the nursing staff. Nervousness may occur in the patient. One of the recorded ways to reduce these negative feelings may be, for example, to open the door to the hallway where other members of the medical team pass by.

Cultural Peculiarities

Sacred Writings

Torah. It means the traditional designation of Pentateuch – the Five Books of Moses. The Torah literally means “a teaching”, interpretation of the Jewish conception of the world and of the human kind. It includes the prophets’ writings, the Book of

Joshua, the Book of Judges, the Book of Kings, Psalms, the Proverbs of Solomon, the Book of Ruth, the Cry of Jeremiah, the Book of Job, Solomon's Song of Songs, the Book of Ester, the Book of Nehemiah, the Book of Ezra and the Chronicles. The words of the Torah were made apparent to Moses on Mount Sinai. The text was dictated to Moses by God himself and therefore it is very sacred in nature

The Talmud means "a teaching", "studying". The first part of the Talmud is called Halakha ("procedure" in Hebrew, Jewish law). The Talmud contains the teachings of the Mishna ("repetition" or "doctrine" in Hebrew) which is older and records orally transmitted teachings. The second part follows the first, and is referred to as the Gemara. It collects comments and remarks on the Mishnah.

Jewish calendar, holidays, Shabbat

Judaism has its own calendar, which is very different from the most widely used Christian calendar. It is distinguished not only by the year, but also in the naming of months and other working weeks. The era begins with the creation of the world, which occurred according to tradition in 3760 BC. The year in Christian calendar is 2020, but in the Jewish calendar, it is the year 5781 and 2021 will be 5782 for Jews. The last day of creation of the world was Saturday (Shabbat), when God was resting. Saturday is followed by Sunday, which is the first day on the Jewish calendar. So the new week starts after Saturday. The Jewish Year is composed of twelve months and is based on the lunar cycle.

Jewish holidays

The entire Jewish year is accompanied by a series of holidays that are completely different from Christian ones. They are distinguished into holidays of pilgrimage, lesser holidays and important high feasts. A day similar to a holiday occurs every Saturday of the week and carries great importance to Jews, as on this day, the Shabbat is held. Pilgrimage holidays were observed already in the biblical period when the second temple had not yet been built to provide opportunity to travel to Jerusalem. Jews understand pilgrimage as a solid part of their religious life. The first three pilgrimages remind them of leaving Egypt, wandering through the desert and coming to Mount Sinai. Through the pilgrimage holidays, they also thank for the harvest of wheat, barley, fruit and wine. Holidays always have the same order of Passover, Shavuot and Sukot. Lesser holidays include Hanukkah which lasts for eight days and is an analogue to the Christian Christmas holiday. Another holiday is the Purim holiday and the last minor holiday is Rosh Chodesh, which in Hebrew means "head of the month". This is the first day of the month. High Feasts include: Rosh Hashanah and Yom Kippur. Rosh - Hashanah means New Year's Day also called the Day of Judgment and the Day of Trumpets, as the shofar (ram's horn) is blown to announce the arrival of the Rosh - Hashanah and Yom Kippur. Yom Kip-

pur is the most important Jewish feast day, which is called Shabbat Shabbat (the Shabbat of all Shabbats) or also the Day of Reconciliation, and very strict instructions apply to that day.

Shabbat

The last day of the week is the day of rest. Jews are not allowed to work on this leisure day, as indicated in the following passage from the Torah: "Remember the day of rest that it shall be holy to you. You're going to work for six days and do all your work. But the seventh day is the day of rest of the Lord, your God. You will not do any work, neither you, nor your son and your daughter, nor your slave and your slave, nor your cattle, nor your guest who lives in your gates. (Ex. 20,8-10) (50, p. 145)". In connection with the above, some 39 more activities are forbidden according to Maimonidese. It is forbidden to smoke, drive a car or turn on the television and other electrical appliances. The Shabbat is also found in the Ten Commandments and has a very sacred character for the Jews. Friday is a sign of preparations for the Shabbat. One gets up early in the morning and the cleaning of the whole home begins. This is followed by the preparation of all three meals for Saturday and baking breads called Challah. Prepared food is stored in an oven that will keep it warm all Saturday. Before Shabbat, it is customary to take a full bath and a general hygiene of the body, cleaning the nails and shaving. The Shabbat entails wearing holiday clothes, as well as a festive white tablecloth on the table and the latest dishes, shrouded in the nicest holiday tablecloth, which is usually white. The newest latest crockery and cutlery are used, as well. In the middle of the table, there is a candlestick with two candles and two loaves of bread (Challah) with a cup of wine for Kiddush.

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2.2.4. Ukrainian Culture

Characteristics of the Ukrainian Culture

In Bulgaria and Poland, the historical roots of the Ukrainian migration are conditioned by other contexts and, therefore, it is not surprising that the Ukrainian diaspora in Bulgaria is not numerous - we can only talk about a community of about 20 thousand people of Ukrainian origin. In Poland, the situation is different. Due to labour migration, especially nowadays, i.e. at a time of war between Ukraine and Russia over the eastern part of its territory, the number of Ukrainians working in Poland increased strongly - namely, according to estimates, by up to half a million. However, how can one estimate the number of these often unrecorded workers? An original solution was devised where according to an app which runs in Ukrainian, there are 1,270,398 Ukrainian mobile users on the territory of Poland as of January 2019, which represents 3.5% of the population of Poland. Calculating on the basis of how many people have Ukrainian set as system language on their mobile is more accurate than the census.

The beginnings of systematic settlement of Ukrainians in the Czech Lands fall on the period after the First World War when Ukrainian territory was hit by the fights of the Russian Civil War and armed conflicts with Poland. Associative structures started forming even among the Ukrainian military refugees in internment camps in Czechoslovakia in the early 1920s. Part of this first generation of immigrants took the opportunity to return after the stabilization of the situation in their country. Many of these returnees later fell victim to the Stalinist purges of1932–1934 and 1937–1938.

Those of the Ukrainian refugees did not opt for re-emigration settled mainly in large and medium-sized cities of the inter-war Czechoslovakia. There they created an extensive network of expatriate associations of various focuses while Ukrainian education became available with state support. Overall, the representation of the Ukrainian community in the First Republic enjoyed good relations with state administration. Let us also not forget the ties of former Carpathian Ruthenia with the First-Republic Czechoslovakia which further supported the migration from the troubled western Ukraine, suffering under the Bolshevik regime. Ukrainian migrants gained the possibility of a rich development in all spheres of social life from Czechoslovakia. The Ukrainian Free University in Prague was established already in 1921 (more in Ňachajová, 1998).

The conclusion of World War II and the ensuing months were thus associated with an intense wave of Ukrainian and Ruthenian immigration, mainly from the territory Carpathian Ruthenia which was ceded to the Soviet Union.

In post-war Czechoslovakia, there were remainders of the inter-war emigration with its own organizational structure independently of the scattered communities of the refugees from Carpathian Ruthenia and the Rusyns from East Slovakia. The

state apparatus viewed these groups across the board as Ukrainian, trying to limit their political, cultural and religious manifestations.

The fall of communism and the beginning of the 1990s then brought a spirit of recovery into the life of the Ukrainian community. Soon, the Civic Forum of Ukrainians and the Association of Ukrainians in the Czech Republic were established. There is the still active Ukrainian Initiative in the Czech Republic which divided from the Association of Ukrainians in 1994, as well as the Forum of Ukrainians.

The end of the cold war also enabled a new wave of Ukrainian immigration to the Czech Republic, this time primarily economically motivated. The current wave of migration to the Czech Republic from the Ukraine began in the early nineties, mainly due to work opportunities. The job opportunities were the most motivating factor for migrants. Another impetus for immigration was the armed conflict in the Ukraine which has been going on since 2014.

Ukrainians are the largest group of foreigners staying in the Czech Republic. According to the Ukrainian Embassy in the Czech Republic, there were around 150,000 people working in the Czech Republic from the Ukraine at the end of 2016. The number of persons with Ukrainian citizenship rose from the number 14,230 registered in 1994 to 131,302 in 2018. These figures are gathered based on citizenship. Some of these people then received permission to stay for a longer period. Furthermore, the embassy states that about 1000 children of Ukrainian origin are born in the Czech Republic each year.

More and more cases of permanent establishment of Ukrainians who acquire Czech citizenship and whose children attend Czech schools occur. However, from the perspective of European comparison, the number of citizenships granted to foreigners in the Czech Republic is rather low. Apart from manual labour in construction, textile industry and hospitality, Ukrainians are increasingly applying themselves to qualified vocations, especially health care. Statistics and sociological surveys show a high degree of integration of Ukrainians into the Czech society while maintaining Ukrainian traditions and customs.

The Role of Men and Women in the Ukrainian Culture

Ukrainian society seems to be more patriarchal than modern societies of Western democratic states. Based on Christianity, among other things, family is the declared foundation of the society. Despite that, it is not unusual for the grandparents and other relatives, even elder siblings, to bring up children, as both parents have left to work abroad and only come back from time to time. Ukrainian professional community is of the opinion that current Ukrainian society is finding itself in a crisis whereby a rapid transformation occurs. Traditional family values disintegrate and this fact is reflected in the life of Ukrainian migrants.

The absence of family happiness among migrants in the Czech Republic who stay without their children or partner often becomes the source of many problems which they may try to alleviate by abuse of alcohol or other addictions. It is therefore not surprising that the vies that "the family should be the main priority for both men and women" still prevails in the Ukraine.

Strong ties to the family often makes the Ukrainian migrants rather transmigrants whose souls are still in their homeland even though they have even set up a permanent residence in the foreign country. Therefore, they return to the Ukraine regularly and they are "at home" here and there (more on the issue of transnational migration in Szaló 2007).

In Ukrainian society, men still have a strong position. A number of daily rituals are derived from this, for example the fact that men only shake hands among themselves. When a man meets a gender diverse group, he will initiate a conversation with a man or men in this group, never with a woman. Men also have the decisive voice in Church life which lends high social status to priests as well, although most of them do start families and raise children.

A woman in the traditional society which is influenced by Christianity has a lower status than a man. According to sociological research from 2009, 74% of women agreed that a "woman should be willing to reduce other hobbies, and even paid work for the benefit of her family". Yet nowadays, Ukrainian women exercise all professions, including the most prestigious ones, and can also be part of the Ukrainian army. According to the law, the status of women in the Ukraine is equal to men; in real life, this is often not the case.

Children in the Ukraine are often apart from their parents for a long time. However, they love them and children are no less important to them than to parents elsewhere. They often justify going away from their family to work by their concern for the children and the elderly grandparents and the need to provide for them, pay for the children's education and secure a better life than they have themselves.

Senior citizens have a very difficult economic position in the Ukraine, whether in the countryside or in the city, often living on the brink of poverty and dependent on the assistance of their children. When they do not work, their income is minimal. However, grandparents, often replace the absent parents to the children and therefore, they have an important position in the traditional family.

Relationship to Human Sexuality

Motherhood, childbirth, maternity leave. Ukrainians see to it that the birth of a baby is associated with pure powers and the child is baptised soon, observing certain customs and rituals upon its birth and during the post-partum period. Their prams often have a red ribbon or the children have a red ribbon at the cra-

dle / crib - red is to protect the child against impure forces. “Ukrainian mothers are very friendly and have no special requirements for care. They do not show their emotions overly. Ukrainians who are living in our country consider prenatal care as very important and regularly attend regular check-ups. During pregnancy, they behave very responsibly. We are increasingly seeing the Ukrainian women accompanied by their partner during labour. This was not true before. Because mothers with newborns are often cut off from family members who live outside the territory of the Czech Republic, they often do not tend to have frequent visits at the hospital. One of the problems with taking care of them can be their lack of knowledge of the Czech language, which can be a problem in communication with and education of the mothers.

Education. Although the majority of Ukrainians in Europe perform unskilled profession, a growing number of highly skilled Ukrainians may be encountered at hospitals as doctors or nursing staff, in science and research. Nevertheless, migrants from Ukraine are still prevalent in positions of manual labour.

Sexuality. From the above it follows that there is no difference between the relationship to sex and sexual behaviour among Ukrainians and other nations of Europe. Due to sufficient education and awareness in relation to motherhood, education towards parenthood and prevention of sexual diseases is insufficient among Ukrainians, especially those who are part of the minority communities in the Czech Republic.

Relationship to Physical Hygiene and Clothing Characteristics

Clothing. It is not different from the European kind of clothing other than among socio-economic status of various population groups. It is a well known fact that Ukrainian women care very much about their appearance and are willing to spend considerable financial resources on fine clothes and shoes. “They dress more or less according to male and female roles, which is typical in a traditional society.

Hygiene. Due to the diverse socio-economic statuses, the population of the Ukraine often faces problems with hygiene. The countryside is very different from the cities. In the countryside, the rural way of life is a standard. There is often the lack of water, sewerage, etc. This obviously has an impact on sanitation and hygiene habits of the population of the Ukrainian countryside.

Relationship to Health and Prevention

According to numerous authors, healthcare in the Ukraine is in poor condition. For example: “Patients who have to be hospitalized are given a list of things that you have to buy and take with you before entering the hospital. These include pyjamas, sheets, drapes, but also even the purchase and delivery of one’s own sy-

ringes and bandages. Thanks to that, the Ukrainian patients who come to hospital are usually very disciplined and have almost no specific requirements. They readily adapt to and understand the regime orders of their ward. The problem that may arise is that of the representatives of the Ukrainian ethnic not having contracted a valid health insurance. As a result, the doctors and other healthcare professionals may treat them with suspicion.

Dietary Characteristics

Ukrainian food and gourmet specialities of the Ukrainians are well-known. Ukrainians also open restaurants or grocery stores in a number of cities, focusing on their specialities. Ukrainian cuisine is based on local crops and also often on what people can grow themselves in their gardens. In the season, a lot of fresh fruits and vegetables can be bought in marketplaces in the season. Local people often pick mushrooms and berries in the forest. Ukrainians like to cook compotes and pickle cucumbers and other vegetables that are consumed in the winter. Game and fish from local rivers, as well as black and red caviar are very popular.

So is the traditional Ukrainian soup called borscht. Borscht - soup, a meat broth with beetroot which gives it a distinctive red colour, cabbage, onions or other vegetables and potatoes. A richer version of this soup is served with sour cream. Ukrainian pasta, for example varenyky, is renowned and delicious. Varenyky - filled pasty similar to Italian ravioli. They tend to have a square or crescent shape and potatoes, meat, cabbage, cottage cheese or fruit as filling. Varenyky are served poured over with melted butter and with sour cream, sweet variants with sugar. Another option is to add cracklings, onions and cream. Another is holubtsi - rolls stuffed with spiced meat and rice (or buckwheat) braised in tomato sauce. The Ukrainian shashlik is an unforgettable dish - an equivalent of the “shish kebab” - marinated pieces of meat grilled on needle. Shashlik is well known in most countries of the former Soviet Union. Country dishes are made of different kinds of grains, buckwheat is often used. Even bread can be baked from buckwheat. Otherwise, however, the majority of pastry products are made using wheat which is widely available. In short, Ukrainian cuisine is diverse and healthy.

The prevailing soft drink is leaven - sweet and sour frothy (sometimes slightly alcoholic) drink made of yeast, sugar and (mostly rye) bread. The most often enjoyed alcoholic beverages are beer, wine, vodka or the Ukrainian equivalent to cognac.

Even the significant Ukrainian religiosity translates into culinary arts. During Christmas and Easter celebrations, Ukrainians bring the specific products of their national cuisine over to our country, for example Kutya, the Sweet Porridge Ukrainian dish, is associated with Christmas. It is a dessert served at the beginning and end of the Christmas cycle, containing poppy seeds, wheat, honey, nuts and a vari-

ety of candied fruit. At Easter, then, they bake their own "form" of the Czech sweet bread ("mazanec") called "kulich paschalnyi".

Relationship to Illness and Death

Thus, there are two contrasting approaches: "On one side of an imaginary line, there is the view that uninsured immigrants are not entitled to access to healthcare services. This view is often derived from the idea that a large part of the uninsured migrants are illegally staying in the country. On the other side, there is a contradictory view according to which they are entitled to the treatment as a fundamental human right of every human being. In practice, the conflict of these views brings about a certain compromise. Every person, regardless of their residence status are granted the necessary and urgent health care the exact scope of which is discussed extensively and which is mainly applied in direct danger to life. However, in reality, some doctors have pity on migrants without insurance, according to their testimony they mostly even help and advise them in the absence of the necessary funds (usually on a one-time basis)." There is a need to highlight one risk - the majority of illegal migrants try to be "invisible" and therefore, they often do not ask for medical care even in extreme cases, which can be a great problem, especially in the present global pandemic.

Dying, Death. Rituals are connected both with the birth of a child and with the death of a person. Death is often accompanied by transition rituals. Voluntary death is impure and the deceased are treated differently than if they had died a common death. Unexpected death causes fears of the soul's return due to the fact that it was not ready to leave this world. Fear of the soul returning due to its unprepared state is also related to the effects of evil demons and unclean forces. Not being prepared to die also potentially means that the soul of the deceased might succumb to the evil demons easier (as the body was not protected by sacraments). The death of an old person is connected with their preparation for death and the end. A priest comes, there is a ceremony of the sacrament of reconciliation and of parting with their neighbours, etc.

Communication and Methods of Information Exchange

Ukrainians are helpful and communicative. Also, related languages of the Slavonic family can facilitate communication in the Czech Republic. Nevertheless, as clear from the view of the elaborators of this topic of qualification works, it holds true that "Ukrainians in the Czech Republic have very poor knowledge of foreign languages and communication with them is usually difficult. They are very straightforward and tell you how they feel - when asked: "How are you?", they will detail their feelings." Another thesis researcher even argues that according to her research, it is the language barrier that makes the care for Ukrainian patients the most diffi-

cult. This is specifically due to the fact that 53% percent of its respondents encountered language barrier when treating a Ukrainian patient. This is also the view of another author who even sees the inability of quality and productive communication between the nurse and the patient in connection with imperfect knowledge of the Czech language as a direct obstacle to the provision of nursing care. “In the Ukraine, not much emphasis is put on learning foreign languages, which causes the Ukrainians in the Czech Republic to have only weak knowledge of Czech, but also other Western languages. Even despite the fact that the Czech language is not very different from the Ukrainian language, communication between the Ukrainians and medical staff often causes problems - an inability to express themselves correctly or understand the meaning of the message, or tendency to confuse similar words. It is important to note that some Ukrainian patients who do not understand, show signs of understanding only in order not to cause unnecessary trouble. Therefore, it is necessary for the nurses to provide feedback. The central element of non-verbal communication applied by Ukrainians in conversation with other people is especially eye-to-eye. This direct eye contact expresses confidence in and respect for the other person. It is important for them to offer a handshake both when meeting and when parting.” However, hands are only shaken among men. It may occur that the man reaches out to all men in a company if he knows them or becomes acquainted with them, but the women are skipped altogether, which is common.

Cultural Peculiarities

Religion

Ukrainian society is religiously diverse / heterogeneous. Whether a given area is uniform or diverse in terms of faith, religion and the Church have great impact on everyday life of Ukrainians. The church with the largest field of action is the Orthodox Patriarchate of Moscow. As the name suggests, a very important feature of this church is its Russophilism, although the canonization of this church has occurred under Kievan Rus already (cf. Маґочій, 2012, p. 685). The second largest church is Orthodox Patriarchate of Kiev, which follows the tradition and glory of Kievan Rus, and is thus against the pro-Russian orientation which is currently felt very strongly. Supporters of this church can be found mainly in the central part around Kiev, but this religion also appears in the western regions. Third in line comes the Greek Catholic Church. The Greek Catholic Church was founded in Galicia in 1596 on the basis of the Union of Brest concluded under the agreement of the Polish King between the Roman Catholic Church and the Ruthenian Orthodox Church.

By combining archaic ideas with Christianity itself, the Ukrainian breed of Christianity acquires the character of a national religion. Here, Christianity has its holy places and cult system. It corresponds to the local national traditions and ideolo-

gies. Ukrainians both worship saints and bows before personified forces of nature, which is still retained in certain ceremonies and rituals. Generally speaking, rites and beliefs in supernatural forces are ascribed a significant role in Ukrainian Christianity. We can therefore say that traditional life in Ukraine today is influenced by the Church but the Church is constantly influenced back by living traditions, including mythology. Ukrainian mythology is one of the main characteristics of the Ukrainian national world-view. These ideas form the basis of the whole Ukrainian culture.

However for Ukrainian emigrants, faith also has another dimension. Ukrainian labour migrants are often integrated into impersonal client systems of job placement services, residence permits or accommodation. For this service, they surrender up to half the salary for the entire period of work. From this rather difficult situation, existential and social problems may arise which can be solved more easily in the Christian community, offering help in overcoming the initial estrangement.

Customs and traditions

Against the background of the state with a strong Christian legacy, we see the influence of much older cultures. Pre-Christian traditions full of mythological images are still stored in the living awareness which often does not take into account the modern achievements of the 21st century.

Typical Christian holidays like Christmas and Easter are celebrated similarly to how they are celebrated in the Czech Republic but many other holidays associated with Christianity are still also linked with living mythological ideas. Ukrainian mythology is one of the main characteristics of the Ukrainian national world-view. These ideas form the basis of the whole Ukrainian culture.

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2.2.5. Romani Culture

Characteristics of the Romani Culture

The following summary does not present the characteristics of the Romani as patients or clients in general, but rather what the majority society (based on a number of studies referenced, i.e. articles, theses from bachelor's ones to dissertations, professional publications) stereotypically perceives to be true about members of this community. We may add that the generalized information about the Romani community below is based on surveys among the Romani (not large groups) living on the fringes of society in socio-economically excluded localities. Social exclusion, however, concerns a maximum of 80 thousand Romani living in the Czech Republic. According to informed estimates, however, there are more than twice the number of the Romani living in the Czech Republic, however these Romani are integrated

into the society and not visible, therefore not attracting the attention of the majority. Whenever we talk about the Romani as the bearers of certain attributes, it is appropriate to recognize this fact and at the same time to realize that the identity we attribute to them is only one of many possible identities. In other words, the question is in which terms we segregate the Romani population, i.e. based on what attributes and characteristics of their culture or ethnicity we testify of them.

The 2011 census saw a total of 5,135 people reporting themselves as being of the Romani nationality. According to estimates, the total number of Romani in the Czech Republic is approximately 160,000–250,000. The estimate for Europe is 3–6 million and for the world 10–12 million. In Poland, the estimates are between 50,000 and 60,000 in Poland and much larger in Bulgaria: 700,000 to 800,000. In the states of South and Southeast Europe, up to 10% of the population are Roma.

Historical roots, culture development

Sources speak of the presence of the Romani in Europe since the 14th century. The Romani reached Bohemia and Moravia in the 15th century. They went on further to Germany, France and Spain.

Already in the Middle Ages, the Romani summoned distrust by their differing appearance, character and unfamiliar customs. This was associated with the occasional theft and poaching which they practised to sustain themselves, as the Romani did not own the land and only travelled from place to place. The initial misunderstanding soon escalated into an open aversion. Subsequent centuries became a period of repression and persecution of the Romani.

Since the 18th century, permanent settlement of the Romani started to assert itself, however, the Romani were still mostly not settled up until the 19th century in Bohemia. The situation was different in Moravia where there already existed so-called Romani camps or villages. These were more or less isolated units on the edges of other municipalities whose inhabitants allowed Romani settlement.

Legal measures in the early 20th century, aimed at gradual integration of the Romani into the society. In the inter-war period, several basic groups of the Romani lived in former Czechoslovakia - the largest group were the so-called Slovak Roma, who lived permanently in the Slovak Republic. Another large group were the Hungarian Romani living in the Hungarian-speaking part of Slovakia. In Bohemia and Moravia, most of the Romani belonged to the group of the Czech Roma. In addition, there were the German Romani (Sinti) and the nomadic Olah Roma.

After the Romani Holocaust during World War II, however, the territory of Bohemia and Moravia counted only a few dozen families of the Czech Roma. Depopulated areas and industrial cities started to be settled by the Romani from eastern Slovak settlements, resulting in today's Romani population in the Czech Republic

being mostly of Slovak origin. Compared to the development in Slovakia, most of the Romani in Bohemia and Moravia live in cities.

In the 1960's, there was another wave of displacement of the Romani population in Slovakia into communities in Bohemia and Moravia. As opposed to post-war migration, this was a planned scattering of individual families which did not respect kinship ties. About two thousand Romani came to the Czech Republic based on these movements.

The Romani culture which influences their lifestyle, cannot be characterized as homogeneous. To the contrary, it is influenced by local conditions and varies greatly in different areas.

The Role of Men and Women in the Romani Culture

Generally speaking, the Romani family is governed by great cohesiveness. The family means everything to the Romani and constitutes the greatest value in their lives. The largest Romani family in the Czech Republic is a fourteen-member family. The Romani very often move to and visit one another. Unemployment is commonplace among them so they have enough time to spend together with their family. In their families, everyone supports each other and help one another. The children are mostly taken care of by the mother, but all family members are also involved in providing care to children, the elderly and the ill. Old people are honoured and it is still common in this ethnic that they die in the family circle. Romani residents of senior homes may be encountered occasionally, but to most of the Roma, this option is unthinkable.

Nowadays, traditional Romani family in this form is less and less common. This is due to the transformation of lifestyles and cultural models that can be observed in all communities of the world. An emerging problem is posed by the increasing proportion of Romani children in orphanages. The main causes of this phenomenon include insufficient family income for their basic needs and unsatisfactory housing situation. Similarly, family solidarity changes and causes some individuals to find themselves in retirement homes, social care institutions, etc. The values professed by traditional families do still mainly include an easy-going, free way of life, recognition of ancestral hierarchy and honouring ancestral traditions, love for children and understanding of money as a means absolutely necessary for survival. Among life values, the family, health, humanitarian ideals, equality, material values, social security and labour are among the first ones most often named. Decision-making in families takes place collectively, as everyone makes decisions together. This means that the resulting option is adopted by identification, not subordination. This corresponds to the basic features of the social system of the Roma, which is shared decision-making, inability to be alone, the perception of expulsion

as the greatest punishment, but also with constant change, the need for it and the need for high degree of flexibility.

The family has always been a place where children are educated, and therefore the "Gadjo" method of education was not ascribed and has still not been ascribed much value by the Roma.

Higher rates of criminal activity are detected in socially excluded localities, which stems directly from the lack of resources (especially financial ones) and the related lack of job opportunities. Due to the fact that excluded localities are largely populated by the Roma, a phenomenon comes into being there which can be described as "ethnicisation of crime" in the Czech society.

20–30% of the economically active Romani obtain subsistence through illegal means. Their proportion in prisons is estimated at more than 60% and their relapse rate is up to 50%. Most often, the Romani participated in burglary (22%) and thefts (19%). Their share on the criminal offence of sexual abuse is also not negligible (20%). Due to the numbers of Romani population, the overall crime rate of the Romani is approximately five times higher than in the rest of the population. The current means of livelihood of most of the Romani is unskilled labour in construction, in logging, rail or at various kinds of earthwork and city cleaning services.

The husband is the head of the family whom everyone must obey and who is paid great respect by the family. In the past, when the couple went out together, the woman had to go a few steps behind him and the man showed his superior position in the family. A man has always had more rights than a woman and he bears responsibility for the entire family. Most Romani prefers a son as their first child. He is raised by his mother until the age of six years when his father takes over the upbringing. The eldest son helps with the education of younger siblings, and especially cherishes his sisters so that they remain chaste. When the son gets married, he almost always stays with his wife and lives with his parents. The man shows love for his wife, for example, by occasionally striking her in a row because there is a rule that he who is jealous, he loves. The duty of every man is to financially secure the family but the man's income can often be only occasional. When a man is unemployed, he usually maintains good family relationships and the woman must obtain finances herself, however, her position in the family does not improve as a consequence.

It may seem like discrimination against women but in the family, it meant a certain respect for the customs and rules. The woman was recognized according to how many children she gave birth to. When she was barren, a man could break up with her with clear conscience. Romani women mostly occupy the role of mother and housewife in the household. Their position has passed through changes over the long years. At present, although the woman is subservient to her husband, she may also seek fulfilment in the outside world.

Raising children is much freer than in the majority society. Children have plenty of free time and have no other duties besides taking care of their own siblings, since there is no regular daily routine to organize the children's lives; therefore it is not unusual that children participate in family events until late at night. Parents of children do not hide anything from them, not even their intimate life. Romani children are deprived of the carefree life and grow up very quickly. Their day has no targeted incentive and children usually run in the streets on their own, playing without the supervision of their parents. Unfortunately, it is frequent among Romani children that they do not recognize any authority, take no interest in value and some are already in their early age met with drugs and prostitution.

The Romani value their family very much and different generations often live together. If they do live together, elder family members are raising their grandchildren and their opinion has great gravity and respect. Old people are never considered unnecessary members in the household because their position is the same as those of the others. Young Romani appreciate their wisdom and experience gained in their life and also because old people are always right.

Education, family upbringing and sexuality

Education. The Romani are often associated not only with a lack of skills and low education, but also lack of literacy.

In the modern society, education forms a prerequisite for success in working life. However, knowledge, abilities and skills acquired at school are vague, and thus unnecessary for the children and they can do without them. The Romani raise their children by example, through experiences, and school knowledge is intransferable to the personal plane of such nature.

Why Romani children fail in the learning process? Ethnicization of education leads to a deepening and strengthening of social exclusion. Children from socially excluded localities or Romani ghettos may even never encounter a member of the majority population even over a long stage of their life, as they may not receive compulsory education in mainstream schools, but at a practical school or so-called Romani school, which is adjusted by curriculum to fit most learners of the minority.

The Romani themselves often prefer education in vocational or so-called Romani schools with adapted educational program. However, this prevents them from achieving secondary or higher education. There are several schools in the Czech Republic which are ethnically homogeneous - Roma. The Romani often do not see a reason to invest in higher education for their children. A school where pupils from the majority population outnumber the Romani is perceived as foreign environment. Romani children are stigmatized at school. (The Romani are often visibly differentiable.) School results of Romani children in regular schools depend on how they cope with their stigma.

Thus, the Romani are caught in the trap of social exclusion from their very childhood. Socialization of Romani children and their integration into mainstream society are moving in a vicious circle. Accepting the humiliating position of a pupil in mainstream school is only possible with the knowledge that school education will be the factor of social value to bring the individual considerable benefits in the future. However, the postponement of these benefits into the distant future does not represent enough of a motivational incentive to the majority of Romani youth.

Maternity**.** The most important value of a woman is her fertility, since her position in the family rises with the number of children she has brought into the world. Pregnancy is always welcome: the more children the spouses have, the more prestige their family achieves. In the past, the period associated with pregnancy and childbirth was a time for various customs to be observed which have, however, disappeared completely in the present.

However, the birth of a new family member is a great social event for the whole family as well. The pregnant woman should improve her regime and take good care of her health but the opposite is true, as Romani women smoke and drink alcohol, not realizing that they are potentially child causing their child health problems. During pregnancy, they work less or cease to work completely. In the past, women worked until the last moment before birth. Romani women usually become mothers around their twentieth year of life. A few days before the birth, the family are all eagerly awaiting the birth of the child and experiencing this time in an emotional way.

Today, women usually give birth in maternity hospitals. When a woman is in the delivery room, several members of the family wait impatiently in the hallway at the hospital. After the birth, everyone wants to see and welcome the baby which is why we encounter the family and relatives in abundant numbers. The Romani make it clear that way that they are accepting the child into the family circle.

Pregnancy and childbirth are a great event for a Romani family. Romani mothers love their children blindly. This is factored by the psychological immaturity of the mothers (6% of the women give birth between 14 and 16 years of age, a percentage three times higher than in non-Romani mothers; about 19% of women give birth for the first time when they are 16). Up to 60% of children's homes are of Romani origin, almost half of those are children of single mothers.

The issue of the attitude of "Romani mothers" to newborn care. From published studies, it has been found that there is a difference in the care of newborns in relation to maternal ethnic group. "There is a clear difference in neonatal care between women from the Romani and non-Romani communities. Higher frequency of leaving infants in maternity hospitals by Romani mothers as compared to non-Romani mothers has been demonstrated. However, according to the authors, these results can only be applied to the examined part of the Romani and non-Romani women.

Most frequently, Romani women leave the hospital at their own risk on the first day after the birth, often even in the first two hours after the birth, or on the same day. Although the highest value for the Romani is the family, a full half of the Romani women universe have abandoned their newborn child in the past in the maternity hospital and fourteen Romani women, more than thirty percent, were about to take this step again at the time of completing the questionnaire, while nine Romani women were not yet quite decided whether they would leave their baby (results of published studies). Thus, the final number of Romani women who have left their newborn could eventually be higher. On the other hand, the most common reason for leaving the newborn baby given by almost half of the Romani women was unsecured care of the children they have at home, which underscores their family-centred thinking. The question remains, why other members of the family cannot provide this care temporarily for a few days when the Romani still live together in large numbers in the same household. The largest number of Romani women (almost half) stated that they have lived in a household with 4–5 people, and almost a third of them live count 6 or more people in their household. One can assume that Romani women need more time to create the same positive relationship to their newborns as they have to their family. A Romani man is not accustomed to do chores or take care of children, according to them, this is the woman's role. This may be one of many reasons why Romani women hurry home after giving birth, in order to ensure proper operation of the household and take care of their children and husband."

Social inequality among women giving birth affects not only the attitude of midwives to the woman in labour and to the woman hospitalized after childbirth at the post-partum department, but it also already affects the preparation of the mothers for childbirth, the possibility of presence of accompaniment at birth or the possibility to use paid forms of analgesia during labour. The analysis of research showed that age and level of education have an impact on maternal education and maternal cooperation with the midwife, for some midwives also affecting the actual attitude of the midwife to the woman in labour. But what also affects the attitude of some midwives, rather in a negative sense, is the mother's belonging to a minority group. The core of the issue stems from the fact that in certain situations, the healthcare encounter members of different cultures, like physicians and nurses from the majority population and patients and their family members from various minority ethnic groups and the like. This creates problems not only on the level of language and communication, but also on the level of values, customs and rituals. Also, the post-partum department midwives stated problems in the behaviour of Romani clients, especially in relation to smoking, early termination or hospitalization or numerous visits that come to the hospital to see them. The Romani culture does not consider an illness as an individual's matter. If a Romani person is hospi-

talized, the entire extended family will be coming to visit them, often outside visiting hours, which can lead to conflicts with medical staff.

Romani mothers eat normal food, preferring pates, sausages and salami, liver, butter and lard over other fats, they will consume French fries, chips, sweetened soft drinks and delicatessen products, preferring white bread and rolls over whole grains. Apparently, a different hierarchy of values, mentality and overall life attitudes are demonstrated here. A somewhat different approach to the care of one's health is also influenced by traditions and historical and cultural roots. We cannot ignore economic factors as well. Pregnant women and lactating women have to eat what they want, as Romani superstition indicates that should they be deprived of anything, their child would be born sick or prematurely. Therefore they do not omit alcohol from their diet, especially beer, which is to strengthen the ability of breastfeeding. However, studies in recent years have not shown higher alcohol consumption among the Romani than in the majority population.

The professional literature reads: "Treating patients of Romani nationality is very difficult because they are distrustful of the medical staff; communication with them is difficult, as in failure to comply with their wishes, they display their aggression and also as they are not accustomed to ask for things politely or thank for them. As patients, Romani women are sensitive to pain, emotional and often groan loudly, often only to draw attention to themselves. They only comply with treatment until symptoms have subsided. Romani mothers do not talk to the newborns as they consider it unnecessary, but they do take care to touch them abundantly. Generally, the contact between family members is rather haptic (touch) because they like to be close to one another and touching each other."

Intimate zone is smaller/narrower for the Romani than for the general population.

Relationship to Physical Hygiene and Clothing Characteristics

It is estimated that 90% of all working-age Romani from socially excluded localities have no job. And these are long-term unemployed. In the approximately 300 existing Romani settlements, poverty is growing and new dwellings are erected - usually shacks without basic facilities, running water or electricity. This is related to deterioration of health, increase in other negative phenomena (alcoholism, crime) on the one hand, and the rise of intolerance and xenophobia in the majority society on the other hand.

Socially excluded localities are also spacially separated from majority society and located in the outskirts of municipalities. In such enclaves "there is a concentration of socially pathological phenomena which in turn reinforce their inhabitants' exclusion." In the absence of functioning social checks, socially pathological, deviant phenomena (such as crime, prostitution, drug or alcohol addiction) are sub-

stantially tolerated. It is obvious that life in socially excluded locality affects, if not determines, the behaviour of individuals.

In connection to the existence of socially excluded localities, some researchers have started to use the term ghetto and ghettoisation of the Roma. Some of them blame Romani exclusion from the publicly shared space on the majority society which has not only allowed this situation, but in successive steps also directly contributed to its creation.

The Romani paid great attention to their clothing and they used to wear colourful and showy clothes, in order to separate themselves from the general population. Now, the Romani have adopted the style of dress from mainstream society and their specificity in traditional dress has disappeared completely.

Relationship to Health and Prevention

It is important during the provision of healthcare, including nursing care, to take into account the patient's ethnic and cultural values and beliefs which relate to their health, lifestyle, illness and death.

"It is generally believed that the health needs of the Romani relate mainly to the conditions of their life and their way of life. Both reflect low education and low living standards, low standard of dwelling, often risk behaviour in relation to health, tendencies to become subject to addictions to alcohol and drugs more often, difficulties integrating into the majority society and other psychosocial determinants. We may also encounter lower sense of personal responsibility for one's own health and less significant motivation to be well and care for one's health, which play an important role, as well."

Health is only third in the Romani value ranking (after love and family). If Romani are hospitalized at the hospital, healthcare professionals may find it rather difficult to provide care to them, as the Romani will not trust them. A significant problem may also be communication with the family of the hospitalized. Therefore, it is important to find out who in the family is to be provided with information and who will be dealing with the healthcare professionals on behalf of the family. Sometimes, this contact with the family is not established, which can then lead to consequences on the health of the ill person. The Romani tend to have relatively great fear of pain and of death, they are very emotional and often moan loudly. Women tend to be anxious and some of them may find hospitalization hard to endure.

During a period of illness, the Romani are weak-willed and cannot be persistent or patient. They have strong family ties and they are helpless and feel fear and anxiety without the family. They may even exhibit aggressive behaviour and unwillingness to cooperate with the medical staff at the hospital. Overall, they are wary of the staff and take the advice of healthcare professionals lightly. Educating the pa-

tient, the medical staff should ensure that they understand and that they realize what will be asked of them, which is why they choose the correct way to communicate, using simple verbal expressions.

Their approach to their own health is very problematic. Excuses, such as living a long distances away from the medical facility, lack of funds for travel, treatments, medication or insurance, are typical of them. They most visit their general practitioner, but they underestimate or neglect prevention with their medical specialists, such as gynaecologists, dentists, ophthalmologists and the like. Mothers ignore regular vaccination and preventive examinations of their children, because it is essential for them to see their children happy and satisfied. They will only address their health when some kind of health problems and complications occur.

Dietary Characteristics

The dietary habits of the Romani minority are very well captured by the following quotation: "A Romani can be poor as a church mouse, but they must have enough food even at the cost of the fact that there will not be any left for tomorrow." This suggests the usual eating habits. Food was not unusually a regular ritual, yet it was closely connected with the status of the family. Food was only eaten when there was some, that is usually once a day. The composition of the diet depended completely on the conditions and possibilities of the environment in which the Romani were staying. Due to the fact that Romani people did not belong to producers of animal or plant food in the past, they depended on the production of the rest of the population. Therefore, they were passive consumers, not stocking food and practically living from day to day.

At present, Romani families cook frequently, especially after the payment of wages, well-fare or other benefits. Parents often try to make up to all the children what they themselves were deprived of.

It is not customary to distinguish baby food from adult food and the consumption of meat, sausages and sweets prevails. Fruits and vegetables are not consumed either.

Typical Romani dishes include goja, a dish made of pig intestines, fat, flour or potatoes and spices. Floury pancakes or lockshe, are made in the traditional manner from flour, lukewarm water, milk or buttermilk and salt. It's a dish that is used as an accompaniment to roast meats and many other dishes. Other traditional dishes include holubki (stuffed cabbage leaves) or the gnocchi-like halushky. These may be served with cheese, egg, onion, beef and also sauerkraut, chicken or the like. An integral part of the Romani diet are also noodles which can be prepared in various ways. They are usually used as a garnish for soups or as a main course for lunch. Soups occupy a special place in the diet, as they are considered essential and there

is no full lunch without one. In this minority, soups are often the main course which is why they are thick and often served with pasta or bread. Other meals include the "krupoto" (a kind of hulled grain risotto) made with pork, chicken or veal, barley hulled grain and spices, as well as cabbage rolls, potato goulash, dumplings with jam, fried scones or "págle" (also called "opekance").

The problem of healthy lifestyle and overweight in the Roma. The Romani diet is very similar to majority cuisine nowadays. Their diet mostly consists of fat and meat dishes and sweets. They put emphasis on the consumption of meat, including dairy products, fruits and vegetables in their diet scarcely. They neglect the drinking regime very much and prefer to drink sweet drinks. Traditional Romani meals also include: holubki (stuffed cabbage leaves), pishot, meaty machanka (traditional Romani soup), Hungarian style strudel, potato gulash, baked potatoes and others. Generally, it has been valid from the past until today that one eats when there is something to eat. So many Romani families are experiencing so-called skinny and rich days during the month. The basis of food used to be crops and fresh foodstuffs that the Romani were able to inquire after, receive or otherwise obtain. They like meat and fatty foods, but most of their food consisted of potatoes and pancakes made from flour, that is the cheapest food.

The eating habits of the Romani are associated with a lifestyle that affects them not only through the organization of everyday life. Eating habits and especially the choice of food and the regularity of food intake may have an impact on their way of spending their leisure time and the way the use their potential. In this regard, the weight of an individual seems to present certain limitations which bring about some pitfalls and implications for the individual's health. Among those mentioned were particularly shortness of breath, leg pain and back pain. Some of the respondents suffered from diabetes or hypertension. These influences on the health may be motivational to them, especially when, as reported, the physician recommends weight reduction. It was interesting to observe the category of motivation that interferes with lifestyle and eating habits. Its influence on lifestyle appeared mainly in an effort to comply with the regime measures which Romani are successful at for rather short periods of time.

Overweight and obesity are connected with lifestyle in the Roma, as there are identified modifiable risk factors which are to some extent associated with life in the communities and affected by culture. As reported by Davidová et al. (2010), the Romani generally underestimate prevention and healthy lifestyle. This is also the reason why they pay attention to their health only when problems or deficiencies occur. Based on the above, we can say that the particular modifiable risk factors for overweight and obesity among the Romani are inactivity, lifestyle, improper com-

position of the diet (dietary habits) and to some extent also socio-economic factors (in terms of housing security, and life in socially excluded localities).

Relationship to Illness and Death

The Romani generally dislike hospitals, as according to them, there is a high incidence of diseases, bacteria and death, but if there is no other option, they will let themselves be hospitalized. The Romani wish that information about their health status is made known to them and to their family, that complex care is provided to them in the medical facilities, and therefore, the medical staff needs to be familiar with the specifics of the Romani ethnic group. It is generally known that members of the Romani ethnic group have a lower pain threshold. If they feel pain, they will immediately ask the staff for painkillers or other drugs for pain control. Even if their medical condition is not serious, they will let their pain be known loudly and the family usually shares the pain of the patient with them.

Romani die at a significantly younger age compared to the majority population and the differences in these statistics are great. "A large part of the Romani population picture their health as total absence of illness and their illness is perceived as inability and helplessness leading to death. In their ranking, health only falls to the tenth place which differs significantly from the majority population who always put health to the first place. They seek a physician only when their complications are acute or their illness is chronic. They have a peculiar attitude towards physicians and medical staff: on the one hand, they respect physicians, as they are educated and can cure their disease or postpone their death, but on the other hand, they are bearers of bad news. Therefore, they generally perceive healthcare professionals as those who can be a problem because they pointed out problems. When they find that a certain physician has helped them and that their treatment works, their whole family will turn to that physician with their health problems. The Romani normally only adhere to the treatment regimen until their painful symptoms subside and once they do, they will stop taking the medication and disregard medical advice. This negligence reflects negatively on the efficiency of treatment and hospitalization, which is then repeated for chronic disease. It is important to repeat to the patient and their family constantly what the impact of non-therapeutic regimen may have on the patient's health.

Pain perception in Romani patients. The Romani feel great fear of pain and death, even if their medical condition is not serious. It might seem a trifle for Czechs, but no pain is banality to the Roma. This is due to their temperament and origin. They are very emotional, and often moan loudly. Fear of pain is manifested even in children. "Fear of corporal punishment is twice higher than that of a non-Romani child. In the event that the Romani must be hospitalized, it is perceived as separation from

their family. The family is not accustomed to privacy and so it is not unusual or embarrassing when a man cries at the hospital. He is alone in a strange environment, unprotected by the family and forced to subdue himself to a foreign order. Women are anxious and tolerate hospitalization very badly. At the moment when the family come to the medical facility, a Romani ill person can express their pain to them. Others experience pain with the patient, suffering with them, but support them, as well. The ill person discusses medical decisions with the family. The entire family decides as they know what is best for them. A Romani person feels better when the whole family are with them. They are weak and threatened when alone. How the Romani will tolerate pain is influenced by many factors. It is influenced by the conditions and causes of pain, duration of pain, localization, intensity, quality and type of pain, factors that cause pain or soothe it, accompanying symptoms, impact on daily activities, previous experience of the patient with pain, their opinion on pain, the defence manners used and the affective responses to pain. For the Roma, life is of the highest value. Everything that threatens or limits life is perceived negatively. If pain limits the patient, a Romani person perceives it only as a necessary evil that must be eliminated.

Pain that is associated with pregnancy and conception is acceptable to the Romani as something important will come from it for the individual and for the family. Childbirth and complications in childbirth are suffered by women with other members of the family who support them emotionally. Today, Romani mothers have acquiesced to the majority society and give birth in hospitals. At this important moment, they lack support and attention of their own families very much. It is therefore quite typical that most of the family members spend time near the maternity hospital.

The Romani express pain both by verbally and mimic means. Loud groaning, moaning, complaining, crying, etc. They manifest it aloud before the whole family who thus experience pain with the patient. The Romani do not try to hide their pain from their environment. The reaction of the organism to pain is manifested by tachycardia, bradycardia, increased or decreased systolic blood pressure, tachypnea, sweating, increased muscle tone, pallor, dilated pupils, accelerated speech, raised voice or excessive agility, nausea, vomiting, warm and dry skin, syncope or even collapse, narrowing of the pupils, slow monotone speech and unsociability. Another possible reaction are changes in the behaviour of the patient, manifested by mobility, tiredness, restlessness, writhing, unnatural position, moaning and weeping. The patient feels fear, anxiety, anger, hopelessness, helplessness, punishment, fatigue, exhaustion and depression." Funeral is an important ceremony for the Romani and they have kept their traditional customs associated with the death of a family member for years up until the present times. Unlike the majority population, they often die at home in the family circle. They believe that after death, the

souls of the deceased turn into spirits and that the spirit remains outside the body, along with other spirits of the dead ancestors, until the funeral when both leave for the afterlife. When a woman dies, her jewellery is taken off and her hair is loosened so that the spirit could leave the body easily. If a man dies, his wife must according to the traditions and customs let her hair be cut. The body of the deceased remains in the house until the day when the funeral takes place. From the death to the funeral of the deceased, the family sit around, holding guard, playing cards and telling stories about the deceased and drinking alcohol. Before they start to drink, they spill a little from the first drink on the ground to express remembrance of the deceased. The deceased is dressed up in festive new clothes, their eyes are pushed closed by coins so that the deceased would not take anyone with themselves and the person's mouth is tied closed with a scarf.

Romani funerals tend to be large, showy and very expensive, since relatives lavishes on them. Throughout the mourning period, women walk dressed in black and men at least wearing a black tape. Mourning holds for a year when the relatives of the deceased do not attend any celebrations, do not dance of sing. After a year, the relatives gather at the grave of the deceased and drink a toast to their honour.

Communication and Methods of Information Exchange

The communication reflects their temperament (vocal intonation - cries, gestures), and therefore, they use these means of communication to emphasize their verbal expressions. As part of communication, both inside and outside the community, their own common language may not prevail, but the local dialect, often related to the dominant language, is present, while both non-verbal communication and differences in the perception of time on the past-present-future axes are important.

Although the common language is Romani, individual Romani ethnics vary based on which dialect they use. There are about 60 Romani dialects described in Europe, while namely in the Czech Republic alone, in addition to literate Romani, another eight dialectic subgroups are used. The vocabulary of all dialects is formed by the original words, borrowed and newly created ones (neologisms). In the Czech Republic, the most frequent Romani is the Slovak, Hungarian, Olah, Czech and German one, with the Slovak dialect spoken by 80% and the Hungarian and Olah by 10% of the minority society.

The Romani mother tongue is gradually being abandoned, which is still happening today. Older generations of the Romani before 1945 spoke purely Romani. Most of the Romani population in the Czech Republic use their native language passively.

However, the Romani do have common organization of their society where the basis is formed by the family. The way they experience time and space is somewhat

of a peculiarity, with its preference of experience, internalization of the dream, a different way of social communication, specific conception of family upbringing and the negation of individualism. In this regard, it is important to remember that Romani time does not heal as the past is perceived without critical distance. It is constantly present and arouses emotions no matter when it happened. Preference of experience is then directed to pleasant events which bring satisfaction and joy. This do not always have concern relationships, but also money. This is also why they spend it very quickly without any consideration of the future. Their ability of social communication is different from the majority society. They can very well read in facial expressions, gestures and eyes. They will recognize hypocrisy the moment they meet a person.

Cultural Peculiarities

Religion

If the Romani are religious, the majority are Christians. It is reported that the Hindu religion has still been retained by the Roma. However, migration to other countries and the time interval did bring about with them adoption of the religion of the countries they live in. In the Czech Republic, the Romani adopted Christianity. The Romani faithful experience religion more intensely than the majority society. In their case, Christianity i traditionally associated with a number of superstitions, for example, belief in the magical significance of dreams, the evil eye, the power of curses, lucky attributes, such as holy pictures, the red colour and golden jewellery. The young Romani of the Czech Republic are currently largely atheists, as a result of the atheistic orientation of the majority society.

Customs and traditions

They often host parties with a large number of family members at their homes where they dance and sing. Quarrels are frequent among them and they tend to be very loud for those living in their surroundings.

The most traditional celebrations include those associated with baptisms or funerals. Baptism protects the child from evil forces and from someone taking or swapping him, helps the child sleep well and be well. The godfather / godmother is obliged to provide the child with equipment and pay part of the feast, and from that point onward, they become part of the immediate extended family - the fajta.

We may encounter devastation of flats and it has been stated that these acts of vandalism are an expression of defiance, despair, bitterness, but also aversion to the majority society and their way of life. The Romani tend to live in rented flats and due to their inability to manage money, it is no exception for them to lose even the roof over their head. This problem is solved by moving in with their relatives. Mov-

ing together of relatives entails the problem of overcrowded dwellings, and especially poor sanitary and social conditions. Therefore, the Romani spend a lot of time outdoors and they tend not to dwell in their homes. In the past, they were mostly outdoors, where they also ate and where the women cooked, laundered and took care of their family, etc. Today, we may encounter this practice in the excluded localities of the village type, e.g. in Eastern Slovakia.

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2.3. Conclusion

Inter-cultural education can lead to the promotion of reflection and critical thinking, however, it can also reinforce existing stereotypes. Which way it finally leans depends on many factors. However, one of them can be significantly influenced - it depends what the stance of the teacher or tutor themselves will be." This applies to multicultural nursing as well, of course. "The nurse who provides care to patients from different cultures should be equipped with appropriate knowledge in the field of multicultural / transcultural nursing, sensibility and understanding, and high communication culture, as each communication with the patient can either help and hurt them. The nurse should also have wider cultural knowledge to apply in their vocation, including knowledge such as the culture of dying and the related cultural customs and rituals. Given that the number of foreigners living in the Czech Republic is rising year by year, it is fully desirable that medical staff were prepared for practice." Unity in diversity. "The content of this motto is tolerance, respect to differences, that is under the condition that we recognize the same base values mutually. Multiculturalism is a phenomenon that is part of our culture, it is also part of globalization. The ideal of multiculturalism is harmonious interplay of cultures, including customs, behaviours, traditions, rituals and the goal for all members of all different nations and nationalities live in mutual tolerance. Generally, the fastest development recorded in history has always occurred in civilizations who have been in contact with different cultures, competing with them and forced to define themselves against them. When isolated, culture stagnates. Thanks to inter-cultural

confrontation, there has been and still is exchange of knowledge, learning about other traditions, customs and hierarchies of values. Each culture has "something" to offer and each culture has space to accept "something", as well.

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3. Procedure for selected diseases in non-standard situations in nursing and obstetrics

Progress in European higher education systems is also visible in teaching medicine and similar fields of study. These days in education, emphasis is put on the need to have and improve social competences that are so important for working with patients. These include, above all, organisational behaviour understood as cooperation in an interdisciplinary team and with patients at each stage of diagnosis and treatment (including patients with chronic illnesses). Furthermore, the spectrum of organisational behaviour includes history taking skills, as well as delivering difficult news.

At each stage of providing medical care, ethical problems often arise. These are mostly related to meeting the individual – not group – needs of each patient. Individual needs are understood as: respecting human dignity, supporting autonomy, continuous security, considering needs in terms of organisational and formal issues.

Many dilemmas present themselves in relation to medical care, that need to be resolved taking into account the patient's autonomy, his or her right to self-determination, and the professional obligations of the medical practitioner. A perfect example of that is society's ageing, where institutional care over the elderly is more and more common.

Each medical practitioner in his or her line of work is constantly exposed to difficult situations. The most common causes of such situations include disproportion between the number of obligations and the number of staff, possible infections, anxiety over the possibility of making an irreversible error, lack of fluent cooperation in an interdisciplinary team. Most importantly, all medical practitioners, irrespective of their education, job or tenure, are aware of the fact that in their line of work they are responsible for the highest of values: human health and life.

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3.1. Patient in a non-standard situation

3.1.1. Patient with a sensory disability: blind, deaf

3.1.1.1. CharCharacteristics of the disease – essence, symptoms

It is estimated that 1 in 6 of the general population has some degree of hearing loss. There are many reasons why some people are deaf, hearing impaired, or lose their hearing. The most common is age-related deafness with more than 50% of people over the age of 60 with some hearing loss. Other people may lose their hearing because of exposure to noise at work or because of prolonged and repeated exposure to loud music.

Visual impairment and/or blindness:

- Visual impairment: Decrease or severe reduction in vision that cannot be corrected with standard glasses or contact lenses and reduces an individual's ability to function at specific or all tasks.
- Blindness: Profound inability to distinguish light from dark, or the total inability to see.
- About 80% of global blindness is preventable.

Hearing loss and/or deafness:

- Hearing Loss: A decrease in hearing sensitivity of any level is termed hearing loss.
- Deafness: Profound or total loss of hearing in both ears.
- Over 50% of causes of hearing loss are preventable.

Symptoms

Signs of a problem can include:

- needing to turn up the volume on the television or radio.
- difficulty following a conversation.

- not hearing noises such as a knock at the door.
- asking others to speak loudly, slowly, and more clearly.
- needing to hold books or newspapers very close.
- sitting close to the television.
- difficulties in moving around unfamiliar places.

3.1.1.2. The specificity of nursing in these diseases

The individual abilities and needs of a deafblind person should be assessed soon after they arediagnosed. This will allow a tailored care plan to be drawn up.

The care plan will aim to:

- Preserve and maximise any remaining sensory functions the person has teach alternative communication methods such as the deafblind manual alphabet.
- Help the person retain as much independence as possible – for example, by recommending they receive training to use a long cane or guide or through the provision of a communicator guide.
- For young children, ensure their educational needs are met.

Recommendations for good nurse practices:

- Treat deaf, hearing impaired, and deafblind people with dignity and respect.
- Be aware of their patients' communication needs and should check the patients haveunderstood the information given.
- Document a patient's sensory impairment and it should be clearly visible in the casenotes.
- Actively inform patients of their entitlement and availability to communicationsupport.
- Be aware of how to book a special interpreter or communicator.
- Offer an extended appointment time for patients who require communication support.
- Be aware of relevant information in accessible formats, for example, large print, easy to read for those with a learning disability, or plain English for patients where English is not their first language.
- Be aware of how to operate different sensory impairment equipment in the department, for example, text phones, loop systems, and be aware of who is responsible for the maintenance of the equipment.
- Be able to reassure patients about any concerns they may have relating to the equipment used such as loop systems and confidentiality issues.
- Know how to use text relay and know where to access the relevant numbers.
- Check patients' hearing aids if communication appears to have deteriorated or is difficult. Often it is a simple change of battery that is required.

- Be aware of existing FIRE procedures. Patients who are deaf, hearing impaired, or deafblind may need to be alerted in the event of a FIRE evacuation.
- Engage regularly with their service users and obtain feedback from deaf, hearing impaired or deafblind people. Involving them in service design will ensure that these people's specific needs can be met.
- Ensure sensory impairment equipment is routinely available at staff meetings, training and any consultation events.
- Consider deaf/deafblind awareness training as part of their continuing personal development plan (PDP).
- Be able to guide patients to specialist organizations, that can offer additional support.

Several examples of good practice were identified by participants:

- GP practices displaying information on posters.
- GPs and hospitals should book interpreters in advance.
- Deaf patients should be able to book appointments and receive information using textsand email.
- Deaf people would like their disability clearly indicated on case notes and referralforms.
- Information should link across the systems, ambulance services, GP practices, andhospitals.
- Ambulance services/paramedics should phone ahead and make sure an interpreter is accessible.
- Information should be available on the website.
- Appointment letters should state that an interpreter has been arranged.
- Information should be available in different formats.
- Staff should know what the individual patient's needs are and give information inappropriate formats.
- Letters sent should be in large print.
- Return appointments should be booked at the time of consultation not sent out in thepost.
- Appointment letters could benefit from having a tick section for patients to highlighttheir requirements, for example, BSL interpreter or a loop system.
- Deaf awareness training should be available for all staff and should include addressing staffattitudes.
- The training should form part of routine registration training and after they arequalified. It should include awareness of how to treat a deaf person.
- Staff should know how to communicate with deaf people and should be able to usebasic sign language.

- Staff should know how to work with interpreters, for example, doctors should avoid the use of medical jargon.
- Employing permanent interpreters and deafblind communicators to be based in the hospital setting would be beneficial.
- Extended visiting hours for the deaf and the deafblind would help to prevent them from feeling isolated.
- Subtitles for TV would be advantageous.
- There needs to be a range of different ways for people to communicate with andreceive communication.
- Communication needs should be assessed regularly.
- Important information relating to a patient's disability and particular needs should beshared amongst staff.
- Longer appointment times are needed to ensure people have sufficient time to give andalso to receive information.
- Posters should be in place to remind staff people may have a disability.
- Use of pagers or other electronic devices would be helpful to alert you when called foran appointment.
- Deafblind patients should be involved when planning services.
- A flashing light should be used in conjunction with buzzer operated entry systems.
- There should be a textphone in each department.

Equipment to improve communication for people who are deaf and hearing-impaired and helpthem to access services would be considered a reasonable adjustment to provide one or more of the following:

- Written information in an accessible format (such as a leaflet or guide).
- A verbatim speech-to-text transcription service.
- Induction loop systems. Be aware of confidentiality issues.
- Portable loop system.
- Information displayed on a computer screen / Sign On Screen (SOS) via an online platform with a real-time link accessed from the internet and connects to a registered sign language interpreter (BSL) which opens channels of communication between a deaf person and a health professional.
- Accessible websites.
- Telephones, telephone amplifiers, and inductive couplers.
- Teletext displays.
- Audio-visual telephones.
- Audio-visual fire alarms.
- Pagers.
- SMS and Text Relay.

- CDs/Videos or DVDs with BSL interpretation or subtitles.
- BSL interpreters or lipspeakers.

People who are deafblind may require additional equipment and support:

- Plain English.
- Large print.
- Moon (this is a very simple tactile communication method used by some deafblind people).
- Braille.
- Magnifiers.
- Combinations of equipment due to dual impairment.

There is a wide range of technical solutions. The best solution will be identified by direct discussion with the patient.

3.1.1.3. Assistance Dogs

Assistance Dogs are permitted access to most of the hospital departments. Under certain circumstances access may be denied, for example, access into high-risk areas like High Dependency and Oncology wards. However, this will be rare and there must be justifiable grounds for denying an assistance dog access. Hearing dogs can be identified by their burgundy working coat with "Hearing Dog" written on the coat. They alert their owners who are deaf or hearing impaired to sounds, such as fire alarms, doorbells, or within a medical context, to being called for consultation when sitting in a waiting room. Dogs wearing a red and white striped harness indicate their owner is deafblind. Staff should be aware when they see such a dog that the owner is deaf, hearing impaired, or has a dual impairment and communicate with the patient appropriately.

3.1.1.4. Useful tips

Tips and activities recommended for effective communication with people with hearing and sight disabilities

- Ensure you have the person's attention.
- Try to establish the person's preferred communication method.
- Face the person, always. Don't turn away.
- Use clear speech.
- Maintain eye contact.
- Keep hands, pens, etc away from your mouth.
- Use normal lip patterns.
- Speak at ear level.
- Write things down.

- Use Fingerspelling.
- Use Deafblind Manual.
- Use block letters when you are not understood.
- Repeat.
- Rephrase.
- Try another communication method.
- Write things down.
- Offer alternative formats such as large print, font sized 18+, white on black, audiotape, email, and computer disc.

3.1.1.5. Prognosis for the patient

1. Alternative forms of communication

   As deafblindness can make communicating by speech and writing difficult, alternative forms of communication may be necessary. The main communication systems used by deafblind people include:
   - Clear speech – speaking clearly is one of the most effective and common ways of communicating with deafblind people, who have some remaining vision and hearing.
   - Deafblind manual alphabet – a tactile form of communication where words are spelt onto the deafblind person's hand using set positions and movements.
   - Block alphabet – a simple tactile form of communication where a word is spelt out in capital letters that are drawn onto the deafblind person's palm.
   - Hands-on signing – an adapted version of British Sign Language (BSL) where the deafblind person feels what's being signed by placing their hands on top of the signer'shand.
   - Visual frame signing – an adapted version of BSL where the signs are adapted to be signed in a smaller space to match the position and size of a deafblind person's remaining sight.
   - Braille – a system that uses a series of raised dots to represent letters or groups of letters.
   - Moon – similar to Braille, but uses raised, adapted capital letters that are simpler to feel.
2. Vision aids

   For some deafblind people, it may be possible to improve vision using low vision aids, such as glasses, magnifying lenses, and task lights. Specially designed items, such as telephones and keyboards, may also help someone who is visually impaired. Many libraries stock a selection of large-print books

and “talking books”, where the text is read aloud and recorded onto a CD. They also offer a talking book subscription service, where books can be ordered and delivered directly to your home or downloaded free of charge.

3. Hearing aids and implants.

   Some deafblind people may benefit from wearing a hearing aid. There are various hearing aid styles available to suit different types of hearing loss and personal preferences. Hearing aids use microphones to collect the sound from the environment, amplify it, and deliver it into the ear canal of the wearer so that it can be processed by the auditory system.

4. One-to-one support.

   Every deafblind person is entitled to help from a specially trained one-to-one support workerif they need it.

   Depending on the person’s situation, this may be a:

   - Communicator guide – someone who works with people who have become deafblind later in life, to offer the support the person needs to live independently.
   - Interpreter – someone who acts as a communication link between the deafblind person and other people, using the deafblind person’s preferred method of communication.
   - Intervenor – someone who works with children and adults who were born deafblind, to help them experience and join in the world around them as much as possible.

5. Treating underlying conditions.

   Some conditions that affect hearing and vision can be treated using medication or surgery. Forexample:

   - Cataracts can often be treated by surgically implanting an artificial lens in the eye.
   - Glaucoma can often be treated using eye drops or laser surgery.
   - Diabetic retinopathy can be treated in the early stages using laser surgery.
   - Some causes of temporary hearing loss are also treatable, such as a build-up of earwax or middle ear infections.

6. Support groups.

   If you’re deafblind or a friend or family member of someone who’s deafblind, you may find ituseful to contact a support group for information and advice.

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3.1.2. Patient with a mental illness – schizophrenia

3.1.2.1. Characteristics of the disease – essence, symptoms

Schizophrenia is a chronic brain disorder that affects different percentages of a country's population. When schizophrenia is active, symptoms can include delusions, hallucinations, trouble with thinking and concentration, and lack of motivation. However, with treatment, most symptoms of schizophrenia will greatly improve.

The exact cause of schizophrenia isn't known. But like cancer and diabetes, schizophrenia is a real illness with a biological basis. Researchers have uncovered several things that appear to makesomeone more likely to get schizophrenia, including:

- Genetics (heredity): Schizophrenia can run in families, which means a greater likelihood to have schizophrenia passed on from parent to child.
- Brain chemistry and circuits: People with schizophrenia may not be able to regulate brain chemicals called neurotransmitters that control certain pathways, or "circuits," of nerve cells that affect thinking and behaviour.
- Brain abnormality: Research has found abnormal brain structure in people with schizophrenia. But this doesn't apply to all people with schizophrenia. It can affect people without the disease.
- Environment: Things like viral infections, exposure to toxins like marijuana, or highly stressful situations may trigger schizophrenia in people whose genes make them more likely to get the disorder. Schizophrenia more often surfaces when the body is having hormonal and physical changes, like those that happen during the teen and young adult years.

Symptoms

The condition usually shows its first signs in men in their late teens or early 20s. It mostly affects women in their early 20s and 30s. The period when symp-

toms first start and before full psychosis is called the prodromal period. It can last days, weeks, or even years. It can be hard to spot because there's usually no specific trigger. You might only notice subtlebehavioural changes, especially in teens. This includes:

- A change in grades.
- Social withdrawal.
- Trouble concentrating.
- Temper flares.
- Difficulty sleeping.

Symptoms fall into several categories:

1. Positive psychotic symptoms: Hallucinations, such as hearing voices, paranoid delusions and exaggerated or distorted perceptions, beliefs, and behaviours.
2. Negative symptoms: A loss or a decrease in the ability to initiate plans, speak,express emotion, or find pleasure.
3. Disorganization symptoms: Confused and disordered thinking and speech, troublewith logical thinking, and sometimes bizarre behaviour or abnormal movements.
4. Impaired cognition: Problems with attention, concentration, memory, and declining educational performance.

Positive Symptoms of Schizophrenia:

In this case, the word positive doesn't imply good. It refers to added thoughts or actions that aren't based in reality. They're sometimes called psychotic symptoms and can include:

- Delusions: These are false, mixed, and sometimes strange beliefs that aren't based in reality, and that the person refuses to give up, even when shown the facts. For example, a person with delusions may believe that people can hear their thoughts, that they are God or the devil, or that people are putting thoughts into their head or plottingagainst them.
- Hallucinations: These involve sensations that aren't real. Hearing voices is the most common hallucination in people with schizophrenia. The voices may comment on the person's behaviour, insult them, or give commands. Less common types include seeing things that aren't there, smelling strange odours, having a funny taste in your mouth, and feeling sensations on your skin even though nothing is touching your body.
- Catatonia: In this condition, the person may stop speaking, and their body may be fixed in a single position for a very long time.

Negative symptoms of Schizophrenia:

Refer to an absence or lack of normal mental function involving thinking, behaviour, and perception. You might notice:

- Lack of pleasure. The person may not seem to enjoy anything anymore. A doctor willcall this anhedonia.
- Trouble with speech. They might not talk much or show any feelings. Doctors call this alogia.
- Flattening. The person with schizophrenia might seem like they have a terrible case ofthe blahs. When they talk, their voice can sound flat, like they have no emotions. Theymay not smile normally or show usual facial emotions in response to conversations or things happening around them. A doctor might call this affective flattening.
- Withdrawal. This might include no longer making plans with friends or becoming a hermit. Talking to the person can feel like pulling teeth: If you want an answer, you have to really work to pry it out of them. Doctors call this apathy.
- Struggling with the basics of daily life. They may stop bathing or taking care of themselves.
- No follow-through. People with schizophrenia have trouble staying on schedule or finishing what they start. Sometimes they can't get started at all. A doctor might call this avolition.

Disorganized Symptoms of Schizophrenia:

These are positive symptoms that show that the person can't think clearly or respond asexpected. Examples include:

- Talking in sentences that don't make sense or using nonsense words, making itdifficult for the person to communicate or hold a conversation.
- Shifting quickly from one thought to the next without obvious or logical connectionsbetween them.
- Moving slowly.
- Being unable to make decisions.
- Writing excessively but without meaning.
- Forgetting or losing things.
- Repeating movements or gestures, like pacing or walking in circles.
- Having problems making sense of everyday sights, sounds, and feelings.

Cognitive Symptoms of Schizophrenia:

- The person will have trouble.
- Understanding information and using it to make decisions (a doctor might call thispoor executive functioning).
- Focusing or paying attention.

- Using their information immediately after learning it (this is called working memory).
- Recognizing that they have any of these problems.

Negative Symptoms of Schizophrenia.

- The word “negative” here doesn’t mean “bad.” It notes the absence of normalbehaviours in people with schizophrenia. Negative symptoms of schizophrenia include.
- Lack of emotion or a limited range of emotions.
- Withdrawal from family, friends, and social activities.
- Less energy.
- Speaking less.
- Lack of motivation.
- Loss of pleasure or interest in life.
- Poor hygiene and grooming habits.

Risk Factors

Researchers believe that several genetic and environmental factors contribute to causation, and life stressors may play a role in the disorder’s onset and course. Since multiple factors may contribute, scientists cannot yet be specific about the exact cause in individual cases.

Since the term schizophrenia embraces several different disorders, variation in the cause between cases is expected.

3.1.2.2. The specificity of nursing in this disease

Caring for a patient with schizophrenia includes ensuring that prescribed medications are administered as directed. You’ll also monitor for adverse drug reactions, in addition to addressing the medical problem that brought the patient to the ICU.

- Minimize stress and keep safety risks to a minimum. Maintain suicide precautions ifindicated and follow your facility’s policy for handling a potentially violent patient.
- Resume the patient’s routine antipsychotic medications as soon as possible, to reduce symptom worsening and problematic behaviour.
- Work to build and maintain a therapeutic relationship by establishing trust.
- Remain calm and unhurried and demonstrate acceptance through a nonjudgmental attitude.
- Sit down with the patient and talk with him, using active listening. Clear communication of expectations, including explaining any procedures and asking permission before performing them can help establish trust.

- Maintaining structure in the patient's environment is essential, as is reality orientation as needed. If the patient reports hallucinations, don't challenge him.
- If the patient becomes agitated, don't turn your back on him. Remain calm, talk softly, and ask what he needs.
- Always be alert of exits and objects in the environment with any patient with a psychiatric illness.
- If you feel threatened, remove yourself from the situation if able and call security per hospital policy.
- Consult psychiatry as soon as possible. A psychiatrist can evaluate the patient and review his medication regimen. The psychiatrist also can ensure that the patient receives appropriate psychiatric services after his discharge from the hospital.
- As a patient's condition improves and discharge is planned, talk with the hospital social worker to determine if he has any needs for assistance upon discharge. If his symptoms are stable and he doesn't need oxygen or physical therapy, he should be able to return to the boarding home.
- The healthcare provider should complete comprehensive medication reconciliation when the patient is discharged.
- Refer the patient to a structured day program for ongoing support upon discharge and give him information on when to follow up with his primary care provider and psychiatrist.

Treatment can help many people with schizophrenia lead highly productive and rewarding lives. As with other chronic illnesses, some patients do extremely well while others continue to be symptomatic and need support and assistance.

- Coordinated speciality care (CSC): This is a team approach to treating schizophrenia when the first symptoms appear. It combines medicine and therapy with social services, employment, and educational interventions. The family is involved as much as possible. Early treatment is a key to helping patients lead a normal life.
- Psychosocial therapy: While medication may help relieve symptoms of schizophrenia, various psychosocial treatments can help with the behavioural, psychological, social, and occupational problems that go with the illness. Through therapy, patients also can learn tomanage their symptoms, identify early warning signs of relapse, and come up with a relapse prevention plan.

Psychosocial therapies include:

- Rehabilitation, which focuses on social skills and job training to help people with schizophrenia function in the community and live as independently as possible.

- Cognitive remediation, which involves learning techniques to make up for problemswith information processing. It often uses drills, coaching, and computer-based exercises to strengthen mental skills that involve attention, memory, planning, andorganization.
- Individual psychotherapy, which can help the person better understand his illness, and learn coping and problem-solving skills.
- Family therapy, which can help families deal with a loved one who has schizophrenia, enabling them to better help their loved one.
- Group therapy/support groups, which can provide continuing mutual support.
- Hospitalization: Many people with schizophrenia may be treated as outpatients. Buthospitalization may be the best option for people:
  - With severe symptoms.
  - Who might harm themselves or others.
  - Who can't take care of themselves at home.
- Electroconvulsive therapy (ECT): In this procedure, electrodes are attached to the person's scalp. While they're asleep under general anaesthesia, doctors send a smallelectric shock to the brain. A course of ECT therapy usually involves 2–3 treatments per week for several weeks. Each shock treatment causes a controlled seizure. A series of treatments over time leads to improvement in mood and thinking.
- Research: Researchers are looking at a procedure called deep brain stimulation (DBS) to treat schizophrenia. Doctors surgically implant electrodes that stimulate certain brain areas believed to control thinking and perception. DBS is an established treatment for severe Parkinson's disease and essential tremors, but it's still experimental for the treatment of psychiatric disorders.

Nursing Assessment

Recognize schizophrenia. Note characteristic signs and symptoms of schizophrenia (e.g.,speech abnormalities, thought distortions, poor social interactions).

Establish trust and rapport. Don't tease or joke with patients. Expect that patient is going toput you through rigorous testing periods. Introduce yourself and explain your purpose.

Maximize level of functioning. Assess the patient's ability to carry out activities of daily living (ADLs).

Assess positive symptoms. Assess for command hallucinations. explore answers. Assess if the client has a fragmented, poorly organized, well-organized, systematized, or extensive system of beliefs that are not supported by reality. Assess for pervasive suspiciousness about everyone and their actions (e.g., vigilant, blaming others for consequences of own behaviour, argumentative, or threatening).

Assess negative symptoms. Assess for the negative symptoms of schizophrenia (as mentioned above).

Assess medical history. Assess if the client is on medications, what these are, and adherence to therapy.

Assess support system. Determine whether the family is well informed about the disease anddo they understand the need for medication adherence.

Nursing Diagnoses

- Impaired Physical Mobility related to a depressive mood state and reluctance to initiate movement.
- Impaired Social Interaction related to problems in thought patterns and speech.
- Decreased Cardiac Output related to orthostatic hypotensive drug effects.
- Risk for Suicide related to impulsiveness and marked changes in behaviour.
- Risk for Injury related to hallucinations and delusions.
- Risk for Imbalanced Nutrition: less than body requirements related to self-neglect and refusal of self-care.

Nursing Care Planning

- Reduce the severity of psychotic symptoms.
- Prevent recurrence of acute episodes.
- Meet the patient's physical and psychosocial needs.
- Help patient gain optimum level of functioning.
- Increase client's compliance to treatment and nursing plan.

Nursing Interventions

- Establish trust and rapport. Don't touch the client without telling him first what you are going to do. Use an accepting, consistent approach. short, repeated contacts are best until trust has been established. Language should be clear and unambiguous. Maintain a sense of hope for possible improvement and convey this to the patient.
- Maximize level of functioning. Avoid promoting dependence by doing only what the patient can't do for himself. Reward positive behaviour and work with him to increase his personal sense of responsibility in improving functioning.
- Promote social skills. Provide support in assisting him to learn social skills.
- Ensure safety. Maintain a safe environment with minimal stimulation.
- Ensure adequate nutrition. Monitor the patient's nutritional status and if the patient thinks his food is poisoned, let him fix his own food if possible or offer him foods in closed containers that he can open. Institute suicide and/or homicide precautions as appropriate.

- Keep it real. Engage the patient in reality-oriented activities that involve human contact (e.g., workshops, inpatient social skills training). Clarify private language, autistic inventions, or neologisms.
- Deal with hallucinations by presenting reality. Explore the content of hallucinations. Avoid arguing about the hallucinations. Tell them you do not see, hear, smell, or feel it but explain that you know that these hallucinations are real to him.
- Promote compliance and monitor drug therapy. Administer prescribed drugs and encourage the patient to comply. Ensure that patient is really taking the drug. Observe for manifestations that warrant hypersensitivity reactions and toxicity.
- Encourage family involvement. Involve family in the patient's treatment and teach members to recognize impending relapse (e.g., nervousness, insomnia, decreased ability to concentrate). Suggest ways how families can manage symptoms.

Evaluation

- Evaluate the effectiveness of drug therapy (absence of acute episodes and psychoticsymptoms).
- Evaluate compliance to health instructions (taking medications on time, showingindependence in activities, involvement of family).
- Level of patient's functioning (ability to engage in social interactions).
- Patient's mental status (oriented to reality).

3.1.2.3. Prognosis for the patient

After the symptoms of schizophrenia are controlled, various types of therapy can continue to help people manage the illness and improve their lives. Therapy and support can help people learn social skills, cope with stress, identify early warning signs of relapse and prolong periods of remission. Because schizophrenia typically strikes in early adulthood, individuals with the disorder often benefit from rehabilitation to help develop life-management skills, complete vocational or educational training, and hold a job. With proper treatment, most peoplewith schizophrenia can lead productive and fulfilling lives.

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3.1.3. Patient with a mental illness – depression

3.1.3.1. Characteristics of the disease – essence, symptoms

Depression (major depressive disorder) is a common and serious medical illness that negatively affects how you feel, the way you think and how you act. Fortunately, it is also treatable. Depression causes feelings of sadness and/or a loss of interest in activities once enjoyed. It can lead to a variety of emotional and physical problems and can decrease a person's ability to function at work and at home.

Depression symptoms can vary from mild to severe and can include:

- Feeling sad or having a depressed mood.
- Loss of interest or pleasure in activities once enjoyed.
- Changes in appetite — weight loss or gain unrelated to dieting.
- Trouble sleeping or sleeping too much.
- Loss of energy or increased fatigue.
- Increase in purposeless physical activity (e.g., hand-wringing or pacing) or slowed movements and speech (actions observable by others).
- Feeling worthless or guilty.
- Difficulty thinking, concentrating or making decisions.
- Thoughts of death or suicide.

Symptoms must last at least two weeks for a diagnosis of depression.Conditions that can get worse due to depression include:

- arthritis,
- asthma,
- cardiovascular disease,
- cancer,
- diabetes,
- obesity.

Symptoms

Depression can be more than a constant state of sadness or feeling "blue." Major depression can cause a variety of symptoms. Some affect your mood, and others affect your body. Symptoms may also be ongoing or come and go. The symptoms of depression can be experienced differently among men, women, and children differently.

Men may experience symptoms related to their:

- Mood, such as anger, aggressiveness, irritability, anxiousness, or restlessness.
- Emotional well-being, such as feeling empty, sad, or hopeless.
- Behaviour, such as loss of interest, no longer finding pleasure in favourite activities, feeling tired easily, thoughts of suicide, drinking excessively, using drugs, or engaging inhigh-risk activities.
- Sexual interest, such as reduced sexual desire, or lack of sexual performance.
- Cognitive abilities, such as inability to concentrate, difficulty completing tasks, or delayed responses during conversations.
- Sleep patterns, such as insomnia, restless sleep, excessive sleepiness, or not sleepingthrough the night.
- Physical well-being, such as fatigue, pains, headache, or digestive problems.

Women may experience symptoms related to their:

- Mood, such as irritability.
- Emotional well-being, such as feeling sad or empty, anxious or hopeless.
- Behaviour, such as loss of interest in activities, withdrawal from social engagements, or thoughts of suicide.
- Cognitive abilities, such as thinking or talking more slowly.
- Sleep patterns, such as difficulty sleeping through the night, waking early, or sleeping too much.
- Physical well-being, such as decreased energy, greater fatigue, changes in appetite, weight changes, aches, pain, headaches, or increased cramps.

Children may experience symptoms related to their:

- Mood, such as irritability, anger, mood swings, or crying.
- Emotional well-being, such as feelings of incompetence (e.g., "I can't do anything right") or despair, crying, or intense sadness.
- Behaviour, such as getting into trouble at school or refusing to go to school, avoidingfriends or siblings, or thoughts of death or suicide.
- Cognitive abilities, such as difficulty concentrating, decline in school performance, or changes in grades.
- Sleep patterns, such as difficulty sleeping or sleeping too much.
- Physical well-being, such as loss of energy, digestive problems, changes in appetite, or weight loss or gain.

Depression is Different from Sadness or Grief/Bereavement. The grieving process is natural and unique to each individual and shares some of the same features

of depression. Both grief and depression may involve intense sadness and withdrawalfrom usual activities. They are also different in important ways:

- In grief, painful feelings come in waves, often intermixed with positive memories of the deceased. In major depression, mood and/or interest (pleasure) are decreased for most of two weeks.
- In grief, self-esteem is usually maintained. In major depression, feelings of worthlessness and self-loathing are common.
- For some people, the death of a loved one can bring on major depression. Losing a job or being a victim of a physical assault or a major disaster can lead to depression for some people. When grief and depression co-exist, the grief is more severe and lasts longer than grief without depression. Despite some overlap between grief and depression, they are different. Distinguishing between them can help people get the help, support, or treatment they need.

Risk Factors for Depression

Depression can affect anyone—even a person who appears to live in relatively idealcircumstances.

- Biochemistry: Differences in certain chemicals in the brain may contribute tosymptoms of depression.
- Genetics: Depression can run in families. For example, if one identical twin hasdepression, the other has a 70% chance of having the illness sometime in their life.
- Personality: People with low self-esteem, who are easily overwhelmed by stress, orwho are generally pessimistic appear to be more likely to experience depression.
- Environmental factors: Continuous exposure to violence, neglect, abuse, or poverty may make some people more vulnerable to depression.

Medication

Brain chemistry may contribute to an individual's depression and may factor into theirtreatment. For this reason, antidepressants might be prescribed to help modify one's brain chemistry. Antidepressants may produce some improvement within the first week or two of use. Full benefits may not be seen for two to three months. If a patient feels little or no improvement after several weeks, his or her psychiatrist can alter the dose of the medicationor add or substitute another antidepressant. Psychotherapy, or "talk therapy," is sometimes used alone for the treatment of mild depression. for moderate to severe depression, psychotherapyis often used in along with antidepressant medications. Cognitive behavioural therapy (CBT) has been found to be effective in treating depression. CBT is a form of therapy focused on the present and problem-solving.

Self-help and Coping

There are a few things people can do to help reduce the symptoms of depression. For many people, regular exercise helps create a positive feeling and improves their mood. Getting enough quality sleep on a regular basis, eating a healthy diet and avoiding alcohol (a depressant) can also help reduce symptoms of depression. With proper diagnosis and treatment, the majority of people with depression will overcome it. If you are experiencing symptoms of depression,a first step is to see your family physician or psychiatrist. Talk about your concerns and request a thorough evaluation. This is a start to addressing mental health needs.

3.1.3.2. The specificity of nursing in this disease

Possibly evidenced by:

- Previous attempts of violence.
- Suicidal plan (clear, specific, lethal method, and available means).
- Suicidal behaviour (attempts, ideation, plan, and available means).
- When depression begins to lift, clients may have the energy to carry out the suicidal plan.

Desired Outcomes

- Patient will seek help when experiencing self-destructive impulses.
- Patient will have a behavioural manifestation of absent depression.
- Patient will have satisfaction with social circumstances and achievements of life goals.
- Patient will identify at least two-three people he/she can seek out for support and emotional guidance when he/she is feeling self-destructive before discharge.

Nursing Interventions	Rationale
Nursing Assessment	
Identify the level of suicide precautions needed. If there is a high risk, is hospitalization required? Or if there is a low risk, will the client be safe to go home with supervision from a family member or a friend? For example, did the patient: · Admit previous suicide attempts. · Abuse any substances. · Have no peers/friends. · Have a suicide plan.	A patient with a high risk will require constant supervision and a safe environment.
Check for the availability of the required supply of medications needed.	Normally, a suicidal patient's medical supply should be limited to 3–5 days.

Nursing Interventions	Rationale
Therapeutic Interventions	
Encourage the patient to express feelings (anger, sadness, guilt) and come up with alternative ways to handle feelings of anger and frustration.	The patient can learn alternative ways of dealing with overwhelming emotions and gain a sense of control over his/her life.
Contact the family, and arrange for crisis counselling. Activate links to self-help groups.	The patient needs a network of resources to help diminish personal feelings of helplessness, worthlessness, and isolation.
If, hospitalized, follow unit protocols.	There are different measures for a suicidal patient in the hospital, clinic, and community.
Implement a written no-suicide contract.	Reinforces action the patient can take when feeling suicidal.

- The patient will not inflict any harm to themself or others.
- The patient will identify support and support groups with whom he/she is in contact within one month.
- The patient will state that he/she wants to live.
- The patient will start working on constructive plans for the future.
- The patient will demonstrate compliance with any medication or treatment plan within the next two weeks.
- The patient will demonstrate alternative ways of dealing with negative feelings and emotional stress.

In connection, depression nursing interventions should be planned accordingly which must go hand in hand with psychotherapy and medical treatments. While in depression, the person may react to a perceived loss with intense feelings of reduced self-esteem or confidence and the client may view themselves negatively, various considerations should be made.

Assessment may encompass several aspects like:

- The patient's appearance may show dishevelled hair and clothes in low tone colours. Posture may be stooped and facial expression may be dull, with reddened eyes from crying, a furrowed brow, or a worried frown. The patient may also be agitated. Note nonverbal behaviours, avoidance of eye contact and consistency of mouth smile.
- Note how the patient responds verbally. The pace of your nurse-patient interaction may be slow since he may lack interest in the topic or has low motivation to talk to other people.
- Observe and check for any physical complaints. Often, a patient with depression will reveal some physical problems like constipation, anorexia, head-

ache, and sleep disturbances - which are often associated with the emotional effects of the disease.

- Assess their behaviour. The most common behavioural symptom is being agitated. The patient may also be withdrawn or isolate themself due to low self-esteem, has impulsive overeating, drinking, or other vices, and sometimes gets themself into fights.
- Assess their feelings. A marked apathy, lack of humour, and irritability are common.

Conceptualize your goals with the patient. Help them identify their strengths and goals for recovery from depression. This would include:

- Acceptance and awareness of self-promotion of a positive concept of self.
- Personal hygiene.
- Expression of anger and guilt in the appropriate way.
- Realistic resolution of problems.
- Resumption of activities as an outlet for unpleasant mood.
- Verbal expression of feelings.

Provide depression nursing interventions:

- Interact with the patient in a slow-paced, low, and firm tone.
- Encourage him to verbalize their feelings, thinking, worries, etc. using broad, leading statements or open-ended questions.
- Maintain a therapeutic distance, exhibiting open posture.
- Do not hurry the patient when interacting, instead, be patient, and show a sense of empathy.
- When the patient is able to regain their energy to do tasks, encourage them to partake in personal hygiene and encourage them that feeling good often starts when you also care about one's self.
- Be calm and supportive when the patient shows irritability or expresses anger. Clarify for statements of blame and help them understand that being irate sometimes makes other people shun away. thus you may also encourage the need to re-establish relationships with loved ones.
- Listen to physical complaints and re-install some behaviour modification techniques.
- Appraise their strengths and recognize an activity accomplished, this way you could help them improve their feelings about themselves.
- Attend to their spiritual needs, too. If needed, ask the assistance of a clergyman or priest.
- Identify or ask the patient what activities may interest them. It should be productive and utilizes their restless energy like drawing, etc. It should be non-stimulating and also limiting in some way that it would not affect the patient emotionally.

- Prevent suicide by helping them feel that life is worth living. Make yourself available for them to confide in and listen for cues of suicidal tendencies. Explain to them that a person with suicidal thoughts is not a bad person instead it is just part of the illness. Expressing their thoughts is helpful and you could do something about it.

3.1.3.3. Prognosis for the patient

Major depressive disorder has significant potential morbidity and mortality, as it is a contributing factor to suicide, incidence and adverse outcomes of medical illness, disruption in interpersonal relationships, psychoactive substance abuse, and lost work time. With appropriate treatment, 70–80% of individuals with major depressive disorder can achieve a significant reduction in symptoms, although as many as 50% of patients may not respond to the initial treatment trial.

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3.1.4. Patient with a mental illness – aggression

3.1.4.1. Characteristics of the disease – essence, symptoms

Aggression has been defined as behaviours, or verbal exchanges, that are intended to upset or harm another person. Some theorists believe that aggression may have had evolutionary significance for humans who were competing for limited resources necessary for survival. However, in industrialized societies acts of aggression (especially physical) may decrease access to resources for the individ-

ual (e.g., being sentenced to a prison term. being fined or sued) and may present a number of serious problems for society as a whole.

Aggression typically falls into two categories:

- Physical or hostile aggression.
- Emotional or relational aggression.

Hostile aggression happens when you attempt to injure an individual by way of hitting, pinching, biting, pushing, or inflicting any other type of physical harm. Destroying property isalso considered hostile aggression. Relational aggression can involve spreading rumours, teasing someone, or intentionally excluding a person so that he or she feels badly.

For many people, aggressive behaviours are learned early in life. Some people behave aggressively while under the influence of drugs, or due to the presence of an untreated mental health disorder.

- Genetic: Certain heritable mental health disorders can trigger aggressive behaviour. Therefore, if you have a family history of such illnesses, you may be more likely to struggle with aggression.
- Environmental: Your environment is capable of influencing whether or not you act aggressively. For example, if you are exposed to violence, crime, trauma, or someone else's aggressive actions, you may also present with aggressive behaviours. Additionally, if you are unable to cope with stress or adversity, you may be more inclined to struggle with aggression as well.
- Mental health disorders: Some mental illnesses either include aggression as a symptom or can lead to aggressive actions if they are not properly managed. The following are examples of mental health disorders that can include or cause aggression:
  - Alzheimer's disease.
  - Attention-deficit/hyperactivity disorder (ADHD).
  - Autism spectrum disorder.
  - Bipolar disorder.
  - Conduct disorder.
  - Dementia.
  - Intermittent explosive disorder (IED).
  - Oppositional defiant disorder (ODD).
  - Personality disorders.
  - Schizophrenia or other psychotic disorders.
  - Substance use disorders.

Risk Factors

- Being the victim of a crime.
- Exposure to violence, crime, chaos, or stress at an early age.

- Having a history of substance abuse.
- Having low self-esteem.
- Lacking healthy coping skills.
- Lacking positive role models as a child or adolescent.
- Suffering from a mental health disorder.
- Surviving a trauma.

Symptoms

There are many telltale signs of aggression. The following symptoms suggest you arebehaving in an aggressive manner:

Behavioural symptoms

- Biting another person or an object.
- Bullying.
- Destroying property.
- Excluding others.
- Gossiping.
- Having difficulty calming yourself down after exerting aggressive behaviour.
- Hitting another person or an object.
- Ignoring someone on purpose.
- Kicking another person or an object.
- Name-calling.
- Pinching someone.
- Pulling someone's hair.
- Pushing another person or an object.
- Spitting on another person or an object.
- Spreading rumours about someone.
- Teasing a person or a group of people.
- Yelling.

Physical symptoms

- Accelerated breathing.
- Clinched fists.
- Flushed skin.
- Increased body temperature.
- Increased heart rate.
- Sweating.
- Teeth grinding.
- Tense muscles.
- Tension headache.

Cognitive symptoms

- Feeling as if you "blackout" when angry.
- Inability to think clearly.
- Poor decision-making.
- Problems focusing.
- Problems with concentration.

Psychosocial symptoms

- Abrupt mood changes.
- Angry mood.
- Feeling agitated.
- Feeling irritated.
- Low tolerance threshold.

3.1.4.2. The specificity of nursing

Nursing care plan – risk for Violent Behaviour

Violence can be defined as the use of physical force with the intent to injure another person ordestroy property, while aggression is generally defined as angry or violent feelings or behaviour. A person who is aggressive does not necessarily act out with violence.

Risk for Violent Behaviour

- General goals:
  - The patient can control violent behaviour.
- Specific goals:
  - The patient can build a trusting relationship.
- Expected outcomes:
  - The patient shows signs of believing in the nurse.
  - Bright face, smiling.
  - Want to get acquainted.
  - No eye contact.
  - Willing to share feelings.
- Nursing Interventions:
  - Develop a relationship of trust.
  - Greet each interaction.
  - Introduce the names, nicknames nurses and nurses interact purposes.
  - Ask and call the name of the patient's favourite.
  - Show empathy, honesty, and keep promises whenever interacting.
  - Ask about the patient's feelings and problems faced by the patient.

- Create a clear interaction contract.
- Listen attentively to the patient's expression of feelings.

The patient can identify the causes of violent behaviour accomplishments

- Expected outcomes:
  - The patient tells the causes of violent behaviour is doing. tells cause annoyance / upseteither of themselves or their environment.
- Nursing Interventions:
  - Help patient express feelings of anger.
  - Motivate the patient to tell the cause of resentment or annoyance.
  - Listen without interrupting or give an assessment of each patient's expression offeelings.

The patient can identify signs of violent behaviour

- Expected outcomes:
  - The patient tells the signs of violent behaviour occurs when:
- Physical signs:
  - red eyes,
  - hands clenched,
  - tense expression, or others.
- Signs of emotional:
  - feelings of anger, resentment, or speaking harshly.
- Social sign:
  - hostile experienced during a violent behaviour.
- Nursing Interventions:
  - Help the patient reveal signs of violent behaviour that happened.
  - Motivate the patient to communicate the physical condition (physical signs) when the violent behaviour happened.
  - Motivate the patient to share his emotional condition (signs of emotional) during violent behaviour.
  - Motivate the patient to tell the condition of the relationship with others (social signals) during a violent behaviour.

The patient can identify the type of violent behaviour they have done

- Expected outcomes:
  - The patient was able to talk about their past behaviour.
  - The types of anger expression that had been done.
  - Felt when violence.
- Nursing Interventions:
  - Discuss with the patient violent behaviour is usually done.

- Motivate the patient to speak about the kinds of violence that had been done.
- Motivate the patient to communicate the patient's feelings after the incident ofviolence occurred.
- Discuss whether the acts of violence can overcome the problems experienced.

The patient can be identified as a result of violent behaviour

- Expected outcomes:
  - The patient explained that due to the violence that is done:
    - Self: wounds, shunned friends, etc.
    - Another person / family: irritability, fear, etc.
    - Environment: goods, broken objects, etc.
  - The effectiveness of the methods used in solving problems.
- Nursing Interventions:
  - Discuss with the patient due to the negative (losses) how that is done:
    - Self
    - Others / family
    - Environment

The patient can identify constructive ways of expressing anger

- Expected outcomes:
  - Explaining healthy ways of expressing anger.
- Nursing Interventions:
  - Does the patient want to learn a new way of expressing anger healthily.
  - Explain the various alternative options to express anger besides the known violentbehaviour by the patient.
  - Explain healthy ways to express anger.
    - Physical way: a deep breath, hit a pillow or mattress, sports.
    - Verbal: revealed that he was upset to others.
    - Social: assertiveness training with others.
    - Spiritual: prayer, meditation, etc. according to their religious beliefs.

The patient can demonstrate how to control violent behaviour

- Expected outcomes:
  - The patient demonstrates how to control violent behaviour:
    - Physical: take a deep breath, hit a pillow or the mattress.
    - Verbal: express the feeling irritated / annoyed at others without hurting.
    - Spiritual: prayer or meditation in accordance with their religion.

- Nursing Interventions:
  - Discuss ways that may be selected and encourage the patient to choose the possible ways to express anger.
  - Train by showcasing correct behaviour to selected patients: demonstrate how to implement the chosen method, explain the benefits of this method to encourage clients to replicate the demonstrated method, give reinforcement to the patient, and correct the patient when they make mistakes.
  - Encourage patients to use tools already trained when angry / annoyed.

The patient has family support to control violent behaviour

- Expected outcomes:
  - Explain how to care for a patient with violent behaviour.
  - Expressed pleasure in caring for the patient.
- Nursing Interventions:
  - Discuss the importance of the role of the family to support the patient in addressingviolent behaviour.
  - Discuss potential families to help the patient resolve violent behaviour.
  - Explain the meaning, causes, consequences and how to care for the patients of violentbehaviour that can be carried out by the family.
  - Demonstrate how to care for the patients (to handle violent behaviour).
  - Give the family the opportunity to demonstrate again.
  - Give praise to the family after the demonstration.
  - Pochwalenie rodziny po prezentacji.

The patient uses the appropriate therapy program that has been set

- Expected outcomes:
  - The patient explained:
    - Benefits of taking medication.
    - Downsides to not taking the medication.
    - Medicine name.
    - The shape and colour of drugs.
    - The dose.
    - Time usage.
    - How to use.
    - Effects felt.
- Nursing Interventions:
  - Explain the benefits of using the medication regularly and the harm if the patient doesnot use medication.

- Explain to the patient: the type (name, colour, and form of the drug), the correct dose for the patient, time of use, how to use it, and the effect will be felt by the client.
- Advise the patient: Ask for and use medication on time, report to the nurse / physician if the patient is experiencing unusual effects, give praise to encourage the patient to use the drug, and ask the family how they feel after trying the training methods.

Find a safe environment

If possible, try to move the person away from other people to an environment where he or shecan feel safe and which is also safe for you.

Position yourself correctly

Stand in a position of safety – usually between the person and the doorway, but not directly in front of the door so that the individual also has an escape route. Our first reaction as nurses is to move toward patients, offering a comforting touch.

Be calm and respectful

Remain calm and respectful. The aggressive person who has lost control over rational thought is more tuned to non-verbal cues than to what you might be saying. Even though, on the inside, you might feel terrified or ready to lash out you must maintain a calm appearance in your gestures, facial expressions, movements, and tone of voice.

Use principles of therapeutic communication

Do
• Stay calm and keep your emotions in check • Adopt a passive and non-threatening body posture (e.g., hands by your side with empty palms facing forward, body at a 45 degree angle to the aggressor). • Let the client air his/her feelings and acknowledge them. • Ask open-ended questions to keep a dialogue going. • Be flexible, within reason. • Use the space for self-protection (position yourself close to the exit, don't crowd the patient). • Structure the work environment to ensure safety (e.g., have safety mechanisms in place such as alarms and remove items that can be used as potential weapons). • Make sure other patients are out of harm's way.

Don't
• Challenge or threaten the patient by tone of voice, eyes, or body language. • Say things that will escalate the aggression. • Yell, even if the patient is yelling at you. • Turn your back on the patient. • Rush the patient. • Argue with the patient. • Stay around if the patient doesn't calm down. • Ignore verbal threats or warnings of violence. • Tolerate violence or aggression. • Try to disarm a person with a weapon or battle it alone.

3.1.4.3. Prognosis for the patient

The concept of aggressive behaviour across a person's life span is very complex. An overarching theme appears to involve both risk factors that precipitate and increase the predisposition towards aggression as well as situations that actually elicit the aggression. Effective prevention strategies may need to reduce risk factors as well as mitigate the ability of those situations to elicit aggression. Aggressive behaviour is unique in that its causes and manifestations can vary across different age groups. Therefore, it is imperative that nurses understand these age-related differences in order to successfully tailor and develop effective prevention and intervention plans.

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3.1.5. Patient / addicted patient: narcotic drugs or legal highs

3.1.5.1. Characteristics of the disease – essence, symptoms

The word "addiction" calls up many different images and strong emotions. Too often we focus on the wrong aspects of addiction so our efforts to deal with this difficult issue can be terribly misguided.

Defining addiction

Three decades of scientific research, coupled with even longer clinical experience, has taught us that focusing on this physical vs. psychological distinction is off the mark and a distractionfrom the real issue.

Physical dependence is not that important because, firstly, even the complex withdrawal symptomsof heroin and alcohol addiction can be managed with appropriate medications. Therefore, physical withdrawal symptoms should not be at the core of our concerns about these substances.

Secondly, and more importantly, many of the most addicting and dangerous drugs do not even produce very severe physical symptoms upon withdrawal. Crack cocaine and methamphetamine are clear examples. Both are highly addicting, but stopping their use produces very few physical withdrawal symptoms, certainly nothing like the physical symptoms of alcohol or heroin withdrawal.

Essence of addiction

Drug craving and other compulsive behaviours are the essences of addiction. They are extremely difficult to control, much more difficult than any physical dependence. They are theprincipal target symptoms for most drug treatment programs. For an addict, there is no motivation more powerful than drug craving. The addict's entire life becomes centred on getting and using the drug. Virtually nothing seems to outweigh drug craving as a motivator. People have committed all kinds of crimes and even abandoned their children just to get drugs.

Symptoms

Drug addiction symptoms or behaviours include, among others:

- Feeling that you must use the drug regularly — daily or even several times a day.
- Having intense urges for the drug that block out any other thoughts.
- Over time, needing more of the drug to get the same effect.
- Taking larger amounts of the drug over a longer period of time than you intended.
- Making certain that you maintain a supply of the drug.

- Spending money on the drug, even though you can't afford it.
- Not meeting obligations and work responsibilities, or cutting back on social orrecreational activities because of drug use.
- Continuing to use the drug, even though you know it's causing problems in your life orcausing you physical or psychological harm.
- Doing things to get the drug that you normally wouldn't do, such as stealing.
- Driving or doing other risky activities when you're under the influence of the drug.
- Spending a good deal of time getting the drug, using the drug, or recovering from the effects of the drug.
- Failing in your attempts to stop using the drug.
- Experiencing withdrawal symptoms when you attempt to stop taking the drug.

Recognizing unhealthy drug use in family members

Sometimes it's difficult to distinguish normal teenage moodiness or angst from signs of druguse. Possible indications that your teenager or other family member is using drugs include:

- Problems at school or work — frequently missing school or work, a suddendisinterest in school activities or work, or a drop in grades or work performance.
- Physical health issues — lack of energy and motivation, weight loss or gain, or redeyes.
- Neglected appearance — lack of interest in clothing, grooming, or looks.
- Changes in behaviour — exaggerated efforts to bar family members from entering his or her room or being secretive about where he or she goes with friends or drastic changes in behaviour and in relationships with family and friends.
- Money issues — sudden requests for money without a reasonable explanation. or yourdiscovery that money is missing or has been stolen or that items have disappeared from your home, indicating maybe they're being sold to support drug use.

Recognizing signs of drug use or intoxication

Signs and symptoms of drug use or intoxication may vary, depending on the type of drug.

- Marijuana, hashish and other cannabis-containing substances
  - Signs and symptoms of recent use can include:
    - A sense of euphoria or feeling "high".

- A heightened sense of visual, auditory, and taste perception.
- Increased blood pressure and heart rate.
- Red eyes.
- Dry mouth.
- Decreased coordination.
- Difficulty concentrating or remembering.
- Slowed reaction time.
- Anxiety or paranoid thinking.
- Cannabis odour on clothes or yellow fingertips.
- Exaggerated cravings for certain foods at unusual times.

- Long-term (chronic) use is often associated with:
  - Decreased mental sharpness.
  - Poor performance at school or at work.
  - Reduced number of friends and interests.

- K2, spice, and bath salts
  - Two groups of synthetic drugs — synthetic cannabinoids and substituted or synthetic cathinones — are illegal in most states. The effects of these drugs can be dangerous and unpredictable, as there is no quality control and some ingredients may not be known. Synthetic cannabinoids, also called K2 or Spice, are sprayed on dried herbs and then smoked, but can be prepared as herbal tea. Signs and symptoms of recent use can include:
    - A sense of euphoria or feeling “high”.
    - Elevated mood.
    - An altered sense of visual, auditory and taste perception.
    - Extreme anxiety or agitation.
    - Paranoia.
    - Hallucinations.
    - Increased heart rate and blood pressure or heart attack.
    - Vomiting.
    - Confusion.
  - Synthetic cathinones, also called “bath salts,” are mind-altering (psychoactive) substances like amphetamines such as ecstasy (MDMA) and cocaine. Packages are often labelled as other products to avoid detection.
  - Despite the name, these are not bath products such as Epsom salts. Synthetic cathinones can be eaten, snorted, inhaled, or injected and are highly addictive. These drugs can cause severe intoxication, which results in dangerous health effects or even death. Signs and symptoms of recent use can include:
    - Euphoria.
    - Increased sociability.

    - Increased energy and agitation.
    - Increased sex drive.
    - Increased heart rate and blood pressure.
    - Problems thinking clearly.
    - Loss of muscle control.
    - Paranoia.
    - Panic attacks.
    - Hallucinations.
    - Delirium.
    - Psychotic and violent behaviour.
- Barbiturates, benzodiazepines, and hypnotics
    - Barbiturates, benzodiazepines, and hypnotics are prescription central nervous system depressants. They're often used and misused in the search for a sense of relaxation or a desire to "switch off" or forget stress-related thoughts or feelings.
    - Barbiturates. Examples include phenobarbital and secobarbital (Seconal).
    - Benzodiazepines. Examples include sedatives, such as diazepam (Valium), alprazolam (Xanax), lorazepam (Ativan), clonazepam (Klonopin), and chlordiazepoxide (Librium).
    - Hypnotics. Examples include prescription sleeping medications such as zolpidem (Ambien, Intermezzo, others) and zaleplon (Sonata).
    - Signs and symptoms of recent use can include:
        - Drowsiness.
        - Slurred speech.
        - Lack of coordination.
        - Irritability or changes in mood.
        - Problems concentrating or thinking clearly.
        - Memory problems.
        - Involuntary eye movements.
        - Lack of inhibition.
        - Slowed breathing and reduced blood pressure.
        - Falls or accidents.
        - Dizziness.
- Meth, cocaine, and other stimulants
    - Stimulants include amphetamines, meth (methamphetamine), cocaine, methylphenidate (Ritalin, Concerta, others) and amphetamine-dextroamphetamine (Adderall, Adderall XR, others). They are often used and misused in search of a "high," or to boost energy, to improve performance at work or school, to lose weight, or to control appetite.

- Signs and symptoms of recent use can include:
  - Feeling of exhilaration and excess confidence.
  - Increased alertness.
  - Increased energy and restlessness.
  - Behaviour changes or aggression.
  - Rapid or rambling speech.
  - Dilated pupils.
  - Confusion, delusions, and hallucinations.
  - Irritability, anxiety, or paranoia.
  - Changes in heart rate, blood pressure, and body temperature.
  - Nausea or vomiting with weight loss.
  - Impaired judgment.
  - Nasal congestion and damage to the mucous membrane of the nose (if snorting drugs).
  - Mouth sores, gum disease and tooth decay from smoking drugs ("meth mouth").
  - Insomnia.
  - Depression as the drug wears off.
- Club drugs
  - Club drugs are commonly used at clubs, concerts, and parties. Examples include ecstasy or molly (MDMA), gamma-hydroxybutyric acid (GHB), flunitrazepam (Rohypnol — a brand used outside the U.S. — also called roofie) and ketamine. These drugs are not all in the same category, but they share some similar effects and dangers, including long-term harmful effects.
  - Signs and symptoms of the use of club drugs can include:
    - Hallucinations.
    - Paranoia.
    - Dilated pupils.
    - Chills and sweating.
    - Involuntary shaking (tremors).
    - Behaviour changes.
    - Muscle cramping and teeth clenching.
    - Muscle relaxation, poor coordination, or problems moving.
    - Reduced inhibitions.
    - Heightened or altered sense of sight, sound, and taste.
    - Poor judgment.
    - Memory problems or loss of memory.
    - Reduced consciousness.
    - Increased or decreased heart rate and blood pressure.

- Hallucinogens
  - The use of hallucinogens can produce different signs and symptoms, depending on the drug. Themost common hallucinogens are lysergic acid diethylamide (LSD) and phencyclidine (PCP).
  - LSD use may cause:
    - Hallucinations.
    - Greatly reduced perception of reality, for example, interpreting input from one of yoursenses as another, such as hearing colours.
    - Impulsive behaviour.
    - Rapid shifts in emotions.
    - Permanent mental changes in perception.
    - Rapid heart rate and high blood pressure.
    - Tremors.
    - Flashbacks, a re-experience of the hallucinations — even years later.
  - PCP use may cause:
    - A feeling of being separated from your body and surroundings.
    - Hallucinations.
    - Problems with coordination and movement.
    - Aggressive, possibly violent behaviour.
    - Involuntary eye movements.
    - Lack of pain sensation.
    - Increase in blood pressure and heart rate.
    - Problems with thinking and memory.
    - Problems speaking.
    - Impaired judgment.
    - Intolerance of loud noise.
    - Sometimes seizures or coma.
- Inhalants
  - Signs and symptoms of inhalant use vary, depending on the substance. Some commonly inhaled substances include glue, paint thinners, correction fluid, felt tip marker fluid, gasoline,cleaning fluids, and household aerosol products. Due to the toxic nature of these substances, users may develop brain damage or sudden death.
  - Signs and symptoms of use can include:
    - Possessing an inhalant substance without a reasonable explanation.
    - Brief euphoria or intoxication.
    - Decreased inhibition.
    - Combativeness or belligerence.
    - Dizziness.

- Nausea or vomiting.
- Involuntary eye movements.
- Appearing intoxicated with slurred speech, slow movements, and poor coordination.
- Irregular heartbeats.
- Tremors.
- The lingering odour of inhalant material.
- Rash around the nose and mouth.

- Opioid painkillers
  - Opioids are narcotic, painkilling drugs produced from opium or made synthetically. This classof drugs includes, among others, heroin, morphine, codeine, methadone, and oxycodone.
  - Signs and symptoms of narcotic use and dependence can include:
    - Reduced sense of pain.
    - Agitation, drowsiness, or sedation.
    - Slurred speech.
    - Problems with attention and memory.
    - Constricted pupils.
    - Lack of awareness or inattention to surrounding people and things.
    - Problems with coordination.
    - Depression.
    - Confusion.
    - Constipation.
    - Runny nose or nose sores (if snorting drugs).
    - Needle marks (if injecting drugs).Make an appointment to see a doctor if:
    - You can’t stop using a drug.
    - You continue using the drug despite the harm it causes.
    - Your drug use has led to unsafe behaviour, such as sharing needles or unprotected sex.
    - You think you may be having withdrawal symptoms after stopping drug use.

Staging an intervention

People struggling with addiction usually deny that their drug use is problematic and are reluctant to seek treatment. An intervention presents a loved one with a structured opportunityto make changes before things get even worse and can motivate someone to seek or accept help. An intervention should be carefully planned and may be done by family and friends in consultation with a doctor or professional

such as a licensed alcohol and drug counsellor or directed by an intervention professional. It involves family and friends and sometimes co-workers, clergy, or others who care about the person struggling with addiction.

Causes

Like many mental health disorders, several factors may contribute to the development of drug addiction. The main factors are:

- Environment. Environmental factors, including your family's beliefs and attitudes and exposure to a peer group that encourages drug use, seem to play a role in initial drug use.
- Genetics. Once you've started using a drug, the development of addiction may be influenced by inherited (genetic) traits, which may delay or speed up the disease progression.

Changes in the brain

Physical addiction appears to occur when repeated use of a drug changes the way your brain feels pleasure. The addicting drug causes physical changes to some nerve cells (neurons) in your brain. Neurons use chemicals called neurotransmitters to communicate. These changes can remain long after you stop using the drug.

Risk factors

People of any age, sex, or economic status can become addicted to a drug. Certain factors canaffect the likelihood and speed of developing an addiction:

- Family history of addiction. Drug addiction is more common in some families and likely involves genetic predisposition. If you have a blood relative, such as a parent or sibling, with alcohol or drug addiction, you're at greater risk of developing a drug addiction.
- Mental health disorder. If you have a mental health disorder such as depression, attention-deficit/hyperactivity disorder (ADHD) or post-traumatic stress disorder, you'remore likely to become addicted to drugs. Using drugs can become a way of coping with painful feelings, such as anxiety, depression, and loneliness and can make these problems even worse.
- Peer pressure. Peer pressure is a strong factor in starting to use and misuse drugs, particularly for young people.
- Lack of family involvement. Difficult family situations or lack of a bond with your parents or siblings may increase the risk of addiction, as can a lack of parental supervision.
- Early use. Using drugs at an early age can cause changes in the developing brain and increase the likelihood of progressing to drug addiction.

- Taking a highly addictive drug. Some drugs, such as stimulants, cocaine, or opioid painkillers, may result in faster development of addiction than other drugs. Smoking or injecting drugs can increase the potential for addiction. Taking drugs considered less addicting — so-called "light drugs" — can start you on a pathway of drug use and addiction.

Complications

- Methamphetamine, opiates, and cocaine are highly addictive and cause multiple short-term and long-term health consequences, including psychotic behaviour, seizures, or death due to overdose.
- GHB and flunitrazepam may cause sedation, confusion, and memory loss. These so-called "date rape drugs" are known to impair the ability to resist unwanted contact and recollection of the event. At high doses, they can cause seizures, coma, and death. The danger increases when these drugs are taken with alcohol.
- Ecstasy or molly (MDMA) can cause dehydration, electrolyte imbalance, and complications that can include seizures. Long-term, MDMA can damage the brain.
- One danger of club drugs is that the liquid, pill, or powder forms of these drugs available on the street often contain unknown substances that can be harmful, including other illegally manufactured or pharmaceutical drugs.

Due to the toxic nature of inhalants, users may develop brain damage of different levels of severity.

Other life-changing complications

Dependence on drugs can create a number of dangerous and damaging complications,including:

- Getting a communicable disease. People who are addicted to a drug are more likely to get an infectious disease, such as HIV, either through unsafe sex or by sharing needles.
- Other health problems. Drug addiction can lead to a range of both short-term and long-term mental and physical health problems. These depend on what drug is taken.
- Accidents. People who are addicted to drugs are more likely to drive or do other dangerous activities while under the influence.
- Suicide. People who are addicted to drugs die by suicide more often than people who aren't addicted.
- Family problems. Behavioural changes may cause marital or family conflict and custody issues.

- Work issues. Drug use can cause declining performance at work, absenteeism, and eventual loss of employment.
- Problems at school. Drug use can negatively affect academic performance and motivation to excel in school.
- Legal issues. Legal problems are common for drug users and can stem from buying or possessing illegal drugs, stealing to support the drug addiction, driving while under the influence of drugs or alcohol, or disputes over child custody.
- Financial problems. Spending money to support drug use takes away money from other needs, could lead to debt, and can lead to illegal or unethical behaviours.

Prevention

The best way to prevent an addiction to a drug is not to take the drug at all. If your doctor prescribes a drug with the potential for addiction, use care when taking the drug and follow the instructions provided by the doctor.

Preventing drug misuse in children and teenagers

- Communicate. Talk to your children about the risks of drug use and misuse.
- Listen. Be a good listener when your children talk about peer pressure, and be supportive of their efforts to resist it.
- Set a good example. Don't misuse alcohol or addictive drugs. Children of parents who misuse drugs are at greater risk of drug addiction.
- Strengthen the bond. Work on your relationship with your children. A strong, stable bond between you and your child will reduce your child's risk of using or misusing drugs.

Preventing relapse

- Stick with your treatment plan. Monitor your cravings. It may seem like you've recovered, and you don't need to keep taking steps to stay drug-free. But your chances of staying drug-free will be much higher if you continue seeing your therapist or counsellor, going to support group meetings, and taking prescribed medication.
- Avoid high-risk situations. Don't go back to the neighbourhood where you used to get your drugs. Stay away from your old drug crowd.
- Get help immediately if you use the drug again. If you start using the drug again, talk to your doctor, your mental health professional, or someone else who can help you right away.

3.1.5.2. The specificity of nursing

Addiction is a treatable disorder. Research on the science of addiction and the treatment of psychoactive substance use disorders has led to the development of research-based methods that help people to stop using drugs and resume productive lives, also known as being in RECOVERY. Like other chronic diseases such as heart disease or asthma, treatment for drug addiction usually isn't a cure. But addiction CAN be managed successfully. Treatment enables people tocounteract addiction's disruptive effects on their brain and behaviour and regain control of their lives.

Additionally, medications are used to help people detoxify from drugs, although detoxification is not the same as treatment and is not enough to help a person recover. Detoxification alone without subsequent treatment generally leads to the resumption of drug use. Different types of medications may be useful at different stages of treatment to help a patient stop abusing drugs, stay in treatment, and avoid relapse.

- Treating withdrawal. When patients first stop using drugs, they can experience various physical and emotional symptoms, including restlessness or sleeplessness, as well as depression, anxiety, and other mental health conditions. Certain treatment medicationsand devices reduce these symptoms, which makes it easier to stop drug use.
- Staying in treatment. Some treatment medications and mobile applications are used to help the brain adapt gradually to the absence of the drug. These treatments act slowly to help prevent drug cravings and have a calming effect on body systems. They can help patients focus on counselling and other psychotherapies related to their drug treatment.
- Preventing relapse. Science has taught us that stress cues linked to drug use (such as people, places, things, and moods), and contact with drugs are the most common triggers for relapse. Scientists have been developing therapies to interfere with these triggers to help patients stay in recovery.

Common medications used to treat drug addiction and withdrawal:

- Opioid
  - Methadone
  - Buprenorphine
  - Extended-release naltrexone
  - Lofexidine
- Nicotine
  - Nicotine replacement therapies (available as a patch, inhaler, or gum)

  - Bupropion
  - Varenicline
- Alcohol
  - Naltrexone
  - Disulfiram
  - Acamprosate
- Behavioural therapies help people in drug addiction treatment modify their attitudes and behaviours related to drug use. Behavioural therapies can also enhance the effectiveness of medications and help people remain in treatment longer.
  - Cognitive-behavioural therapy seeks to help patients recognize, avoid, and cope with situations in which they're most likely to use drugs.
  - Contingency management uses positive reinforcement such as providing rewards or privileges for remaining drug-free, for attending and participating in counselling sessions, or for taking treatment medications as prescribed.
  - Motivational enhancement therapy uses strategies to make the most of people's readiness to change their behaviour and enter treatment.
  - Family therapy helps people (especially young people) with drug use problems, as well as their families, address influences on drug use patterns and improve overall family functioning.
  - Twelve-step facilitation (TSF) is an individual therapy typically delivered in 12 weekly sessions to prepare people to become engaged in 12-step mutual support programs. Twelve-step programs, like Alcoholic Anonymous, are not medical treatments, but provide social and complementary support to those treatments. TSF follows the 12-step themes of acceptance, surrender, and active involvement in recovery.

Treatment must address the whole person.

3.1.5.3. Prognosis for the patient

Stopping drug use is just one part of a long and complex recovery process. When people entertreatment, addiction has often caused serious consequences in their lives, possibly disrupting their health and how they function in their family lives, at work, and in the community. Because addiction can affect so many aspects of a person's life, treatment should address the needs of the whole person to be successful.

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3.1.6. Patient with a genetic disease: e.g., Down syndrome

3.1.6.1. Characteristics of the disease – essence, symptoms

Down syndrome (sometimes called Down's syndrome) is a condition in which a child is born with an extra copy of their 21st chromosome — hence its other name, trisomy 21. This causes physical and mental developmental delays and disabilities.

What causes Down syndrome?

In children with Down syndrome, one of the chromosomes doesn't separate properly. The baby ends up with three copies, or an extra partial copy, of chromosome 21, instead of two. This extra chromosome causes problems as the brain and physical features develop.

Trisomy 21

Trisomy 21 means there's an extra copy of chromosome 21 in every cell. This is the most common form of Down syndrome.

Translocation

in this type of Down syndrome, children have only an extra part of chromosome 21. There are 46 total chromosomes. However, one of them has an extra piece of

chromosome 21 attached. Certain parents have a greater chance of giving birth to a child with Down syndrome. According to the Centers for Disease and Prevention, mothers aged 35 and older are more likely to have a baby with Down syndrome than younger mothers. The probability increases the older the mother is.

Other parents who are more likely to have a child with Down syndrome include:

- People with a family history of Down syndrome.
- People who carry the genetic translocation.

It's important to remember that no one of these factors means that you'll definitely have a baby with Down syndrome. However, statistically and over a large population, they may increase the chance that you may.

Symptoms

At birth, babies with Down syndrome usually have certain characteristic signs, including:

- Flat facial features.
- Small head and ears.
- Short neck.
- Bulging tongue.
- Eyes that slant upward.
- Atypically shaped ears.
- Poor muscle tone.

People with Down syndrome usually have some degree of developmental disability, but it's often mild to moderate. Mental and social development delays may mean that the child could have:

- Impulsive behaviour.
- Poor judgment.
- Short attention span.
- Slow learning capabilities.

Medical complications often accompany Down syndrome. These may include:

- Congenital heart defects.
- Hearing loss.
- Poor vision.
- Cataracts (clouded eyes).
- Hip problems, such as dislocations.
- Leukemia.
- Chronic constipation.
- Sleep apnea (interrupted breathing during sleep).
- Dementia (thought and memory problems).
- Hypothyroidism (low thyroid function).

- Obesity.
- Late tooth growth, causing problems with chewing.
- Alzheimer's disease later in life.

Screening for Down syndrome during pregnancy

Preventive medicine is the most important part of today's prenatal care. The screening tests for Down syndrome are offered in all countries with good health-care systems. However, there is a lack of knowledge about the possibilities and the limitations of available prenatal Down syndrome tests among pregnant women in Bulgaria. If you're a woman over 35, if your baby's father is over 40, or if there's a family history of Down syndrome, you may want to get an evaluation.

First trimester

An ultrasound evaluation and blood tests can look for Down syndrome in your fetus. These tests have a higher false-positive rate than tests done at later pregnancy stages. If results aren't normal, your doctor may follow up with an amniocentesis after your 15th week of pregnancy.

Second trimester

An ultrasound and quadruple marker screen (QMS) test can help identify Down syndrome and other defects in the brain and spinal cord. This test is done between 15 and 20 weeks of pregnancy. If any of these tests aren't normal, you'll be considered at high risk for birth defects.

Additional prenatal tests

Your doctor may order additional tests to detect Down syndrome in your baby. These may include:

- Amniocentesis. Your doctor takes a sample of amniotic fluid to examine the number of chromosomes your baby has. The test is usually done after 15 weeks.
- Chorionic villus sampling (CVS). Your doctor will take cells from your placenta to analyze fetal chromosomes. This test is done between the 9th to 14th weeks of pregnancy. It can increase your risk of a miscarriage, but according to the Mayo Clinic, by only less than 1 percent.
- Percutaneous umbilical blood sampling (PUBS, or cordocentesis). Your doctor will take blood from the umbilical cord and examine it for chromosomal defects. It's done after the 18th week of pregnancy. It has a higher risk of miscarriage, so it's performed only if all other tests are uncertain.

Tests at birth

At birth, your doctor will:

- perform a physical examination of your baby.
- take a blood test called a karyotype to confirm Down syndrome.

3.1.6.2. Treating Down syndrome

There's a wide variety of support and educational programs that can help both people with the condition and their families. Available programs start with interventions in infancy. Federal law requires that states offer therapy programs for qualifying families. In these programs, special education teachers and therapists will help your child learn:

- Sensory skills.
- Social skills.
- Self-help skills.
- Motor skills.
- Language and cognitive abilities.

School is an important part of the life of a child with Down syndrome, regardless of intellectual ability. Public and private schools support people with Down syndrome and their families with integrated classrooms and special education opportunities. Schooling allows valuable socialization and helps students with Down syndrome build important life skills.

The specificity of nursing in this disease

- When caring for a patient with Down syndrome, it is important to remember that the patient may struggle with speech, learning, mobility, and self-care needs. These needs may be extensive, especially in the home. The patient still has the right to make choices if able and to be treated with dignity and respect.
- Always provide quality care with a positive attitude. When working with the child keep in mind that the parents may be grieving and struggling with how to handle all of the complications associated with the disease. It is important to emphasize resources such as child healthcare professionals and group counseling as well as literature to help the family learn and deal with the child's problems.
- Be sure to help promote independence and self-help skills such as self-feeding. Some areas that should be observed are socialization skills, verbal skills, activities of daily living, preventative health, nutrition, and behaviours.
- Anything that the child needs to learn should be broken down into the smallest components or baby steps to help them digest the information.

- Socializing can be difficult for the patient with Down syndrome. Role-playing and positive reinforcement can be particularly helpful. Teach and encourage parents to show the child socially acceptable behaviours such as waving goodbye, saying hello, responding to their name, and greeting visit visitors.
- Educating the family is very important. If there are cognitive impairments, the child or adult may not be able to recognize cues from others. This can be frustrating to the patient as well as the family. One strategy is to practice exaggerated cues to help the patient recognize behaviours of others and respond appropriately. Short-term memory may also be a problem. Explaining directions in simple, short sentence, one step at a time may be helpful.
- Remember that verbal skills may be delayed more than other physical skills. In order to speak, hearing and interpretation of sounds should be checked to make sure the patient can hear properly. Assistive devices may be needed to help the process. Sometimes a picture board may be used to help the child express their feelings and thoughts or children and adults may also learn sign language.
- When working with a person who has Down syndrome, observations should include noticing if the patient is irritable, unresponsive to contact, abnormal eye contact during feeding, gross motor problems, decreased alertness to voice cues, or difficulties with activities of daily living. If any of these areas show change, the nurse should be alerted.
- Be sure to assist the family with the prevention of other problems. Discuss the need for modifications as part of the daily routine to aid in patient care. For example, the joints of a baby or toddler may be limp and the child may sag in the parent's arms. Encourage parents to swaddle the newborn tightly and hold the toddler close supporting their head and spine.
- Observe for respiratory problems due to decreased muscle tone. An underdeveloped nasal bone may lead to inadequate draining, stuffiness, and dry mouth. The child may also be at risk for upper respiratory infections. Be sure the parents know how to properly suction the nasal passages if needed. Suggest the parents rinse out the child's mouth after eating and be sure to sit the child upright for feedings.
- Observe for gagging or choking. Food should be eaten slowly, and they should take small bites. Fluids should be consumed slowly as well. Dysphagia is often a concern due to the patient's short neck. This can increase the risk for aspiration pneumonia. Be sure to educate the parents or patient on the importance of taking the time to eat meals. Additionally, the Down syndrome patient often has problems with gastric motility such as gastric reflux or gas-

trointestinal upset. Observe for nonverbal cues of pain and use a rating scale for pain levels. Be sure to note all food intake.

- Because of poor muscle tone, gastric motility may be slowed causing constipation. Make sure fibre is a regular part of the diet. Eating habits should be carefully observed and documented. Height and weight measurements should be monitored regularly to check for obesity and high BMI.
- The child may grow more slowly and not reach developmental milestones on time. Keep a growth chart to measure height and weight on a regular basis.
- Skincare is also important. Be sure to check the skin for cracks or reddened areas. Be sure to apply lotion when necessary and use sunscreen when outside. Check bony prominences such as heels and elbows for red areas or sores. Furthermore, check skin folds for rashes. Be sure the area is washed and patted dry. Apply topical barrier creams if indicated by the treatment plan. If any areas look to be of potential concern, report to the nurse for additional treatment planning. Do not use any perfumed or alcohol-based products as this can cause irritation.
- Recreational activities are also important. Not only do these activities help with muscle tone, balance, and coordination but also help to manage weight. Furthermore, activities in the community can help with socialization skills. Make sure the activities are within the limits of the child or adult and will not cause undue stress on joints and weak muscles.
- Following a nutrition plan is also important. The patient should eat three meals a day that include the food groups. Self-management techniques can include a food diary to monitor the intake of calories and sodium if heart conditions are present.
- When working with children and adults, check for proper oral hygiene. The patient may not be able to brush effectively due to decreased motor skills or cognitive impairments made need instructions on how to brush and floss effectively. There are also several products available that can help patients with their oral hygiene. Be sure to check the treatment plan for aids or talk to the nurse if you notice problems.
- Safety is also a concern. The patient may have poor neck control or be generally weak. Protecting the neck and proper transferring of bedridden patients is essential. Logrolling techniques can be used as well as a two-person lift, or equipment designed to lift patients may need to be used. Other medical equipment may be used as well to help prevent falls. Examples are wheelchairs, shower chairs, or walkers.
- In older adults, arthritis may be an issue. Special pillows or rolled towels may be needed to support the neck. Additionally, a flat towel may be a better al-

ternative than a pillow, so the neck is not hyper flexed. Wedges may also help to alleviate back and hip pain. Document any pain and notify the nurse if the pain is new or has worsened.

- Prevention of illness is also important. Be sure to teach the patient to thoroughly wash hands and to stay away from people who are ill. When teaching the patient, it may be necessary to break up the task into steps. Use simple, short sentences and if possible, ask the patient to repeat each step back to you.

Midwife/nursing assessment

- Physical assessment. The midwife/nurse should perform a thorough, systemic, head-to-toe assessment of the newborn.
- History. Nurses should obtain a history of the mother's pregnancy, birth history, and genetic testing.

Nursing diagnoses

Based on the assessment data, the major nursing diagnoses are:

- Delayed growth and development related to impaired ability to achieve developmental tasks.
- Self-care deficit: bathing and hygiene, dressing, feeding, and toileting related to cognitive impairment.
- Impaired verbal communication related to impaired receptive or expressive skills.
- Risk for infection related to decreased muscle tone and poor drainage of mucus.

Nursing care planning and goals

The major goals for a child with Down syndrome are:

- The child will be able to perform motor, social, and/or expressive skills typical of the age group within the scope of present capabilities.
- The child will perform self-care and self-control activities appropriate for their age.
- The child will be able to establish a method of communication in which needs can be expressed.
- The child will be able to achieve timely wound healing. be free of purulent drainage or erythema and be afebrile.

Nursing interventions

- Provide adequate nutrition. Assess the child's ability to swallow, provide information on the proper way of giving food, and provide good nutrition counselling.

- Frequent consultations are a must. Encourage parents to have the child's hearing and vision checked regularly.
- Assess understanding of Down syndrome. Educate the parents about Down syndrome and the care of a child with the disease.
- Provide emotional support and motivation. The family caregiver needs support during these trying times. They need strong support and guidance from the time the child is born.

Evaluation

- The child was able to perform motor, social, and/or expressive skills typical of the age group within the scope of present capabilities.
- The child performed self-care and self-control activities appropriate for their age.
- The child was able to establish a method of communication in which needs can be expressed.
- The child was able to achieve timely wound healing. be free of purulent drainage or erythema and be afebrile.

Emotional impact

In some cases, you may not find out that your baby has Down syndrome until they are born. Giving birth can be an exciting, scary, and tiring experience, and finding out that your baby has this condition can be an unexpected shock.

If you have recently found out your child has Down's syndrome, you may be experiencing a whole range of feelings, such as fear, sadness, or confusion. Some people feel numb about the situation, while others develop an almost immediate sense of protectiveness over their child.

Support groups

If your child has Down syndrome, it is important to remember that you are not alone in your situation. There are thousands of people in the world with Down syndrome. There are also many people, such as family members, carers, and friends, who have had experience supporting and caring for those with the condition. You may find it helpful to talk about your experiences with other families. They may be able to offer you advice and talk through any fears, or concerns, that you may have. If you are not sure about how to find appropriate support groups, your GP should be able to put you in touch with a support group.

Early intervention

Early intervention programmes are specially designed for children with disabilities and learning difficulties. They focus on providing support to babies and children

with Down syndrome - from when they are born until they reach five years of age. Early intervention programmes provide health care, educational programmes and treatments, such as speech therapy and physiotherapy. They also provide advice and support to the family who is looking after the child. Early intervention is important because the earlier a child with Down syndrome receives the necessary help and support, the more independent and healthy they are likely to be later in life.

Support team

There are a number of different health professionals who will help to monitor and treat someone with Down's syndrome.

- Physiotherapist: A physiotherapist can help someone with Down syndrome to improve their range of movement. A child with Down syndrome will often have physiotherapy from a young age. For example, babies with Down syndrome may have poor muscle tone, so a physiotherapist can help them learn to roll over, sit up or walk.
- Speech therapist: Children with Down syndrome may have problems learning to speak, so a speech therapist can help them to learn how to communicate more effectively.
- Occupational therapist: An occupational therapist can provide people with practical support to help them live more independently. They can also help someone with Down syndrome to learn important social skills.
- Dietician: People with Down syndrome may find it more difficult to control their weight than other people. A dietician will help someone with Down syndrome to devise a diet plan that is tailored to their needs to ensure that they are getting a healthy, nutritious, and well-balanced diet.
- GP: Your GP will help you to deal with any more general health problems, and some of the day-to-day management of Down syndrome.
- Social worker: People with Down syndrome may need help in overcoming some social problems, such as finding accommodation or applying for financial benefits. A social worker will help them to do this, allowing them to live more independently.
- Audiologist: People with Down syndrome can sometimes experience hearing problems. An audiologist will be able to monitor your hearing so that any problems can be detected as soon as possible.
- Ophthalmologist and orthoptists: An ophthalmologist is someone who specialises in treating eye conditions. Those with Down syndrome are at an increased risk of having eye problems, such as eye infections, or cataracts. An orthoptist often works with an ophthalmologist to treat eye conditions that

involve problems with the movement, or focusing ability, of the eyes, such as squints (strabismus) or 'lazy eye' (amblyopia).
- Paediatrician: A paediatrician is a doctor who specialises in the treatment of children. They often help coordinate all the different types of treatment that your child has.
- Cardiologist: People with Down syndrome also have an increased risk of developing heart problems. Therefore, the health of their heart should be regularly checked. A cardiologist is someone who specialises in heart conditions.

Monitoring

Both children and adults with Down syndrome will have to go for regular check-ups so that their health can be monitored. People with Down syndrome are more likely to develop health problems, such as cataracts, or hearing problems. It is therefore important to monitor their condition so that any health problems can be detected and treated as soon as possible.

Living independently

With help and support, many people with Down syndrome can live an independent and active life. Many children with Down syndrome can go to mainstream schools. However, if your child is severely affected by Down syndrome, or you feel that they would benefit more from specialist schooling, there are a number of schools and other institutions that offer schooling specifically for those with special needs.

3.1.6.3. Prognosis for the patient

The lifespan of people with Down syndrome has improved dramatically in recent decades. In the 1960s, a baby born with Down syndrome often didn't see their 10th birthday. Today, life expectancy for people with Down syndrome has reached an average of 50 to 60 years.

Important information about Down syndrome

- Each year, approximately 6000 children are born with Down syndrome.
- Down syndrome accounts for about one-third of all moderate and severe mental handicaps in school-aged children.
- The prevalence of Down syndrome worldwide has increased because of increases in lifespan in the last few decades.
- The characteristic morphologic features will be obvious in children older than 1 year.

- On rare occasions, the disease can be observed in a few members of a family. the risk for recurrence of Down syndrome in a patient's siblings also depends on maternal age.
- The male-to-female ratio is slightly higher (approximately 1.15:1) in newborns with Down syndrome, but this effect is restricted to neonates with free trisomy 21.
- Perhaps 50% of female patients with trisomy 21 are fertile, and these females have up to a 50% chance of having a live child who also has trisomy 21.

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3.1.7. Patient with a disease of the neuromuscular system: e.g., MS

In this chapter, multiple sclerosis was selected as a disease entity of the neuromuscular system.

3.1.7.1. Characteristics of the disease – essence, symptoms

Multiple sclerosis (MS) is a chronic illness involving the central nervous system (CNS). The immune system attacks myelin, which is the protective layer around nerve fibres. This causes inflammation and scar tissue or lesions. This can make it hard for your brain to send signals to the rest of your body.

Symptoms of MS

People with MS experience a wide range of symptoms. Due to the nature of the disease, symptoms can vary widely from person to person. They can also change in

severity from year to year, month to month, and even day to day. Two of the most common symptoms are fatigue and difficulty walking.

Fatigue

Around 80 percent of people with MS report having fatigue. Fatigue that occurs with MS can become debilitating, affecting your ability to work and perform everyday tasks.

Difficulty walking

Difficulty walking can occur with MS for a number of reasons:

- Numbness in your legs or feet.
- Difficulty balancing.
- Muscle weakness.
- Muscle spasticity.
- Difficulty with vision.
- Overwhelming fatigue.

Difficulty walking can also lead to injuries due to falling.

Other symptoms

- Acute or chronic pain.
- Tremor.
- Cognitive issues involving concentration, memory, and problem-solving skills. The condition can also lead to speech disorders.

MS can develop all at once, or the symptoms can be so mild that you easily dismiss them. Three of the most common early symptoms of MS are:

- Numbness and tingling that affects the arms, legs, or one side of your face. These sensations are similar to the pins-and-needles feeling you get when your foot falls asleep. However, they occur for no apparent reason.
- Uneven balance and weak legs. You may find yourself tripping easily while walking or doing some other type of physical activity.
- Double vision, blurry vision, or partial vision loss. These can be an early indicator of MS. You may also have some eye pain.

What causes MS?

If you have MS, the protective layer of myelin around your nerve fibres becomes damaged. It's thought that the damage is the result of an immune system attack. Researchers think there could be an environmental trigger such as a virus or toxin that sets off the immune system attack. As your immune system attacks myelin, it causes inflammation. This leads to scar tissue or lesions. The inflammation and scar tissue disrupt signals between your brain and other parts of your body.

How is MS diagnosed?

Diagnostic testing may include the following:

- MRI scan. Using a contrast dye with the MRI allows doctors to detect active and inactive lesions throughout your brain and spinal cord.
- Visual evoked potentials test. This test requires the stimulation of nerve pathways to analyze electrical activity in your brain. In the past, brainstem auditory and sensory-evoked potential tests were also used to diagnose MS.
- Spinal tap (lumbar puncture). Your doctor may use a spinal tap to find abnormalities in your spinal fluid. It can help rule out infectious diseases.
- Blood tests. Doctors use blood tests to eliminate other conditions with similar symptoms.

Medications

Having MS means you'll need to see a specialist experienced in treating MS. The specialist may prescribe other medications to treat specific symptoms.

Diet and exercise

A well-balanced diet, low in empty calories and high in nutrients and fibre, will help you manage your overall health. Regular exercise is important for physical and mental health, even if you have disabilities. If physical movement is difficult, swimming or exercising in a swimming pool can help. Some yoga classes are designed just for people with MS.

Other complementary therapies

Studies regarding the effectiveness of complementary therapies are scarce, but that doesn't mean they can't help in some way.

The following may help you feel less stressed and more relaxed:

- Meditation.
- Massage.
- Tai chi.
- Acupuncture.
- Hypnotherapy.
- Music therapy.

What are the dietary recommendations for people with MS?

Diet hasn't been shown to have an impact on the nature of the disease, but it can help with some of your challenges. If you're fatigued, for instance, a diet high in fats and simple carbohydrates won't help.

Your diet should mainly consist of:

- A variety of fruits and vegetables.
- Lean sources of protein, such as fish and skinless poultry.
- Whole grains and other sources of fibre.
- Nuts.
- Legumes.
- Low-fat dairy products.
- Adequate amounts of water and other fluids.

The better your diet is, the better your overall health. You'll not only feel better in the short term, but you'll be laying the foundation for a healthier future.

You should limit or avoid:

- Saturated fat.
- Trans fat.
- Red meats.
- Foods and beverages high in sugar.
- Foods high in sodium.
- Highly processed foods.

Specialized diets such as the keto, paleo, or Mediterranean diets may help with some of the challenges faced by people with MS. Read food labels. Foods that are high in calories but low in nutrients won't help you feel better or maintain a healthy weight.

Nursing management in a patient with multiple sclerosis

Nursing Interventions	Rationale
Determine the current activity level and physical condition. Assess the degree of functional impairment using a 0–4 scale.	Provides information to develop a plan of care for rehabilitation. Note: Motor symptoms are less likely to improve than sensory ones.
Encourage the patient to perform self-care to the maximum of ability as defined by the patient. Do not rush the patient.	Promotes independence and a sense of control. may decrease feelings of helplessness.
Assist according to the degree of disability. allow as much autonomy as possible.	Participation in own care can ease the frustration over the loss of independence.
Encourage patient input in the planning schedule.	A patient's quality of life is enhanced when desires and likes are considered in daily activities.

Nursing Interventions	Rationale
Note the presence of fatigue.	Fatigue experienced by patients with MS can be very debilitating and greatly impact the ability to participate in ADLs. The subjective nature of reports of fatigue can be misinterpreted by healthcare providers and family, leading to conflict and the belief that the patient is "manipulative" when, in fact, this may not be the case.
Encourage scheduling activities early in the day or during the time when the energy level is best.	Patients with MS expend a great deal of energy to complete ADLs, increasing the risk of fatigue, which often progresses through the day.
Allot sufficient time to perform tasks, and display patience when movements are slow.	Decreased motor skills and spasticity may interfere with the ability to manage even simple activities.
Anticipate hygienic needs and calmly assist as necessary with the care of nails, skin, and hair. mouth care. shaving.	The caregiver's example can set a matter-of-fact tone for acceptance of handling mundane needs that may be embarrassing to the patient and repugnant to the SO.
Provide assistive devices and aids as indicated: shower chair or elevated toilet seat with arm supports.	Reduces fatigue, enhancing participation in self-care.
Reposition frequently when the patient is immobile (bed or chair bound). Provide skincare to pressure points, such as sacrum, ankles, and elbows. Position properly and encourage to sleep prone as tolerated.	Reduces pressure on susceptible areas and prevents skin breakdown. Minimizes flexor spasms at knees and hips.
Provide massage and active or passive ROM exercises on a regular schedule. Encourage the use of splints or footboards as indicated.	Prevents problems associated with muscle dysfunction and disuse. Helps maintain muscle tone and strength and joint mobility, and decreases the risk of loss of calcium from bones.
Encourage stretching, toning exercises, use of medications, cold packs, and splints and maintenance of proper body alignment, when indicated.	Helps decrease spasticity and its effects.
Problem-solve ways to meet nutritional and fluid needs.	Provides for adequate intake and enhances the patient's feelings of independence or self-esteem.

Nursing Interventions	Rationale
Consult with a physical and/or occupational therapist.	Useful in identifying devices and/or equipment to relieve spastic muscles, improve motor functioning, prevent and reduce muscle atrophy and contractures, promoting independence and an increasing sense of self-worth.

Administer medications as indicated	
Tizanidine (Zanaflex), baclofen (Lioresal), carbamazepine (Tegretol).	Newer drugs used for reducing spasticity, promoting muscle relaxation, and inhibiting reflexes at the spinal nerve root level. Enhance mobility and maintenance of activity. Tizanidine (Zanaflex) may have an additive effect with baclofen (Lioresal) but use with caution because both drugs have similar side effects. A short duration of action requires careful individualizing of dosage to maximize therapeutic effect.
Diazepam (Valium), clonazepam (Klonopin), cyclobenzaprine (Flexeril), gabapentin (Neurontin), dantrolene (Dantrium).	A variety of medications are used to reduce spasticity. The mechanisms are not well understood, and responses vary in each person. Therefore, it may take a period of medication trials to discover what provides the most effective relief of muscle spasticity and associated pain. Note: Adverse effects may be increased muscle weakness, loss of muscle tone, and liver toxicity.
Meclizine (Antivert), scopolamine patches (Transderm-Scop).	Reduces dizziness, allowing the patient to be more mobile.

"Nursing Management of the Patient with Multiple Sclerosis" AANN, ARN, and IOMSN Clinical Practice Guideline Series https://rehabnurse.org/uploads/about/cpgms.pdf

Learning to redefine control and independence

Sometimes MS symptoms can progress to the point that they significantly interfere with daily activities. Changes like this can threaten your self-confidence and feelings of self-worth. When this happens, we should remember that maintaining control and independence in everyday life doesn't necessarily mean doing everything the same way you did it before.

By allowing yourself to do things differently, such as:

- Gain access to the world of assistive technology (AT)—an array of energy- and labour-saving tools and devices that allow you to stay active and productive.

- Rehabilitation professionals can help you navigate the world of AT and suggest ways to modify your environment at home and at work to optimize control and independence.
- Complex rehabilitation technology (CRT) are medically necessary products — such as individually configured manual and power wheelchairs and seating and positioning systems — that enable people with significant disabilities including progressed MS to have their medical needs addressed and remain independent. Essential components of complex rehab technology include "accessories" such as customized seat cushions, tilt-in-space features, and head and trunk support systems.

Depression and other mood changes are common in MS, and grief is a normal reaction to the changes and losses that can accompany advanced MS. Building resilience and getting the support you need to deal with these emotional challenges is essential to maintaining your quality of life.

Avoiding complications

People with more advanced MS are at greater risk for certain kinds of complications. Examples include:

- Osteoporosis - loss of bone density related to reduced mobility and weight-bearing exercise, as well as treatment with corticosteroids.
- Pressure sores - damage to the skin caused by lack of mobility or long hours in a bed or wheelchair.
- Aspiration pneumonia - a problem caused by swallowing problems that allow food particles into the lungs.
- Severe bladder or kidney infections - resulting from chronic urinary dysfunction.

To reduce your risk of complications, schedule regular check-ups with your MS doctor and primary care provider and report any unusual fevers or changes in your symptoms.

Meeting caregiver challenges

As MS progresses, caregivers at home sometimes cannot continue to provide the physical help needed. Family relationships often improve when family members no longer are primary caregivers. Without the stress on the caregiver to be constantly available and do very physical work, and without the person with MS having to depend on the family member, they can go back to a more normal family relationship. People with MS often move to a nursing home when their health declines rapidly and health problems require professional care.

3.1.7.2. Prognosis for the patient

It's almost impossible to predict how MS will progress in any one person. About 10 to 15% of people with MS have only rare attacks and minimal disability ten years after diagnosis. This is sometimes called benign MS. About half of people with MS use a cane or other form of assistance 15 years after receiving an MS diagnosis. At 20 years, about 60% are still ambulatory and less than 15% need care for their basic needs.

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3.1.8. Elderly patient with Alzheimer's disease

3.1.8.1. Characteristics of the disease – essence, symptoms

Alzheimer's is the most common cause of dementia among older adults. Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—and behavioural abilities to such an extent that it interferes with a person's daily life and activities. Dementia ranges in severity from the mildest stage, when it is just beginning to affect a person's functioning, to the most severe stage, when the person must depend completely on others for basic activities of daily living.

Alzheimer's disease is named after Dr Alois Alzheimer. In 1906s, Dr Alzheimer noticed changes in the brain tissue of a woman who had died of an unusual mental illness. Her symptoms included memory loss, language problems, and unpredictable behaviour. After she died, he examined her brain and found many abnormal clumps (now called amyloid plaques) and tangled bundles of fibres (now called neurofibrillary, or tau, tangles).

Changes in the brain

The damage initially appears to take place in the hippocampus and the entorhinal cortex, parts of the brain essential for forming memories. As more neurons die, additional parts of the brain are affected and begin to shrink. By the final stage of Alzheimer's, the damage is widespread, and brain tissue has shrunk significantly.

Symptoms

The first symptoms of Alzheimer's vary from person to person. For many, the decline in non-memory aspects of cognition, such as word-finding, vision/spatial issues, and impaired reasoning or judgment, may signal the very early stages of Alzheimer's disease. Researchers are studying biomarkers (biological signs of disease found in brain images, cerebrospinal fluid, and blood) to detect early changes in the brains of people with mild cognitive impairment (MCI) and in cognitively normal people who may be at greater risk for Alzheimer's. Studies indicate that such early detection is possible, but more research is needed before these techniques can be used routinely to diagnose Alzheimer's disease in everyday medical practice.

What causes Alzheimer's?

In people with early-onset Alzheimer's, a genetic mutation may be the cause. Late-onset Alzheimer's arises from a complex series of brain changes that occur over decades. The causes probably include a combination of genetic, environmental, and lifestyle factors. The importance of any one of these factors in increasing or decreasing the risk of developing Alzheimer's may differ from person to person.

Genetics

Most people with Alzheimer's have the late-onset form of the disease, in which symptoms become apparent in their mid-60s. Researchers have not found a specific gene that directly causes late-onset Alzheimer's. However, having one form of the apolipoprotein E (APOE) gene does increase a person's risk. This gene has several forms. One of them, APOE ε4, increases a person's risk of developing the disease and is also associated with an earlier age of disease onset. However, carrying the APOE ε4 form of the gene does not mean that a person will develop Alzheimer's disease, and some people with no APOE ε4 may also develop the disease.

Health, environmental, and lifestyle factors

Research suggests that a host of factors beyond genetics may play a role in the development and course of Alzheimer's disease. There is a great deal of interest, for example, in the relationship between cognitive decline and vascular conditions such as heart disease, stroke, and high blood pressure, as well as metabolic con-

ditions such as diabetes and obesity. Ongoing research will help us understand whether and how reducing risk factors for these conditions may also reduce the risk of Alzheimer's.

A nutritious diet, physical activity, social engagement, and mentally stimulating pursuits have all been associated with helping people stay healthy as they age. These factors might also help reduce the risk of cognitive decline and Alzheimer's disease. Clinical trials are testing some of these possibilities.

Diagnosis of Alzheimer's disease

To diagnose Alzheimer's doctors may:

- Ask the person and a family member or friend questions about overall health, use of prescription and over-the-counter medicines, diet, past medical problems, ability to carry out daily activities, and changes in behaviour and personality.
- Conduct tests of memory, problem-solving, attention, counting, and language.
- Carry out standard medical tests, such as blood and urine tests, to identify other possible causes of the problem.
- Perform brain scans, such as computed tomography (CT), magnetic resonance imaging (MRI), or positron emission tomography (PET), to rule out other possible causes for symptoms.
- These tests may be repeated to give doctors information about how the person's memory and other cognitive functions are changing over time.
- People with memory and thinking concerns should talk to their doctor to find out whether their symptoms are due to Alzheimer's or another cause, such as stroke, tumour, Parkinson's disease, sleep disturbances, side effects of medication, an infection, or a non-Alzheimer's dementia. Some of these conditions may be treatable and possibly reversible.
- If the diagnosis is Alzheimer's, beginning treatment early in the disease process may help preserve daily functioning for some time, even though the underlying disease process cannot be stopped or reversed. An early diagnosis also helps families plan for the future. They can take care of financial and legal matters, address potential safety issues, learn about living arrangements, and develop support networks.
- In addition, an early diagnosis gives people greater opportunities to participate in clinical trials that are testing possible new treatments for Alzheimer's disease or other research studies.

3.1.8.2. The specificity of nursing in this disease

- Nurses must improve verbal and nonverbal communication with a person with Alzheimer's disease.
- Nurses must use coping with personality and behaviour changes, such as pacing or feeling sad, that are common in people with Alzheimer's disease.
- Nurses must use caregiving tips for managing sleep problems in someone with Alzheimer's disease or related dementia.
- Use coping with sundowning—restlessness or agitation in the late afternoon and early evening in a person with Alzheimer's.
- Learn how to react and keep things calm when a person with Alzheimer's experiences hallucinations, delusions, or paranoia.
- Learn how to make changes at home to discourage someone with Alzheimer's disease from wandering.
- Take steps to protect belongings while letting a person with Alzheimer's rummage through drawers and other storage areas.
- Understand the possible causes of agitation and aggression related to Alzheimer's, and learn how to respond to troubling behaviour.
- Learn how to cope with changes in a relationship as Alzheimer's or another dementia progresses.
- Find out about changes in intimacy, sexuality, and sex.
- After an Alzheimer's diagnosis, use these tips to help educate family and friends about the disease and how to interact with the person with Alzheimer's.
- Help children, teens, and grandchildren understand Alzheimer's disease, plus ideas for spending time together.
- Money problems may be an early sign of Alzheimer's disease. Learn the warning signs and what a family member can do to help prevent financial abuse.
- Przydatna będzie również wiedza o tym, kiedy i jak zacząć przygotowywać plany prawne i finansowe dla osoby z chorobą Alzheimera. Należy upewnić się, że dyspozycja pacjenta, testament i inne warunki zostały określone.
- Można również uzyskać wskazówki dotyczące bezpieczeństwa w domu dla osoby z chorobą Alzheimera lub pokrewną demencją. Oznacza to też zdobycie wiedzy o domowych środkach bezpieczeństwa, potencjalnych zagrożeniach, urazach i zapobieganiu upadkom i nie tylko.
- Find out when and how to start making legal and financial plans for someone with Alzheimer's. Ensure an advance directive, will, and other terms are defined.
- Get home safety tips for a person with Alzheimer's or related dementia. Learn about home safety products, potential dangers, injury and fall prevention, and more.

- Get room-by-room home safety tips to keep a person with Alzheimer's safe throughout the home, including the bathroom, living room, bedroom, and kitchen.
- Be prepared to help a person with Alzheimer's during natural disasters. Find out what supplies to keep on hand and what to do if you must leave home.
- Know the danger signs for when a person with Alzheimer's should limit or stop driving and how to discuss the issue sensitively.
- Healthy foods like fruit and vegetables can help people with Alzheimer's dementia.
- Help people with Alzheimer's take medicine safely. A pillbox and other reminders can reduce confusion.
- Get safety advice for helping someone with Alzheimer's disease take a bath or shower, care for their teeth and nails, get dressed, and more.
- Involve people with Alzheimer's disease and related dementias in daily activities and outings, including gardening, going out to eat, and travelling.
- Learn how to balance busy holiday activities with everyday care for a person with Alzheimer's disease.
- Learn about different facilities, questions to ask, and how to make moving day easier.
- When caring for someone with Alzheimer's disease, watch for these common medical problems, including fever, pneumonia, dehydration, incontinence, and falls.
- Going to the hospital can be stressful for someone with Alzheimer's disease or other dementia. Know what to expect and how to prepare for an ER or hospital visit.
- Read how to keep someone comfortable, care for skin and feet, help with eating, and avoid pressure ulcers.
- Learn how to get help from family, friends, and others. Care for your own physical, mental, and spiritual health.
- Improve communication skills and manage sundowning and other behaviours with these resources for Alzheimer's caregivers.
- Get resources for coping with symptoms of anxiety, stress, and other emotions that spring from caring for a person with Alzheimer's disease.
- Help children and teens cope with their feelings when a family member has Alzheimer's. Find books, articles and websites for children of all ages.

3.1.8.3. Prognosis for the patient

Alzheimer's disease gets worse over time and is ultimately fatal. Persons with Alzheimer's disease live, on average, four to eight years after diagnosis. Some pa-

tients can live 20 years after diagnosis. The course of the disease varies from person to person. Alzheimer's is a neurodegenerative disease and therefore the symptoms progressively worsen, gradually leading to a greater degree of dependence.

The disease progresses through different stages:

- Mild cognitive impairment. Throughout this stage, the patient suffers memory problems but can maintain their independence and does not need help from others.
- Dementia. This is when the patient now finds it hard to carry out activities alone. It could be mild dementia if they only have problems with complicated tasks or severe dementia if they can no longer perform any tasks and have lost the capacity to speak and walk.

Acute complications

- Altered behaviour. Patients with Alzheimer's, especially in moderate or moderately severe stages, can present marked behavioural changes in the form of irritability, aggressiveness or confusion, which may be accompanied by delusions and/or hallucinations. Although these symptoms tend to develop progressively, they can sometimes appear suddenly in a matter of hours or days. These episodes are often caused by changes in the patient's routine or because of a medical problem, even though they may be mild and sometimes hard to identify.
- Respiratory or urinary infections. Respiratory infections and urinary incontinence are frequently observed in the advanced stages of the disease. Patients may also find it hard to swallow food correctly.

Chronic complications

Alzheimer's is a chronic and progressive disease. The possible chronic complications associated with the disease vary according to the patient's stage of evolution. In the early stages, patients often present mood disorders which could be part of the actual disease or because they are worried about cognitive problems they have noticed or the diagnosis itself, especially if this is made early on.

Currently, due to the global Sars-Cov-2 pandemic, one should be aware of the wide spectrum of the virus's influence on human health and life. The widely available research shows that this virus causes memory disorders and other difficulties in mental functioning.

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3.2. Childbirth at home

Childbirth outside of a hospital can happen due to numerous circumstances. Among them are:

- premature birth,
- accelerated delivery at term,
- planned delivery at home.

Stages and periods of labour:

- I. stage of labour - opening, the time of dilation, lasts 8 to 10 hours in nulliparous, 6–7 hours in multiparous. This stage is divided into:
  - latent – gradual contractions at the rate of one per five minutes
  - active – cervix dilates to 4–7 cm, cervix effaced, contractions intensify frequency about 3 minutes, duration 45 seconds
  - transient - cervix dilates to 8 to 10 cm, strong contractions at the frequency of two to three minutes, duration 90 seconds
- II. stage of labour (expulsion) - average duration in nulliparous is 50 minutes, in multiparous 20 minutes, cervix completely dilated to 10 cm
- III. stage of labour – it takes 5 to 10 minutes, up to 60 minutes maximum, if the mother is not bleeding, the uterus is strongly withdrawn
- IV. stage of labour - two hours after the birth, the uterus should be withdrawn between the navel and the pubic symphysis, bleeding needs to be monitored

Childbirth in the field can occur in several situations. The situation may be:

- premature birth,
- precipitous labour at term,
- planned birth at home.

3.2.1. Premature labour

Premature labours can be divided into:

- iatrogenic – premature birth, termination of pregnancy due to foetal or fetomaternal
- complications
- spontaneous preterm labour, which is divided into a spontaneous preterm birth with preserved foetal membranes and premature rupture of membranes

Risk of spontaneous preterm birth is characterized by regular or irregular uterine activity before week 37. Premature birth can take the symptomatic course with uterine activity or rupture of membranes, or the asymptomatic course of cervical shortening.

Problems of pregnant women in preterm birth:

- pain in the lower abdomen and lumbar region,
- increased vaginal discharge,
- regular uterine contractions,
- pressure in the pelvis - the feeling that the baby is pushing down,
- abdominal cramps, diarrhoea,
- bleeding,
- massive rupture of membranes.

3.2.2. Childbirth at term or precipitous labour

Among obstetricians, precipitous labour has a clear definition. It is the spontaneous labour which lasts less than two hours. It often only takes dozens of minutes from the rupture of the amniotic fluid to the baby's birth, making it impossible to reach the hospital in time. Therefore, rather than giving birth on the road, it is better to call an ambulance immediately and remain in place.

Care of the mother:

- providing towels, fabric and scissors, if possible, washing one's hands and putting on gloves, the mother's intimacy must be ensured,
- the mother is positioned in to a half-sitting or lying position with flexed lower limbs and knees apart, or in an alternative position,
- verbal instruction to the mother: "...at each contraction, take a deep breath and hold it, close your eyes and push strongly..." During the first stage of labour, the mother is certainly not to push. It is dangerous and can cause injury. During contractions in the I. stage of labour, it is helpful to take gentle,

quick breaths through the pain. As if to blow a feather off. Between contractions, they should breathe calmly and normally.

- if the birth is without complications, it mostly takes place on itself with minimal assistance. The child is not to be pulled forcibly. After the head is born, it is necessary to wait for external rotation; during the next contraction, the baby's shoulders are gradually born. In case the baby has the umbilical cord wrapped around their neck, insert a finger under the cord and gently pull it off over their head. Newborns need to be provided with "soft landing". We can hold them on the forearm with their face lower than the body so that their airways are drained of residual amniotic fluid and mucus.

Caution!

The child is wet and slippery, you could drop it!

- The newborn should be wiped immediately; wiping should be rough, especially on the back and on the soles. This way, they are also stimulated to start breathing and adapting to the new living conditions. If a child does not begin to breathe within a few moments after birth, resuscitation must be initiated immediately. Before starting the resuscitation, it is necessary to tie off the umbilical cord and cut it. Newborns must be immediately and thoroughly wrapped to prevent them from getting cold, including the head. It is appropriate to lay the wrapped baby onto the mother's body as soon as possible.
- The newborn is connected to the mother by the umbilical cord, which keeps pulsing for a few minutes after the birth. The cutting of the umbilical cord is not urgent. After the pulsation stops, the umbilical cord is ligated in two locations by a lace or even two handkerchiefs. Once the umbilical cord ceases to pulsate completely, it is ligated about 20 cm from the baby's tummy at two locations about ten centimetres apart. These places must be tightened as much as possible as they may cause bleeding out.
- Postnatal treatment of the newborn is performed: drying the newborn, evaluation of heartbeat and breathing in the 1st, 5th, 10th minute after birth (Apgar score), skin colour, tone, reaction to irritation.
- Vital functions are monitored - breathing, pulse, consciousness of the mother.
- Uterine contraction is stimulated by compression of the uterine fundus in case of excessive vaginal bleeding!

Vital functions are monitored in order to be able to react in time to the potential decompensation of the patient's condition. Compression of the uterine fundus stimulates uterine contraction and the contraction of blood vessels, thus contributing to stopping postpartum haemorrhage.

Remember:

- Never!!! Do not attempt to forcibly extract the placenta e.g. by pulling the umbilical cord, etc.
- Never force the foetal head out!
- Remember that a newborn child loses heat very quickly – immediately after birth, protect his body and the back of the head with anything, even a foil bag, leaving the baby's face exposed! The foil perfectly maintains the temperature. Additionally, you can wrap your baby in a blanket or towel.
- The umbilical cord should be tightened tightly to avoid excessive blood loss – tighten the knot tightly. Do not be afraid – the use of force to make the knot does not hurt either the newborn or its mother.
- Unplanned childbirth outside the hospital is a huge stress for the mother in labour – keep calm, support her with your presence, show willingness to help.
- Stay with the woman and the newborn baby until the ambulance arrives – tell the medical team what has happened so far. Tell them everything – even if something has made you particularly uncomfortable..

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3.3. Eclampsia

Eclampsia is defined as spasmodic state during pregnancy, delivery and 10 days after childbirth, meeting at least two of the following criteria diagnosed within 24 hours of the seizure:

- Hypertension ≥ 140/90
- Proteinuria> 300 mg / 24 hours or albumin / creatinine ratio> 30 mg / mmol
- Thrombocytopenia <100x10 ^{9} / l
- Rise in serum AST level > 1,5 µkat/l

Eclampsia occurs as a complication of untreated or inadequately treated severe hypertension or severe preeclampsia. Over the past few decades, developed countries have reduced the incidence of eclampsia significantly, although the incidence of preeclampsia has not changed. This success is based on quality and widely available prenatal care and it is proof that eclampsia is a preventable disease. This is why the incidence of eclampsia is one of the basic indicators of the quality of perinatal care. Most seizures occur after the 28th week of pregnancy. Almost half the cases occur before birth, 10–20% during labour and more than a third will appear after birth, usually within 48 hours.

The seizure typically takes place in four stages:

1. Prodromes
2. Tonic convulsion phase
3. Clonic convulsion phase
4. Loss of consciousness.

The prodromal phase is characterized by symptoms identical to symptoms of severe preeclampsia, i.e. headaches in the frontal or occipital region, visual disturbances, photophobia, epigastric pain, hyperreflexia. Sometimes, little twitches in mimic muscles, eyeballs rolling back can be observed. This stage usually lasts a very short time and goes into tonic convulsion phase. Convulsions usually begin as twitching of the jaw muscles, followed by spasms of the muscles of the chest and diaphragm (leading to apnoea), muscles of neck and back muscles that immobilize the spine into opisthotonus, but also the muscles of the lower and upper extremities (boxing position of the upper limbs, clenched fists). After a few seconds, clonic convulsions appear, lasting within minutes. They manifest themselves by uncoordinated twitching of the body, especially of the limbs. Typical movements of the arms and hands are likened to “tambora drummer”. Also, rattling breath and cyanosis appear. At this stage, there are threats of pulmonary aspiration, heart failure, and placental abruption. In the last phase, the patient falls into a deep coma (pupil mydriasis and deep, regular breathing). This is followed by amnesia. Impaired consciousness may last several hours.

If not adequately treated, eclampsia can lead to accumulation of seizures (recurrent convulsions) and result in the life-threatening status eclampticus. The term eclampsia sine eclampsia refers to forms of the disease when the convulsion stage is missing and the woman falls directly into a coma. Complications of the disease differ from those in preeclampsia.

The therapeutic management is to ensure the vital functions and suppress convulsion activity, as after stabilizing the mother, termination of pregnancy / birth by C-section are indicated; exceptionally, during labour or during second stage of labour, vaginal extraction surgery may be necessary. The basis of pharmacologi-

cal intervention is anticonvulsant therapy to prevent recurrence of the convulsive state. The highest anticonvulsant effect is seen in intravenous magnesium sulfate ($MgSO_4$) Where the initial dose is a bolus of 4–6 g slowly administered intravenously (5–10 minutes) followed by a continuous infusion of 1 g $MgSO_4$ per hour for a period of 24–48 hours. This treatment is often combined with sedatives (diazepam 5–10 mg intravenous bolus, repeatedly). After the eclamptic attack and termination of pregnancy, further care at the ICU / ARO is indicated under the terms of the ward, focusing on intensive monitoring of vital signs, anticonvulsant, and antihypertensive therapy. Therapeutic procedures (including laboratory tests) are not different from the treatment of severe pre-eclampsia or of the HELLP syndrome.

Each convulsive state or impairment of consciousness is an indication of neurological examination. If the disorder persists despite adequate treatment, different aetiology needs to be considered (intracranial haemorrhage, brain tumour, brain oedema, metabolic causes, etc.) and further laboratory tests or imaging methods (CT, MRI, EEG) are added.

A key role in the development of preeclampsia is played by placental tissue or by abnormal development of placental vessels. We are talking about an abnormal remodelling of the spiral arteries. During physiological pregnancy, cytotrophoblastic cells penetrate the decidua and induce conversion of high-resistance spiral arteries into low-resistance, wide open ones, ensuring sufficient supply of maternal blood for the foetus and the placenta. This process occurs after the first trimester in the 18th to 20th week of gestation. In preeclampsia, the remodelling of spiral arteries does not occur, therefore they remain narrow and high-resistance, leading to reduced blood perfusion of the placenta and to its hypoxia and ischemia. Hypoxic placenta produces a number of biologically active substances which after entering into the maternal circulation cause a generalized disorder of the maternal endothelium (blood vessel lining in the mother) - the so-called endothelial dysfunction. Damage to the endothelium is reflected in multi-organ involvement (CNS, liver, lung, kidney, blood), leakage of fluid from blood vessels into the interstitial space and into the third space with the characteristic oedema formation (face and hands), ascites and in severe cases, pulmonary oedema and cerebral oedema. Hypertension probably occurs due to vascular spasms and it is usually the first overt symptom. The dysfunctional placenta also has a negative effect on foetal development, from its slowing to its arrest in growth, the so-called intrauterine growth retardation. The development and progression of the disease affects the amount of immunological, genetic and inflammatory factors. The risk of abnormal placentation is also raised by serious health complications associated with vascular insufficiency, such as pre-existing hypertension, diabetes, systemic lupus erythematosus, renal diseases and the like.

The above-mentioned pathophysiological changes mainly characterize the early form preeclampsia, emerging before the 34th week of pregnancy. Severe foetoplacental unit disorder causes intrauterine growth retardation (low birth weight) and in most cases, the severe course of the disease necessitates a quick termination of pregnancy, often very early before term. Therefore, early preeclampsia is associated with severe neonatal and maternal morbidity and mortality.

Late form pre-eclampsia with onset after the 34th week of pregnancy occurs rather on the basis of a chronic disease of the mother. The disorder of the foetoplacental unit is not as serious and has a good prognosis for both the mother and the foetus who retains physiological growth and has a normal birth weight.

Vulnerable groups of women:

- nulliparous
- age <18 years and > 35 years
- family history of preeclampsia
- personal history of preeclampsia or gestational hypertension
- multiple pregnancy
- high BMI above 35
- pre-existing / chronic hypertension
- pre-existing diabetes mellitus
- renal disease
- vascular disease
- disseminated lupus erythematosus
- antiphospholipid syndrome
- thrombophilic mutations

Early diagnosis of the disease allows particularly well provided prenatal care. At each prenatal counselling check, we are specifically looking for potential risk factors and based on history data, we evaluate the degree of risk of developing the disease. Blood pressure is measured, urine is examined for protein, and weight gain, including oedema formation, is checked regularly. The development and growth of the foetus is monitored.

According to severity, preeclampsia is categorized as:

- Mild: BP values of 140/90 to 159/109 mmHg, with no signs of severe pre-eclampsia
- Severe: BP values ≥ 160/110, oliguria <400 ml / 24 hours, signs of the HELLP syndrome (epigastric pain, pain in the right hypochondrium, thrombocytopenia $<100\times10^9$/l and / or liver enzyme elevation: AST, ALT), pulmonary oedema, evidence of progressive renal failure, newly occurring headaches, visual disturbances, nausea and vomiting

Preeclampsia is characterized by fluid retention in the body with sudden weight gain and the development of generalized oedema especially on the face, neck and hands. In very severe cases, anasarca, ascites, fluidothorax, fluidoperikard, or pulmonary or cerebral oedema may develop. The presence of isolated oedema of the lower limbs in normotensive women belongs to the physiological signs of the third trimester. Weight gain of more than 20% of body weight, or more than 1 kg per week is considered as a risk factor.

Pay attention to the following manifestations

- headache localized in the frontal region and behind the eyes occurs due to vasospasm of blood vessels in the brain and causes the danger of eclamption seizure and brain haemorrhage,
- visual disturbances manifest themselves in the form of the emergence of scotoma (loss of visual field), blurred vision, diplopia (double vision), photophobia (sensitivity to light), due to hypertension, bleeding in the retina with its detachment may occur, as well as vitreous haemorrhage and very rarely cortical blindness.
- epigastric pain or pain in the right hypochondrium causes tensioning of the housing of the liver due to subcapsular haemorrhage. apart from proteinuria, the blood count and biochemical parameters are examined.

Complications of pre-eclampsia can be divided into:

- Parent associated with multi-organ disorder
  - Eclampsia (see chapter on convulsion states)
  - Intracranial haemorrhage
  - Retina oedema
  - Pulmonary oedema
  - Kidney failure
  - Heart failure
  - HELLP syndrome
  - DIC
- Foetal, associated with impaired foetoplacental unit
  - Placental abruption
  - Intrauterine growth restriction
  - Pre-term birth (iatrogenic)
  - Intrauterine foetal death

The basic treatment of preeclampsia is pregnancy termination. If termination of pregnancy becomes necessary before the 34th + 6 week of pregnancy, the foetus must also be treated. We strive to prevent maternal complications of pregnancy and extend the pregnancy by means of pharmacological interventions. There are different approaches to the treatment of mild and severe preeclampsia.

In mild preeclampsia - antihypertensive therapy is engaged already at the blood pressure of 140/90 mmHg. Blood pressure should be kept 140/90 mmHg.

In mild preeclampsia, it is possible to observe pregnant women as outpatients, always taking into account clinical status and laboratory results, of course.

In severe preeclampsia, pregnant women are hospitalized at the ICU.

Nursing care prior to surgical termination of labour

- securing at least one good venous line
- measuring vital signs BP, P, ECG, SpO_2
- control of vaginal bleeding and uterine contractions
- recording the cardiotocograph
- blood sampling for blood count, coagulation factors and crossmatching
- monitoring consciousness, nausea, visual disturbances, headaches, epigastric pain
- monitoring fluid balance
- training and education of mothers for surgical termination of pregnancy
- prevention of thromboembolism

Post-surgical care after surgical birth:

- monitoring vital functions
- monitoring uterine contractility and bleeding condition, measuring blood loss,
- checking vital signs: BP, P, ECG, SpO_2
- monitoring consciousness, nausea, headache and epigastric pain
- monitoring diuresis, fluid balance and waste drains
- sampling of biological material
- therapeutic surgery
- aseptic dressings, evaluation of non-invasive and invasive inputs
- education about drinking regime and early rehabilitation on bed
- inter-disciplinary cooperation
- medical records keeping

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3.4. Epilepsy in pregnancy

3.4.1. Characteristics of epilepsy

Epilepsy is the most common disease of the central nervous system. It entails seizures which are typical for this disease. The disease is as old as mankind. It was described by Hippocrates already. The name comes from the Greek word "epilambein" or engulf, fall.

Epilepsy is not a single-cause disease. There is a group of so-called idiopathic, i.e. primary epilepsy types where no changes to the brain or other organs are found and where a significant role is played by heredity.

Symptomatic epilepsy (secondary) can develop after a brain injury, e.g. in utero, around birth, after suffering an injury, inflammation or bleeding. The cause of brain damage can also be metabolic and degenerative diseases.

Epileptic seizures are transient and short-term conditions, usually lasting seconds or minutes.

Their symptoms are very varied and may include:

- change of consciousness,
- physical symptoms - twitching or extension of limbs, twisting of the head, torso and eyes,
- falling over, or even more complex stereotypes of ineffective activity,
- unusual sensations - visual, olfactory, auditory, tingling in the limbs and the like,
- changes in vegetative system, such as flushing or sweating.

An important role is played by the cause of seizures, their nature, frequency and duration, age of the patient, the total length of the disease, and many other factors. Long generalized seizure with convulsions or an accumulation of such seizures - a so-called status epilepticus, is a serious, life threatening condition.

3.4.2. Current division of epileptic seizures by the International League Against Epilepsy

Partial seizures (partial, focal)

Partial seizures (focal) begin at a certain limited area of the brain and their manifestations are given by the location in this area (i.e. epileptogenic zones). This type of seizure is the most common in adults and the most common site of origin is in the temporal lobes. A portion of the patients feel warnings, or so-called aura, before the seizure. This is actually already a seizure limited to a small part of the brain

that does not necessarily have to spread further and the larger seizure may not develop. Aura appears frequently as discomfort in the abdomen, upper abdomen, rising up, as well as feelings of the already lived or seen, feelings of alienation, olfactory hallucination, etc. If the seizure spreads further, it already develops further into manifestations of the so-called partial complex seizure, where consciousness is already obscured (partially or completely), the patient performs automatic and purposeless movements (licking, swallowing, chewing, manipulating surrounding objects, adjusting their clothes) and can move around aimlessly or even pursue more complex activities which began before the seizure. They may speak, mostly incoherently or nonsensically. Sometimes, physical activity is minimal, on the contrary, as the patient comes to a standstill. After the seizure, confusion is not uncommon, as well as agitation or aggression. The patient mostly does not remembered the seizure. This seizure can spread and turn into a "full-fledged" seizure, generalized secondarily. Partial seizures from other lobes tend to allow for retained consciousness and they manifest themselves, for example, by twitching or cramping on one side of the body, or even just in a particular muscle group, from where they can "travel" further.

Generalized seizures

Epileptic activity affects the entire cerebral cortex of both hemispheres. Therefore, patients immediately lose consciousness. In adulthood, the most frequent generalized seizures are accompanied by convulsions. At the onset, the patient often cries out, bites their tongue and falls. They become stiff, do not breathe and turn blue. Gradually, they proceed to rattling breath, drooling and symmetrical twitching of all limbs. Towards the end of the seizure, they often wet themselves and they stay enfeebled and unconscious (or in deep sleep). Generalized seizures may occur without convulsion (typical in childhood) and can be characterized even just by a short fixing of one's eyes or an "outage".

Generalized seizures involving spasms include:

- myoclonic seizures which are characterized as short and repetitive twitching of individual muscle groups. They manifest themselves by rapid involuntary twitching of the head, limbs or of the entire body
- tonic - clonic seizures - are the most common type of epileptic seizures and are always accompanied by loss of consciousness; the seizure comes suddenly, beginning with violent tonic convulsions (bending of the body backwards into a bow shape) and a fall. The whole body may convulse in jerky spasms, breathing is irregular, urination occurs frequently. The regaining of consciousness is gradual, as is the subsiding of convulsions. After the seizure, amnesia and disorientation set in.

Most seizures are brief and resolved spontaneously. First aid in case of an epileptic seizure:

- keep calm
- do not restrain the spasms or try to stop them
- remove dangerous objects from the vicinity of the patient
- put a soft pad under the patient's head
- loosen their clothing
- after remission of convulsions, position the patient in the recovery position
- monitor the length of seizure and kind of spasms
- monitor the return of consciousness and provide additional treatment

3.4.3. Epilepsy in pregnant women

Epilepsy occurs in 1% of the female population of reproductive age. Adequate treatment with anticonvulsant therapy allows women to lead full lives, including sexual. This allows female patients to become pregnant. Pregnancy should be planned, including a pre-set therapy so that the patient is stable without seizures. However, fertility of women with epilepsy is less reduced than in healthy women. Anti-epileptic medication and convulsive seizures may have negative effects on foetal development. In epileptic women, there are also more frequent complications during labour and in the perinatal period. The risk of death is 10 times higher than in the general population, there is also a higher incidence of vaginal bleeding and of partus praematurus. In 50% of epileptic women, the frequency of seizures does not change during pregnancy. However, 30% of pregnant epileptic women do see an increase in the number of seizures. The causes of this increase are not yet clearly understood.

Maternal metabolic changes may be involved:

- body weight gain
- retention of fluids and sodium
- hypomagnesemia

These changes can have an effect on lowering the levels of anti-epileptics used by the female patient. Women who experience increase in the frequency of epileptic seizures have decreased blood levels of anti-epileptic drugs. Nevertheless, increasing the dosage of anti-epileptic drugs is not recommended, as they increase the teratogenic effects on the foetus. For these reasons, it is often necessary to convert women to anti-epileptic drugs with minimum teratogenic effect. It is also recommended for women to regularly test for levels of anti-epileptics in blood serum and undergo examination by electroencephalogram (EEG).

The teratogenic effect of anti-epileptics is up to 28% risk of congenital malformations. In recent years, available literature has described neural tube defects in foetuses of mothers who used valoproic acid, while the teratogenic effects of adenocarcinoma have been described similarly.

Overall, it is clear that anti-epileptic drugs may have teratogenic effects on the foetus, namely on:

- the formation of cleft neural tube defects
- anemia in pregnancy.

Recommendations for pregnant epileptic women:

- plan pregnancy as soon as possible
- plan the pregnancy and a health stability period
- before the planned pregnancy, discuss everything with a neurologist, document the types of epileptic seizures and their causes
- compensation by means of appropriate therapy with the lowest possible effective dose of anti-epileptics (must eliminate severe seizures)
- before the planned pregnancy, discuss everything with a gynaecologist
- administer folic acid throughout pregnancy
- administer vitamin D and vitamin B throughout pregnancy
- attend regular checks at the neurologist's, monitoring levels of anti-epileptics in blood serum
- monitor all seizures
- adapt your lifestyle - get enough sleep and rest, eliminate alcohol, nicotine,
- stressful situations

The pregnant woman must be informed of the potential adverse effects of anti-epileptic drugs and seizures on the child's health.

Furthermore, before and during pregnancy, risk factors need to be monitored, such as:

- cachexia,
- obesity,
- vitamin B12 deficiency,
- smoking,
- alcohol consumption.

As part of prenatal care, pregnant epileptic women report to the The International Registry of Anti-Epileptic Drugs and Pregnancy (EURAP) which associates countries in Europe, Latin America, Asia and Africa. Currently, there are 45 countries associated. The purpose of this registry is to evaluate the risks and malformations associated with the use of AE, risk and incidence of seizures.

The risks for pregnant epileptic women:

- increased risk of preeclampsia, placental abruption,
- increased risk of infection, induced or C-section births
- the risk of stillbirth
- in the case of partus praematurus, there is a risk of neonatal infection and complications in connection with asphyxia and neonatal infections.

3.4.4. Childbirth in epileptic women

Before labour, the patient should be evaluated by a neurologist who will determine the overall neurological state, including the type of epilepsy, seizures and medication. The report is then available to the obstetrician and neonatologist. The neurologist also gives statement as to the course of the birth and possible induction (when the need for prostaglandins arises), to the administration of anesthesia and analgesia during labour (whether it can be per vias naturales) and, finally, they need to properly take into account the medication, whether it is acceptable during lactation. Indication of C-section only becomes necessary when patients are at risk generalized seizures and status epilepticus. In epileptic women, prolonged ventilation is not desirable, as it can provoke an epileptic seizure. Anti-epileptic drugs must be administered continuously. In order to prevent seizures, the patient should get sufficient rest. The risk of seizures during labour is relatively low, at around 1%. The potential seizure can be terminated administering diazepam into a vein. A neurologist should be present during labour. In patients with a higher risk of major seizure undergo C-section, as an epileptic seizure during birth would cause her to cease to cooperate and the baby could suffocate in the birth canal. Most epileptic women are able to give birth naturally, nevertheless.

3.4.5. Breastfeeding in epileptic women

Breastfeeding with epilepsy is not completely contraindicated. It especially depends on two factors. The first is the kind of anti-epileptics and their dosage. Anti-epileptic drugs pass into breast milk in varying quantities. Medication considered as safe while breastfeeding includes carbamazepine, levetiracetam, phenytoin, valproate and lamotrigine and considered as rather risky are ethosuximide and phenobarbital.

Types of anti-epileptics:

- 1st generation

- 2nd generation
- 3rd generation

The 3rd generation levitiracetam and lamotrigine are considered as most suited for pregnancy and breastfeeding.

High doses of the drug pose the risk of child attenuation. Children fall asleep while breastfeeding, feeling satisfied, and soon wake up hungry. During lactation, regular tests of the child, the level of anti-epileptic drugs in the child's blood and in the mother's milk need to be conducted.

3.4.6. Risk of seizures in the postpartum period

- lack of sleep
- lack of rest
- deliberate progressive reduction of the dosage of anti-epileptics due to breastfeeding

3.4.7. Education of the mother

- ensure the safety of the child, bathing, changing diapers, child overlaying
- always think of an escort when going for walks, when visiting a doctor
- use your anti-epileptics regularly

Remember!

- Risk of seizures in the postpartum period:
- Education of the mother:
- The patient should be asked about the history of previous epileptic seizures (detailed history).
- Inquire about the presence of aura – as a warning of an impending attack.
- If you are taking care of a patient with a history of epilepsy, make sure that seizure medication is present in the delivery ward and it is not expired.
- You can put the controlled medications in the nearest medicine cabinet – in case of an attack you will gain time!
- Do not leave the patient during and after an attack. Provide her with physical and mental support.

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3.5. HELLP syndrome

HELLP syndrome (haemolysis, elevation of liver enzymes, thrombocytopenia) belongs to the most serious complications in pregnancy. It ranks among the most serious critical conditions during pregnancy and affects approximately 0.5–0.9% of all pregnant women. It usually develops between weeks 27 and 37 either alone or, most frequently, setting in on top of severe preeclampsia (80–90% of cases). Overall, it is a generalized disease with multi-organ involvement. Maternal mortality rate is around 4%. It occurs either in combination with classic signs of preeclampsia, which include hypertension and proteinuria, oedema, fluid retention, or without these symptoms, especially manifested by headache, visual disturbances, epigastric pain, nausea and swellings. Typical laboratory symptoms include the so-called trias – haemolysis, elevation of liver enzymes and thrombocytopenia.

It is characterized by typical laboratory result which gives it its name:

- Haemolysis
- Elevated Liver enzymes (elevation of liver function test)
- Low Platelets (thrombocytopenia)

Haemolysis is caused by partial destruction, the so-called fragmentation, of red blood cell. It is mechanical damage to red blood cells brought about especially by obstacles in microcirculation. It plays an important role in local vasospasm. The erythrocytes are damaged, producing irregular cells - schistocytes. The destruction of erythrocytes leads to elevation of lactate dehydrogenase (LHD) and a decrease in haemoglobin. Consequently, haptoglobin levels decrease and unconjugated bilirubin levels increase.

Elevation of liver enzymes – manifests itself by liver cell damage or their functional disorder. Basic laboratory examination is based on the increase in transaminase levels, particularly AST and ALT which are present in hepatocytes and released upon damage to liver cells.

As with preeclampsia, the key role is played by functional placental disorder and subsequent development of maternal endothelial dysfunction. Haemolysis causes destruction of red cells as they pass through damaged blood vessel lining. Schistocytes (damaged erythrocytes) and other indicators of haemolysis - LHD elevation and decreased levels of haptoglobin - are present in peripheral blood. Functional hepatic disorder leads to elevation of ALT, AST, there is thrombocytopenia < $150x10^9$/l.

Thrombocytopenia – a state where there is a reduction in platelets below $150x10^9$/l

Based on laboratory results, HELLP Syndrome is divided into three classes according to the most commonly used Mississippi classification. This classification has been designed by scientists from the University of Mississippi in the United States who based it on a retrospective analysis of more than 500 cases of HELLP syndrome, including maternal and perinatal results. The classification scheme has been proposed on the basis of LHD (lactate dehydrogenase) serum levels and platelet level. These values should reflect the severity and progression of HELLP syndrome.

Diagnostic criteria for individual classes under the Mississippi classification:

- I. Class - the highest risk to the mother and foetus - significant drop in thrombocyte count below $50x10^9$/l
- II. Class - thrombocyte count range $50–100x10^9$/l
- III. Class - thrombocyte count range $100–150x10^9$/l

The clinical course of the disease is generally very fast and difficult to predict. The symptomatological foreground is dominated by headache, epigastric pain or pain in the right hypochondrium and visual disturbances. Frequent concomitants are hypertension, proteinuria and oedema (signs of preeclampsia). However, it may also develop very slowly with characteristics of incipient viral diseases (flu like) – fatigue, weakness, somnolence, pain in joints.

Complication:

- DIC (disseminated intravascular coagulopathy): bleeding complicating surgery and the postoperative period, haematoma formation in subfascial space and intraabdominal haemorrhage
- Neurological complications: cerebral oedema, temporary blindness, intracerebral bleeding
- Subcaspular haematoma and rupture of the liver
- Pulmonary oedema develops especially in the postpartum period due to inadequate treatment of fluid balance

- Acute kidney failure
- Placental abruption
- Significantly worse perinatal results – high incidence of foetal growth retardation, prematurity due to iatrogenic preterm birth, higher incidence of perinatal death

Pregnant women with suspected HELLP syndrome are always hospitalized. Blood pressure and clinical condition of the mother and foetus are monitored intensively.

Laboratory examinations:

- Blood count including schistocytes including,
- ionograph,
- ALT (alanine transaminase), AST (aspartate transaminase), GMT (gamma-glutamyltransferase), ALP (alkaline phosphatase), bilirubin, LHD (lactate dehydrogenase), uric acid, haptoglobin, proteinuria,
- albumin and overall proteins
- coagulation tests

Laboratory examination should be repeated at 8-hour intervals.

As in case of preeclampsia, causal therapy consists of termination of pregnancy within the shortest possible period of time after diagnosis. In pregnancy under week 35 and in good clinical condition of the mother, administration of corticosteroids to induce lung maturity of the foetus may be considered.

Method of conducting the labour depend on the clinical condition of the mother and of the foetus:

- vaginal delivery is gentler, but it takes time
- C-section – faster variant

Therapy should be discussed with a haematologist. Haematologist is always consulted. In case of decrease of thrombocytes below $50x10^9$/l, administering platelet concentrate is recommended. Postoperative and postpartum care of a HELLP syndrome patient should always take place at the ICU/ARO.

Intensive monitoring of:

- vital signs - BP, P, SpO2, breath, ECG, diuresis
- uterine bleeding, laparotomy
- waste from drains,
- intestinal peristalsis
- signs of intra-abdominal haemorrhage risk.

The development of severe coagulopathy may be indicated by bleeding from mucous membranes or skin petechiae. Prevention of blood loss from the uterus is ensured by administered uterotonics infusion.

- The main pillars of supportive and substitution therapy:
- Interdisciplinary cooperation (obstetrician, anaesthesiologist / intensivist)
- Anticonvulsant therapy

- Antihypertensive therapy
- Consistent treatment of fluid balance
- Adjustment of coagulation
- Corticoid therapy

3.5.1. Care of women with HELLP syndrome

Requirements for midwives working in the delivery room and intensive care unit put great demands on the knowledge of pre-eclampsia, hypertension and HELLP syndrome erudition, quick decision making abilities, knowledge of instrumentation, knowledge of medicines and the ability to work in a team.

Nursing care is divided into care in the preoperative period and postoperative period.

The preoperative period is very fast, but history must be taken accurately. The midwife carries out her duties without delay, carries out her competences and carries out medical orders).

The midwifery practitioner ensures immediately that:

- at least two good venous lines are secured
- vaginal bleeding and uterine contractions are monitored
- cardiotocograph is recorded
- blood sampling for blood count, coagulation factors and crossmatching are taken
- physiological functions including cognition and evacuation are measured
- training and education of mothers for surgical termination of pregnancy
- prevention of thromboembolism
- before the termination of pregnancy, blood sample for examination is taken (for HELLP syndrome)

Postoperative care at the ICU entails haemodynamic stabilization of the patient.

Upon arrival to the ICU, the midwifery practitioner ensures immediately that:

- the patient is connected to the monitor of vital signs
- the contractility of the uterus and uterine bleeding status are monitored, blood loss is measured, recorded and reported to the physician
- vital signs are monitored: BP, P, ECG, SpO_2
- consciousness, psychical status and moods are monitored
- diuresis and waste are monitored and fluid balance kept
- oedema, headache, and epigastric pain, visual disturbances, nausea and vomiting are monitored
- in case the mother is in spinal anesthesia, the unwinding of subarachnoid block is monitored

- control samples of biological material are taken according to the physician's office
- therapeutic prescriptions (infusion solutions, uterotonics, miniheparinization, and specific therapy of the underlying disease) are administered
- according to the clinical condition, blood loss, blood count examination and coagulation parameters, assistance is provided to the physicians and blood products (red cell concentrate, freshly frozen plasma, fibrinogen) are being administered
- aseptic re-dressings, evaluation of non-invasive and invasive inputs are performed
- education about drinking regime and early rehabilitation on bed is provided
- working with obstetricians, doctors, specialists, other health professions and family members
- preparing and accompanying the mother to other necessary examinations
- keeping precisely nursing documentation

Symptoms often include impaired consciousness and sometimes, even the primary disease only manifests itself through loss of consciousness. Differential diagnosis of loss of consciousness includes a wide range of pathologies:

- Respiratory failure: airway obstruction, anaphylaxis, respiratory failure, trauma
- Circulatory failure: haemorrhagic shock, aortocaval compression syndrome, arrhythmia, cardiac arrest (congenital heart defects or acquired diseases such as valvular defects or cardiomyopathy), septic shock, amniotic fluid embolism, trauma
- CNS failure in its primary pathology
- Metabolic causes: hypo/hyperglycaemia, hypo/hypercalcemia, hypermagnesemia, hyponatremia (usually iatrogenic origin), thyroid disorders, liver failure

Remember!

Approach to the pregnant woman with HELLP syndrome must be complex and requires interdisciplinary cooperation - obstetrician, intensivist, neurologist, internist. The priority in the treatment process is to ensure the basic life support of the mother:

- ensuring airway patency
- sufficient oxygenation
- stabilizing circulation
- preventing aspiration
- pharmacological suppression of spasmodic activity.

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3.6. Postpartum haemorrhage

The term postpartum haemorrhage is applied to blood loss exceeding 500 ml at spontaneous delivery and 1000 ml during a C-section. Postpartum haemorrhage is divided according to time perspective:

- primary - bleeding occurs within 24 hours of birth
- secondary - bleeding occurs more than 24 hours after birth, during the puerperium

The causes of primary postpartum haemorrhage are different from the causes of secondary postpartum haemorrhage. The causes of primary postpartum haemorrhage are collectively referred to as 4 T's:

- tone - uterine tone disorders
- trauma - birth injury
- tissue - placental pathology
- thrombin - coagulopathy

The causes of secondary postpartum haemorrhage are:

- uterine infection
- retained parts of the placenta
- abnormal involution at the placental site

Peripartal life-threatening bleeding can be defined as:

- loss of one whole blood volume over the period of 24 hours
- 50% loss in blood volume within 3 hours
- blood loss increasing at the rate of 150 ml/min

3.6.1. Tone

Failure of retraction (withdrawal) of the uterine muscle represents 80% of all cases of primary postpartum haemorrhage. They are manifested by uterine hypotonia and atony.

The risk factors include:

- Excessive uterine distention caused by polyhydramnios or multiple pregnancy
- abrupt or protracted labour
- pathological content of the uterus - the remains of placenta, foetal membranes, blood clots
- rough handling of the uterus - upon forceful foetus evacuation, intrauterine manipulation
- disorders of the myometrium - hypoplasia, myomatosis
- multiparity
- foetal macrosomia
- excessive oxytocin use during childbirth - causes tachyphylaxis
- postpartum haemorrhage in history
- surgery on the uterus in history
- intrauterine infection

3.6.2. Uterine Atonia / Hypotonia

A state where no postpartum uterine retraction occurs and tourniquet function of the myometrium fails, is called uterine atony. It represents 80% of all cases of peripartal haemorrhage and it is the most frequent indication for postpartal hysterectomy. It manifests itself by massive uterine bleeding after the evacuation of the placenta, the uterus is soft, paste-like, filled with clots, the uterine fundus is found by touch above the navel and upon compression, expulsion of additional blood or coagulates occurs.

In obstetrics, blood loss is characterized by:

- often violent, sudden and large blood loss
- blood loss can only be estimated with difficulty
- resuscitation in pregnancy is hindered by aortocaval compression syndrome (change in uteroplacental unit perfusion) and abdominal compartment syndrome
- increased risk of haemorrhagic shock
- the possibility of retroperitoneal bleeding into the lesser pelvis.

3.6.3. Trauma

Birth Injury

- Episiotomy (cut to the perineum) belongs to the most common injuries of the soft birth canal. Next, there are the rupture of the perineum and the laceration of external female genitalia. They are rarely cause of serious bleeding, their correct diagnosis and surgical treatment can have a major impact on the quality of the woman's life. This is especially true about perineal laceration which can be divided into four degrees according to scope. The 3rd and 4th degree perineal tear already involves anal sphincter injury. If not properly recognized and treated, this leads to long-term consequences in terms of incontinence of intestinal gas and faeces. Vaginal birth also causes risk of developing urinary incontinence and injuries associated with the pelvic floor muscles, specifically the musculus levator ani.
- Among the less frequent injuries, there are paravaginal haematoma - accumulation of blood between the vaginal wall and the wall of the pelvis due to interruption of blood vessels in this area. Blood loss may be up to 1000 ml with clinical manifestation most often in the 4th stage of labour, often even after the primary surgical treatment. The mother in labour is pale, exhausted, complaining of severe pain in the perineum and painful pressure on the rectum, while there is no outside bleeding of the genitals. Palpation examination will reveal rigid painful bulge on the walls of the vagina and rectum. Therapy involves the incision of the vaginal walls, or the dissolution of previous suture in general anesthesia, emptying the haematoma and careful review of the entire paravaginal space in an effort to find the source of bleeding and treat it. If the source cannot be found, this condition is treated using drainage with careful tamponade of the vagina and monitoring of the state of the patient.
- Injury to the uterine arteries due to cervical laceration or uterine rupture lead to severe bleeding into the uterine parametria with pelvic haematoma formation. It is a hidden retroperitoneal bleeding, which unfolds as haemorrhagic shock. This complication must be considered in the absence of vaginal bleeding and concurrent bleeding into the abdominal cavity. The woman in labour often indicates severe pelvic and lower abdominal pain and the uterus is usually resorting to the contralateral side of the haematoma. An important role in the diagnosis is played by ultrasound, CT or MRI. Pelvic haematomas can reach enormous proportions and spread to the subrenal area. Surgical intervention consists of laparotomy and opening of the pelvic peritoneum, and identifying the source of bleeding, which of course requires sufficient

expertise of the surgeon. Good haemostatic effect can also be achieved by ligation of hypogastric arteries. If the workplace allows for it, the method of choice can be angiographic selective transcatheter embolization.

3.6.4. Tissue

Disorders of placental separation cause about 5% of postpartum haemorrhage. The causes include:

- residues post partum
- insertion of the placenta into a place of imperfect decidualization - for example in the lower uterine segment, above myomas, into the C-section scar, the endometrium after repeated curettage.

3.6.5. Trombin

Coagulopathy causes about 2–4% of all cases of peripartum life-threatening haemorrhage, often in combination with other causes of haemorrhage.

We distinguish coagulopathy:

- genetic (hereditary) coagulopathy (less common)
  - platelets deficiencies (von Willebrand disease)
  - coagulation factor deficiencies (haemophilia A and B, rarely other factor deficiencies, such as fibrinogen)
- acquired coagulopathy (during pregnancy or birth) occurring as part of peripartal life-threatening bleeding
  - DIC (Disseminated intravascular coagulation syndrome)
  - HELLP syndrome
  - anticoagulant therapy (heparin, warfarin)

In hereditary coagulopathy women are monitored prior to pregnancy and childbirth by a haematologist who determines the treatment and prophylaxis of bleeding in high-risk period - surgeries, childbirth, pregnancy, etc. Treatment consists in providing the missing coagulating factors and other measures to prevent bleeding.

Acquired coagulopathies include the disseminated intravascular coagulation syndrome (DIC) which is the most serious secondary failure of haemostasis in pregnancy at high risk of maternal death.

- The first stage leads to the activation of thrombin (blood clots), particularly in the lungs, kidneys, gastrointestinal tract and skin. It will manifest in acute respiratory distress (dyspnea, cyanosis), oliguria to anuria, alteration of consciousness, impaired liver function, skin purpura, petechia.

- In the second phase, coagulation factors and thrombocytes are being consumed, resulting in bleeding when blood visibly does not clot and haemorrhagic shock develops - pallor, tachycardia, hypotension, impaired consciousness, anuria.

This situation can cause:

- placental abruption,
- amniotic fluid embolism,
- dead foetus syndrome,
- thromboembolic disease,
- preeclampsia and eclampsia,
- HELLP syndrome,
- severe infection and sepsis,
- tissue trauma (uterine rupture or intraoperative contusion)
- manual placenta removal, instrumental or manual revision of the uterine cavity.

In cases of suspected development of disseminated intravascular coagulation (DIC), bed-side test with thrombin can be executed directly at the delivery room: 2 ml of venous blood are sampled into a test tube with lyophilized thrombin and it is warmed up in the palm of hand. In case of sufficient level of fibrinogen in the blood, the blood will coagulate immediately, otherwise the blood does not clot and administration of fibrinogen is indicated.

Laboratory DIC blood count (blood count and coagulation test):

- thrombocytopenia
- hypofibrinogenemia
- decrease in antithrombin III
- high concentration of D-dimer
- increased FDP level
- prolongation of aPTT)
- prolongation of the PT (INR> 4)

Since haemostasis changes rapidly during DIC, laboratory examinations must be carried out regularly.

Remember!

The basis for therapy of disseminated intravascular coagulation is to identify and eliminate the causes that brought it about.

3.6.6. Comprehensive approach in the treatment of peripartal bleeding

Solution of peripartal life-threatening bleeding requires coordinated multidisciplinary approach (obstetrician, anaesthesiologist, haematologist, transfusion physician). Every gynaecology and obstetrics department should be have a crisis plan developed for the peripartal life-threatening bleeding.

The basic objective of diagnostic and therapeutic procedure:

- early identification of bleeding and its causes
- immediate start of procedures to eliminate the cause of bleeding
- early identification of tissue hypoperfusion and its timely correction
- early identification of coagulopathy and its treatment

Interventions for the successfully management must be timely and aggressive. The source of bleeding can be identified in examination of the mother quickly using mirrors, bimanual palpation examination and ultrasound examination.

Midwifery and care of a woman

- physiological functions BP, P, BT, SpO_2, breath, diuresis are monitored
- two venous inputs via cannula are opened with a large diameter for rapid application of remedies
- vaginal bleeding is monitored
- Crystalloids are administered, colloids as needed
- blood tests for laboratory tests – blood count, coagulation, fibrinogen, biochemistry, including acid-base balance, blood group
- frozen plasma, packed red cells, fibrinogen concentrate are made available
- urinary Foley catheter is introduced to monitor diuresis
- oxygen delivery is ensured

The goal, as part of managing the source of bleeding, is the target systolic blood pressure of 80–90 mmHg. Upon failure of consciousness, the airway is secured by intubation and mechanical pulmonary ventilation is initiated.

In case of failure to properly implement standard procedures, the execution of postpartum hysterectomy is indicated. Intensive care and monitoring of vital functions continue after the surgery.

Post-Surgery Care

Post-operative care at the ICU entails haemodynamic stabilization of the patient:

- the patient is connected to the monitor of vital signs
- the tone of the uterus, uterine fundus height and bleeding status are monitored, blood loss is measured, recorded and reported to the physician
- vital signs are monitored: BP, P, ECG, SpO_2
- consciousness is monitored

- diuresis and waste are monitored and fluid balance kept
- in case the mother is in spinal anesthesia, the unwinding of subarachnoid block is monitored
- control samples of biological material are taken according to the physician's office
- therapeutic surgery (infusion solutions, uterotonics miniheparinization, or specific treatment of the underlying disease, which may have caused the complications, such as a hypertension disease)
- according to the clinical condition, blood loss, blood count examination and coagulation parameters, assistance is provided to the physicians and blood products (red cell concentrate, freshly frozen plasma, fibrinogen) are being administered
- aseptic re-dressings, evaluation of non-invasive and invasive inputs are performed
- education about drinking regime and early rehabilitation on bed is provided
- working with obstetricians, doctors, specialists, other health professions and family members
- preparing and accompanying the mother to other necessary examinations
- keeping precisely nursing documentation

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3.7. Advanced natural labour in deaf patients

The issue of disability in obstetric care is multi-faceted, especially due to hindered communication that is particularly important in an urgent obstetric situa-

tion. Since disabilities have become so common, the year 2003 has been named the year of people with disabilities.

Disability is a very broad notion. In conclusion, it may be said that disability is such a condition of a person where his or her daily functioning is somewhat restricted. Those restrictions pertain to several areas: physical, psychological, mental, or several of those combined. The term "disability" may also be applied to birth defects, anatomical defects, as well as a loss of a body part as a result of an accident. The diversity of those dysfunctions classifies their duration: a birth defect, an acquired, permanent, or temporary defect, a stabilised or progressive defect.

The European Congress for Persons with Disabilities approved the propositions of the Declaration of Madrid concerning a series of changes to the care of people with disabilities and the society's coexistence with such people. Key propositions include:

- complete acceptance of people with disabilities as citizens and consumers with equal rights,
- seeing people with disabilities as fully self-reliant and independent in terms of decision making,
- seeing the talent and personal skills of people with disabilities – providing support and activities,
- implementing a national policy concerning people with disabilities: creating support programmes, ensuring conditions supporting such people and their caregivers, involving people with disabilities in everyday life.

The term "sensory disability" applies to a blind or deaf patient. This type of disability is especially difficult in terms of providing health care. When caring for a patient, it must be remembered that hearing loss may be a birth defect or may be acquired. There are several, if not several dozens of described hearing loss causes, starting with disordered sound flow to the inner ear, long-term exposure to loud noise, hearing damage, otosclerosis, or commonly occurring middle ear inflammation.

When considering hearing impairment, two types of dependences should be mentioned (that are extremely important when caring for a patient!):

1. Objective dependence – where it is possible to commence and maintain communication, thanks to the use of modern technology and the availability of professional equipment aiding hearing.
2. Emotional dependence – where verbal communication is impossible, and the participation of a third party (a caregiver, a companion) is necessary to take any medial actions.

Both in Poland and all around the world, an increased ratio of pregnant women with hearing impairment can be observed. This is becoming more common due to multiple initiatives of government agencies supporting people with disability, that are effectively encouraging society to respect everyone's dignity, calling for toler-

ance and acceptance, thus reducing exclusion. The momentum of the programmes developed for people with disabilities results in their increased life activity, willingness to start a family and take up jobs outside of their homes. The main aim of all governmental programmes is to break down social barriers.

3.7.1. Process of communicating with a patient with a disability in a delivery room

The most effective and at the same time the most comprehensive action aimed at ensuring dialogue with a patient is to secure the proper form of communication that is known to the patient, e.g., the use of sign language. In general, without the knowledge of sign language or access to a professional sign language interpreter, there is a problem with mutual communication. There are other solutions, though – called immediate half measures. It must be kept in mind that when dealing with a patient with hearing impairment, all actions of the staff aimed at ensuring mutual communication or at least attempts at such communication are desired. Patience and willingness to understand the needs of the patient are the foundation for the communication process.

Hard of hearing patients expect communication by sound with lip-reading, which is why standing in front of the patient is necessary for successful communication. Lip-reading is a complex and difficult endeavour, often overestimated by people without hearing impairment. There are multiple factors that make it much more difficult to lip-read, which is why attention should be paid to the medial practitioner's face lighting, his or her body posture (whether standing or moving), the distance between the medical practitioner and the patient. Key factors also include individual face characteristics and, e.g., facial hair (including a moustache) that make it more difficult to understand what is being said. Faces covered with a protective mask that is required from the medical team during delivery (as well as during pandemics) prove to be an insurmountable barrier. That is why visors are recommended that make it possible to lip-read, facilitating the delivery of the message with the medical practitioner's facial expressions.

If verbal communication is possible, all the words spoken by the medical team should be spoken slower than usual, more clearly and more loudly. Nervous behaviour, excessive gesticulation, including shouting and high tones should be avoided. Short and concise sentences are recommended, so that the patient has time to process the message received. It is important for words to be spoken very clearly. There is a risk that the message recipient (the patient) might hear a distorted word, such as: night-light or day-may. In such a case, many communication errors stem from the medical staff not speaking clearly enough.

Patients usually accept being touched, although sometimes touching the patient's hand may violate her personal space, which is why if it is necessary to attract the patient's attention (for example, if she is looking the other way), it is safe to touch her on the arm.

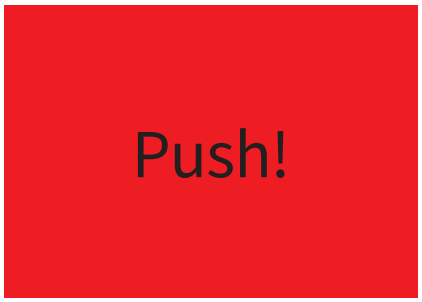
When patients with hearing impairment want to attract the attention of the medical team, they might wave their hands, lightly tap a table or a chair, stamp their feet or tap e.g., a mug with a pen in order to create a sound. The medical team may utilise such strategies as well, provided that the chosen form of communication is not aggressive nor theatrical in a way that might compromise the patient's feeling of acceptance and safety.

Another method supporting communication is the image-based method – a drawing, writing a word down. When choosing this method, it must be kept in mind that unfortunately some people with hearing impairment have trouble reading, which is why an image or a sketch might be the preferred solution.

Many medical facilities in Poland work with sign language interpreters in case the need arises to communicate with a person with hearing impairment. It is the perfect solution both for the patient and the medical team. Nevertheless, the lack of such a solution cannot result in a patient (especially one in labour) being left to herself. If there is no interpreter, the medical team's assertiveness, creativity, and focus on respect for human dignity, irrespective of their beliefs, appearance, or health limitations is key. A set of labour-related pictures, prepared in advance in delivery rooms in case a pregnant woman with hearing impairment is admitted, is a good idea. Such a set would be especially helpful, e.g., in view of the course in which a patient is admitted or the presence of perinatal risk. The pictures should be legible, clear, straightforward, devoid of elements of little importance that may distort the message.

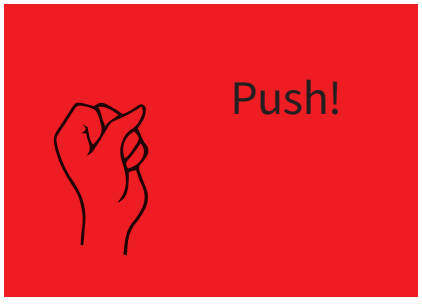
Suggested pictures to be used in a delivery room for a patient with hearing impairment

Showing the patient a piece of paper with a clearly written word "Breathe" may prove to be the most effective form of communication, especially at an advanced stage of labour.

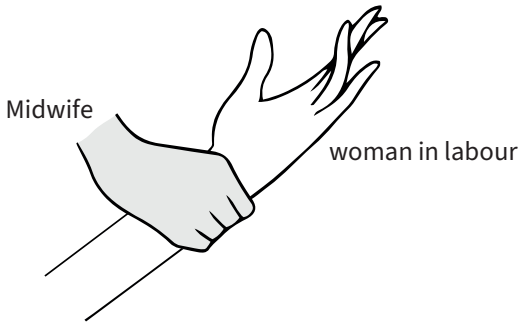


As with the previous picture, showing the patient a piece of paper with the word "Push!" may effectively impact the communication process at the second stage of labour. Sometimes, even the colour of the piece of paper – having first agreed on its meaning – is sufficient (a strong colour may be interpreted as the need to take action immediately).

A picture of an open hand may symbolise relaxation, steady breathing.



A picture of a closed fist may symbolise the use of strength – which is extremely important when pushing at the second stage of labour. Once again, a vividly coloured picture may encourage the patient to take a specific action.



As in the previous picture – the midwife's (or other person assisting with the delivery) hand closed around the wrist of the woman in labour during a uterine contraction may encourage the patient to push.

The presented pictures have been created by the authors. Their exact appearance, size, and choice of symbols depend on the creativity of the medical team. There are no globally standardized pictures adapted for working with a patient with hearing impairment in a delivery room.

Recommendations for the work of a medical team in a delivery room with a patient with hearing impairment

Remember!

Sensory hearing impairment is somewhat easier than visual disability since a lot can be shown and demonstrated to the patient. It is the time and place for your creativity, your professionalism.

- All the medical care in a delivery room should be provided in line with regulations and other ministerial documents, procedural algorithms, recommendations of medical associations applicable in a given country!
- Welcoming the patient should be initiated with physical contact, standing in front of the patient – a handshake, touching the patient on the arm. The patient will interpret the medical team's behaviour, its gestures, and facial expressions.
- The person providing medical care should familiarise him- or herself with any available sources (the patient's companion, medical documentation) as to what type of dependence the patient has and, based on that, adopt the best method of communication for this particular patient. Maybe the patient can lip-read or has a hearing aid that supports the communication process.

- The person providing medical care should always obtain information whether the patient has a hearing aid, since there is medical equipment generating sound in the delivery room, such as a cardiotocograph. In the case of an active hearing aid, high tones and loud sounds should be eliminated since they may affect the patient's sense of calm and safety. The sound of the equipment should be minimised or completely turned off. The patient would be unable to listen to the foetus's heartbeat, but she will be able to see the visual and the number. Apart from medical equipment, all other noise generating factors should be considered. Shouting, loud laughter, slamming the doors of medical cabinets, slamming drawers, etc. should be avoided. All noise has a negative impact on the patient's understanding of communication and leads to her having problems with focusing.
- A method of communicating with the patient must be found. Sometimes, a patient might have a proven system that she shares with the medical team, e.g., writing on a piece of paper, on a tablet screen. The choice of the optimum method is key even in short-term medical care.
- The course of each labour stage will involve representing each medical act prior to its performance in the form of a verbal message (if we are dealing with objective dependence) or in the form of a written message. At the first stage of labour, timed from the start of regular contractions leading to the cervix dilation, the patient should be taught proper breathing technique and shown possible body positions using equipment available in the delivery room: a bean bag chair, a mattress, a wall bar, a rubber ball etc. If the patient's condition allows, she should be encouraged to use water immersion or body relaxation in the shower. If possible in the given hospital, the option of local anaesthesia should be discussed with the patient if her condition allows.
- In general, the biggest problem when caring for a woman in labour is the second stage of labour that starts when the cervix is fully dilated. The patient will experience pushing contractions that often involve very intense and long-lasting pain that may disrupt the communication process. If possible, the patient should be prepared ahead of time – in the first stage of labour – for this new and different experience.
- The second stage of labour is distinctive due to how intense the experience is, which is why it should be noted that not every person accompanying the patient should be present in the delivery room at that time. Due to their subjective feelings towards the patient, the accompanying person will disrupt the delivery or even make the cooperation between the patient and the medical team impossible. In such a case, the midwife – as the person responsible for caring for the patient and a professional in obstetrics – should make

an objective decision concerning the accompanying person's presence in the delivery room.

- The second stage of labour also involves the birth of the baby. It must be kept in mind that a patient with hearing impairment may not be able to hear the baby's cry, which to this day is misconstrued as the first sign of a baby's independent breathing. The midwife should make it possible for the mother to see the baby's face and later place the baby on her naked chest.
- In the case of advanced natural labour, when the patient is admitted to the hospital urgently, the most important and fundamental aspect is to find a quick method of communication to perform the orders of the midwife: pushing or steadying breathing. The person assisting with the labour closing their hand around the patient's wrist may prove to be the best communication method.
- Third stage of labour – called the placental stage – involves the delivery of the placenta. In view of the relatively long duration (provided for in the Standard) of afterbirth, the midwife should facilitate the communication process with methods previously agreed on.
- Fourth stage of labour – called the postpartum stage – involves: observation of the uterus contraction, observation of postpartum discharge (volume and smell), observation of perineal tissue (stitches on the mucosa only or sutures on subsequent layers). This is where the presence of the midwife and an active communication process are necessary as well.
- The postpartum period is usually hard on a patient with hearing impairment, due to the number of actions that she needs to take after she delivers her baby. Helping the baby attach to the breast, learning the proper breastfeeding technique, caring for nipples, bodycare (including the perineum) and all that is involved in caring for a newborn are often difficult. It is always recommended for a professional medical team to educate the patient, which helps her learn the proper techniques and how to recognize the baby's needs. It is worth utilising digital graphic methods, instructional videos, and posters. It might also be worth suggesting professional reading materials to the mother, to expand her knowledge and understanding of each of the processes. Physical instruction on bathing a newborn, umbilical cord care, the baby's body and genitals care, how to lay the baby down or hold it for breastfeeding, proves to be the most effective teaching method. Since our sight is the most important sense for learning about the world, demonstration and visualisation of those tasks are usually most effective for patients with hearing impairment.
- Considering the type of the patient's disability, all annotations made in the mother's and baby's medical documentation should be made available to the patient while she remains in the hospital.

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3.8. Umbilical cord presentation, cord prolapse during labour

The umbilical cord connects the foetus with the placenta. The umbilical cord is made up of two arteries and one vein, Wharton's jelly – protecting the vessels – and the epithelium. The umbilical vein carries blood from the placenta into the foetus, while the arteries supply blood from the foetus to the placenta. The umbilical cord was shown to contain hyaluronic acid and chondroitin sulphate, which allow for the process of transporting and storing substances derived from the foetus's blood or amniotic fluid. The length of the umbilical cord and its thickness differ in each individual. Statistically speaking, it is 50 cm in length and 1.5 cm in diameter.

Umbilical cord prolapse is the presence of an umbilical cord loop or the umbilical cord next to or before the presenting part of the foetus. In the case of umbilical cord prolapse, the membranes of the amnion are ruptured, i.e., the amniotic fluid is leaking. Umbilical cord prolapse may be imperceptible; however, it can be discovered in an internal exam, called a pelvic exam. Sometimes umbilical cord prolapse is visible in the vagina, and sometimes the umbilical cord may even fall out completely and be visible before the vulva.

Professional literature says that the frequency of umbilical cord prolapse is < 1% of all births (including preterm births). This ratio increases, however, in abnormal foetal positions: 4% for breech positions, 12% for shoulder positions.

Risk factors for umbilical cord prolapse include:

- prelabour rupture of membranes (PROM),
- premature birth,
- cephalopelvic disproportion,
- amniotomy (before the presenting part settles in the birthing canal),
- abnormal placenta location, including low-lying placenta,
- marginal umbilical cord insertion,
- external and internal cephalic version,
- polyhydramnios,
- multiple labours,
- long umbilical cord,
- multiple pregnancy,
- foetal malformations.

Cord presentation almost always occurs in case of an unruptured amniotic sac, where the umbilical cord is discovered before the presenting part or next to it.

Remember!

Cord presentation precedes umbilical cord prolapse, which is an extremely dangerous condition!

Statistically speaking, cord presentation happens rarely, according to professional literature, it fluctuates between 1:239 and 1:865 births. Nevertheless, it is always a sudden development. Foetal mortality rate is between 9 and 49%, usually caused by premature labour, anatomical anomalies of the foetus or its hypoxia. The etiology of umbilical cord prolapse is not clear. The literature says that the risk of umbilical cord prolapse or cord presentation occurs in a situation when there is relatively a lot of space for the cord to slide in the birth canal.

Cord presentation risk factors include:

- low birth rate,
- low gestational age (in accordance with EBM the frequency of umbilical cord prolapse is between 2–11% in pregnancies, where the foetal position is other than head-down!),
- abnormal foetal positions, including shoulder positions,
- abnormal foetal alignment, deflected head insertion or head positioned high above the entry during dilation,
- significant disproportion between the foetus's presenting part and its pelvis,

- multiple pregnancy,
- polyhydramnios,
- multiple labours,
- no presenting part in the birth canal,
- incorrect structure of the bony pelvis (e.g., a large pelvis entry).

Umbilical cord prolapse is diagnosed based on a pelvic exam when the member of the medical team locates the umbilical cord in the vagina or next to the presenting part in an internal exam through the vagina. An anomaly in foetal heartbeat (shown on a cardiotocograph output), in the form of deep and variable deceleration, bradycardia – even though the pregnant woman is in the correct position, may point to this condition.

Remember!

All medical acts performed as part of medical care are aimed at minimizing the umbilical cord compression to maintain foetal circulation (foetal oxygenation).

1. In the case of cord presentation with an unruptured amniotic sac, the patient should be helped into a knees and elbows position with her buttocks facing up.
2. Never rupture the amniotic membranes!
3. It is necessary to continually observe the foetus's condition by recording its heartbeat.
4. If the umbilical cord falls out before the foetus's presenting part, a member of the medical team should try to push the presenting part upwards (deeper into the uterus) in a pelvic exam to relieve cord compression – if the advancement of the labour allows. This is referred to as a cord elevation attempt with an operating room ready. Next, an urgent caesarean section is performed; oxitocin is administered in order to intensify the contractions.

Remember!

In the case of umbilical cord prolapse during advanced natural labour, the obstetrician decides on the method of the quickest delivery.
In the case of advanced labour (when the head is positioned very low inside the birth canal), the umbilical cord must not be elevated!

In such a case, a decision has to be made whether to use instruments, such as obstetrical forceps or a vacuum extractor. A caesarean section is the solution that is chosen most often, though.

- Manual cord elevation to the vagina with subsequent observation of its possible pullback is also described in obstetrics literature.
- If a patient who has been diagnosed with umbilical cord prolapse is transported, Sim's position is commonly used, where the patient is lying on the left side (minimising the compression of the inferior vena cava to avoid foetal hypoxia). A wedge should be placed under the left hip that is supposed to elevate the pelvis.
- Several treatments are also mentioned in literature: filling the patient's bladder with a saline solution (to move the presenting part of the foetus in the birth canal) or amnioinfusion – due to the urgency of the situation and danger to the foetus; however, these are not commonly used.

Remember!

Quick diagnosis and actions taken are vital for the foetus's health.

Recommendations concerning the medical team's action in case of umbilical cord prolapse

- All the medical care in a delivery room should be provided in line with regulations and other ministerial documents, procedural algorithms, recommendations of medical associations applicable in a given country!
- If umbilical cord prolapse is diagnosed, additional help must be called for.
- Contact should be made with the woman in labour and persons accompanying her – they should be supported, so that they understand the situation and the actions that are being taken.
- A series of actions should be taken to decompress the umbilical cord and facilitate circulation through the cord vessels.
- Foetal heartbeat must be recorded.
- The location of the umbilical cord must be assessed via a pelvic exam, and the information must be passed on to the team for decision making purposes.
- If the umbilical cord pulls back, the patient may be relieved from the position she has assumed, foetal heartbeat should be monitored and most of all – a "wait and see" attitude should be adopted!
- If there is no progress in the acts taken by the medical team so far, the medical supervision makes further decisions, assessing their risk.
- The medical team support each other, provide assistance and document the incident.

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3.9. Amniotic fluid embolism

Amniotic fluid fills the amniotic sac, forming the best possible environment for the developing foetus. The foundation of amniotic fluid is the presence of the amnion, fluid diffusing from maternal plasma, and fluid derived from the exchange of mother to foetus circulation. In subsequent weeks of pregnancy (over 15 Hbd), the source of amniotic fluid is the filtration of the foetus's renal glomeruli, diffusion through skin. Around 30 Hbd diffusion through skin decreases with an increase in foetal renal function and foetal urine production.

Amnion is the inner layer of the amniotic sac and the area connecting the amniotic fluid with other elements of the amniotic membranes.

Amniotic fluid contains water (98%) and organic and inorganic substances (2%):

- maternal and foetal proteins. Maternal proteins include immune globulins, albumins, globulins, and sex hormone-binding proteins. Foetal proteins include alpha-fetoprotein, the highest concentration of which is observed in 15 Hbd;
- lipids that are actively participating in starting uterine contractions. Their presence is an indicator of foetal lung maturity. Triglycerides and phospholipids are produced by the pulmonary alveoli cells epithelium; they are also often levelled to the amniotic fluid contained in the foetal bronchial tree.
- glucose produced mostly by the foetus, the concentration of which decreases with the pregnancy development;
- electrolytes: sodium, potassium, magnesium, chlorine, calcium, and phosphorus. Their concentration changes periodically due to foetal renal excretion, as well as diffusion through skin;
- hormones: estrogens, progesterone, cortisol, chorionic gonadotrophin, and testosterone;

- enzymes;
- vitamins;
- humoral immunity factors;
- morphotic elements: amnion cells, mucus streaks, bilirubin globules, stratum corneum, and hair of the foetus.

Amniotic fluid is regulated through:

1. maternal and foetal circulation (due to the presence of the umbilical cord),
2. started renal function, understood as the foetus urinating into the amniotic sac,
3. foetal absorption taking place in the gastrointestinal tract of the foetus, its skin, and lungs.

The main tasks of the amniotic fluid:

- protects the foetus,
- ensures foetal mobility,
- prevents the amnion from adhering to the foetus's body,
- maintains temperature in the amniotic sac,
- ensures lung development,
- has a bacteriostatic and bactericidal effect,
- constitutes specific and non-specific immune response.

The volume of amniotic fluid changes depending on the week of pregnancy and amounts to:

- 10 Hbd – 30 ml,
- 20 Hbd – 300 ml,
- 30 Hbd – 600 ml,
- 36 Hbd – 1000 ml,
- 38–42 Hbd – 600 ml.

Amniotic fluid may complicate pregnancy, as well as the perinatal period. The issue of amniotic fluid embolism is known in obstetrics. This is always an urgent condition, which is also unpredictable, due to the lack of warning signs. The consequences of amniotic fluid embolism are significant, often resulting in the mother's death. Statistically speaking, amniotic fluid embolism occurs in 2–6:100 000 pregnancies. Despite a developed treatment plan, the results of the treatment are most often unfavourable.

The pathophysiology of amniotic fluid embolism is complex. Amniotic fluid may enter the blood stream of the mother due to uterine vein rupture during a natural birth. Unfortunately, surgical deliveries are not safe from this issue, the risk of its occurrence has in fact been proven to be higher. Any rupture in a pregnant woman's vessels may result in amniotic fluid entering her blood stream. In general, amniotomy (filling the amniotic sac with fluid) may also cause minor lacerations and thus result in amniotic fluid entering the pregnant woman's blood stream.

Apart from damage to a pregnant women's vessels, professional literature indicates that amniotic fluid embolism may also be caused by mechanical, artificial rupture of amniotic membranes.

Amniotic fluid embolism may thus occur during a natural birth, a caesarean section, during early postpartum period and as a result of mechanical intervention during the perinatal period.

Individual predisposition of women to amniotic fluid entering the blood stream is still unknown. The presence of amniotic fluid in the blood stream may not provoke undesirable changes to body functioning. On the other hand, it may be a case of inflammation, initiating a collapse imitating an anaphylactic or septic shock. Currently, the issue is being broadly discussed in Evidence Based Medicine publications.

Amniotic fluid embolism is most often diagnosed based on an autopsy, by confirming the presence of amniotic fluid and/or foetal morphotic elements in the mother's lungs. In women who have survived such an embolism, the presence of amniotic fluid elements in the mother's pulmonary veins (central veins) is shown. Professional literature shows that amniotic fluid embolism may be diagnosed based on the mother's serum composition analysis, using a specialist test of monoclonal antibodies bonding with meconium glycoprotein, fluorometric testing for zinc coproporphyrin-I, β-tryptase, complement fractions C3-C4 in the patient's blood serum. When an embolism is suspected, to confirm the diagnosis, the diagnostics must be extended with a gasometric test in order to reveal a drop in oxygen partial pressure and the occurrence of respiratory and metabolic acidosis. Coagulation system disorders will cover the indicators of DIC: increased concentration of fibrinogen breakdown, lower fibrinogen concentration, and low platelets, significant prolongation of APTT and PT, and decreased activity of antithrombin III. Echocardiography shows the dilation of the right ventricle, decreased free wall motion disturbances. Constant monitoring of central venous pressure is necessary for professional monitoring of the patient's condition.

In some cases of mothers' deaths, however, it is not possible to make a reliable diagnosis of amniotic fluid embolism, since no foetal morphotic elements are found in the pulmonary veins, despite a preliminary diagnosis of a series of obvious clinical signs. A similar situation happens when a small number of foetal cells are found in the mother's blood, and there is no embolism.

Statistically speaking, the following factors predisposing for amniotic fluid embolism can be listed:

- excessive, intense contractions,
- pregnancy over 35,
- multiple pregnancy,
- multiple labours,
- invasive nature of labour,
- labour induction (simulation),

- polyhydramnios,
- caesarean section,
- manual extraction of a foetus,
- eclampsia,
- placenta praevia.

Signs of amniotic fluid embolism, developed by a team of American experts include:

- sudden drop in blood pressure,
- pulmonary edema, bronchospasm,
- coagulation disorders (DIC) or clinical indicators of purpura,
- circulatory and respiratory arrest,
- respiratory disorders – tachypnoea, shortness of breath, cyanosis.

The signs listed above occur during labour or 30 minutes after its conclusion!

Professional literature also mentions other signs:

- convulsions,
- uterine atony.

The listed signs may occur separately, together, or combined with other signs.

Remember!

Convulsions must be differentiated from eclampsia.

When taking actions aimed at providing medical care in a diagnosed case of amniotic fluid embolism, the following should be done:

- aim for maintaining circulation – secure venous access – do a venepuncture (peripheral venous catheter), supplement fluid in the vascular bed,
- aim for maintaining respiration – introduce ventilation using the available equipment (bag valve mask / tracheal intubation) or mouth-to-mouth resuscitation,
- if necessary – perform chest compressions,
- in case of DIC indicators – introduce anticoagulant treatment.

Signs of endangered life of the foetus (in case of amniotic fluid embolism during labour):

- decelerations,
- bradycardia.

Recommendations concerning the medical team's action in case of amniotic fluid embolism

- All the medical care in a delivery room should be provided in line with regulations and other ministerial documents, procedural algorithms, recommendations of medical associations applicable in a given country!

- Each pregnancy must be assessed on a case-by-case basis.
- It should be considered whether there is an actual need for medications affecting the escalation of uterine contraction.
- Careful consideration should be given in the case of women who had any type of difficulties or complications during their pregnancies or who had mechanical procedures done, such as amniotomy.
- Careful consideration should be given in the case of older pregnant women.
- Careful consideration should be given in the case of multiparas.
- Action should be taken if the patient is complaining of shortness of breath or chest pressure (both during labour and during the early postpartum period).

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3.10. Sudden pulmonary embolism

Pulmonary embolism is a serious condition that leads to the death of many women all around the world. The indexes for many European countries show that diseases related to coagulation system disorders (pulmonary embolism) are the main causes of deaths during pregnancy or following labour. In Poland, it is the fourth cause after haemorrhages, infection,s and hypertension.

Pulmonary embolism takes place when a blood clot travels through the vessels to the lungs.

During pregnancy multiple adaptations take place in a woman's body to keep the pregnancy safe and healthy. Considering the vascular system described here, those adaptations concern venous pressure, hormonal balance, secretion of vasodilators, venous insufficiency symptoms, and changes to the coagulation system. Pregnancy – or its development to be exact – puts a significant load on the functioning of the lesser pelvis vessels and consequently – leg vessels. Furthermore, pregnancy predisposes a woman to increased blood coagulability, which is why pregnant woman are at a higher risk of developing deep vein thrombosis. Blood clots in pregnant women are commonly derived from deep veins in the legs. What is important is the fact that venous thromboembolism may occur at any stage of pregnancy and postpartum, and, statistically speaking, it is five times more frequent in pregnant women than non-pregnant women. During the postpartum period, the risk is even higher.

The clinical signs of pulmonary embolism are directly related with the size of the blood clot. A blood clot may hinder blood oxidation or even make it completely impossible.

Pulmonary embolism symptoms:

- dyspnoea, difficulty breathing or rapid breathing,
- chest discomfort, including pain,
- cough,
- peripheral oedema,
- murmurs heard during a physical examination of the chest,
- hypertension, tachycardia,
- cyanosis,
- fever,
- anxiety, irritation, agitation,
- haemoptysis.

The symptoms listed above may be falsely diagnosed as a pulmonary infection.

The diagnosis of pulmonary embolism involves:

- an ECG test (e.g., revealing a deformation of the right heart),
- a chest X-ray (e.g., revealing atelectasis, surface infiltration, one-sided secretion in the pulmonary pleurae),

- specification of the blood oxidation level via: saturation and an arterial blood gas test (tissue and organs hypoxia can be measured with a pulse oximeter; an arterial blood gas test should be done while the patient is standing).

It must be kept in mind that in the case of pulmonary embolism, not all the measured parameters or performed imaging test will have negative indicators. Sometimes, a chest Xray taken at a preliminary stage of pulmonary embolism will show a correct image of the lungs.

The treatment of pulmonary embolism involves the introduction of anticoagulants to prevent the accumulation of blood clots and restore patency in blood vessels. Treatment starts from the moment venous thromboembolism is diagnosed, both during pregnancy and postpartum. The most used anticoagulants include unfractionated heparin, low-molecular-weight heparin, and warfarin.

When discussing superficial vein thrombosis, it must be mentioned that coagulation occurring in a vessel is relatively heavily linked to the adjacent vein wall which is why the risk of its detachment is negligible. In such a situation, the introduction of heparin-based pharmaceuticals is of significance when the extent of inflammation is very large and when thrombosis enters the deep veins system through perforating veins. The use of commonly used remedies containing heparin that are intended for cutaneous use (ointments, gels) cannot be justified practically nor theoretically. EBM also shows no proof of their effectiveness.

The assessment of the risk of venous thromboembolism occurrence in a population of women who had surgical delivery includes the following factors:

- patient's age > 35,
- obesity > 80 kg,
- multiple labours,
- pre-eclampsia,
- general diseases pertaining to the heart, lungs, bowels, kidneys, cancer related, glucose metabolism disorders,
- delivery suddenly concluded with a surgery,
- varicosity in legs,
- past venous thromboembolism,
- antiphospholipid syndrome,
- past uterine muscle surgeries.

According to EBM, sufficient data that would make it possible to develop uniform recommendations concerning thromboprophylaxis during pregnancy and at the early postpartum stage is not available yet. Three successful interventions have been described so far, including: pneumatic compression and compression stockings, as well as administration of medications based on unfractionated and low-molecular-weight heparin.

In Poland, recommendations concerning the described phenomenon are included in recommendations for the treatment and prevention of venous thrombosis. In pregnant women, close clinical observation is mostly recommended. During the postpartum period, due to an increased risk of venous thromboembolism, anticoagulation treatment is recommended.

The prevention of the phenomenon includes early mobilisation after caesarean section. Lack of such early mobilisation is inadvisable due to the process of flow through the veins. When leg muscles are being worked, endogenous fibrinolytic substances are being released, whose aim is to accelerate fibrinolysis and recanalization of coagulation in the veins.

Recommendations concerning the medical team's action in case of suspected pulmonary embolism

- All the medical care in a delivery room should be provided in line with Regulations and other ministerial documents, procedural algorithms, recommendations of medical associations applicable in a given country!
- Immediate and intense medical action is to be taken.
- Medical assistance must be organised (e.g., a resuscitation team, an anaesthesiologist, the doctor on duty).
- In the case of a circulatory arrest, action must be taken, i.e. chest compressions.
- Oxygen supply must be secured (oxygen mask or nasal tubes).
- Access to a vein must be secured via venepuncture (peripheral venous catheter).
- Medication must be administered in line with doctor's orders (including heparin).
- The condition of the foetus must be constantly monitored (if the embolism occurred during pregnancy).
- The patient's condition must be monitored with an ECG exam.
- If possible, a pulse oximeter should be used.
- Fluid balance should be measured.
- If possible, the patient should be in a sitting position!

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3.11. Silent oscillation in advanced pregnancy

For many years, methods of recording foetal heart rate (FHR) have been undergoing changes. The basic aim of such modernization is to obtain signals free from internal and external interference. A cardiotocograph that also records uterine contraction and sometimes even the mother's heartbeat is commonly used to monitor foetal heart rate.

Cardiotocography (CTG) is a diagnostic method that records and visualizes foetal heartbeat, foetal mobility, and uterine contraction. The reading is a print-out or a file on an electronic data storage medium. CTG is done for every woman during pregnancy and labour. When undertaking CTG, one should aim for obtaining a sound signal that is audible both for the CTG supervisor and the pregnant woman, except for patients with hearing impairment, where sound should be minimised and only the visual should be left.

The obtained CTG data is extremely important in obstetrics in view of anticipating the condition of the foetus. CTG is a type of non-invasive, easy, and quick (when considering what is commonly available) examination. Furthermore, it is important to note that it is possible to use CTG for continuous supervision over women in labour. Modern cardiotocographs are adapted for labour under water, due to the telemetry function that has been introduced, where the device sends a signal to a computer, where the output is analysed.

Cardiotocographs used in obstetrics are comprised of two heads:

- an ultrasonic one that records foetal heartbeat and its mobility,
- a topographic one that records uterine contraction.

Cardiotocographs are often also equipped with a foetal movement marker, with which the patient marks foetal movement that she feels.

Indications for CTG:

- foetal condition assessment during pregnancy (including after the patient is admitted to the hospital, the earliest CTG can be done between 24 and 25 Hbd – in an urgent situation, requiring supervision),

- foetal condition assessment during labour (the aim being the prevention of foetal acidosis and a decrease in intrauterine hypoxia episodes frequency – making correct decisions concerning labour),
- finished 42nd Hbd (introduction of daily CTG for the purpose of monitoring the intrauterine condition of the foetus),
- presence of clinical signs of post-term pregnancy,
- mother's general diseases (e.g., diabetes, infections, heart diseases, renal diseases, endocrine system diseases),
- haemorrhaging during pregnancy,
- suspicion of IUGR (intrauterine growth restriction),
- abnormal foetal position,
- abnormal placenta location,
- the patient reporting not feeling the foetus's movements,
- suspicion of PROM (prelabour rupture of membranes),
- premature birth,
- diagnosed anomalies in the foetal heart structure,
- bad obstetric history,
- leaking amniotic fluid with abnormal colour (e.g., meconium coloured),
- previous abnormal CTG results,
- introduction of exogenous oxytocin for the purpose of stimulating the uterine muscle,
- introduction of local anaesthesia during labour,
- multiple pregnancy and labour,
- condition following an obstetric treatment (e.g., input of a Foley catheter into the uterine cavity),
- condition following a mechanical injury (including traffic accidents),
- life-threatening condition of the mother (e.g., the patient is unconscious or has cancer),
- highly addicted patient (psychiatric medication, narcotics, alcohol).

It must be kept in mind that the indications listed above may be expanded because of sudden, unpredicted circumstances or a rare disease that is also a non-standard obstetric situation.

In terms of the use of cardiotocography in obstetrics, the experts of the Polish Gynaecological Society determined specific indications for CTG during pregnancy over 24 Hbd. They have been divided into maternal and foetal indications.

Maternal indications:

- antiphospholipid syndrome,
- lack of balanced hyperthyroidism,
- hemoglobinopathy,

- cyanotic heart defects,
- lupus,
- chronic kidney diseases,
- type 1 diabetes,
- hypertension.

Foetal indications:

- pre-eclampsia,
- decreased foetal movements,
- abnormal amount of amniotic fluid: oligohydramnios, polyhydramnios,
- multiple pregnancy,
- IUGR,
- post-term pregnancy,
- serological conflict,
- bad obstetric history: stillbirth in history.

To ensure objective results of CTG, the patient should be ensured peace, preferably positioned on her left side, the recording duration should be observed (at least 20 minutes), the start and end time of monitoring should be clear (with a date). If there are any doubts as to the output (e.g., disturbed signal path, illegibility) a repeat is recommended.

The basic terms related with cardiotocography include:

- determination of the basic foetal heart rate referred to as oscillation that is the average amplitude of foetal heart rate. The following can be differentiated:
  - normal heart rate (110–160 bpm),
  - tachycardia (> 160 bpm),
  - bradycardia (< 110 bpm),
- determination of foetal heart rate variability, resulting from a response to stimuli derived from the autonomous system in relation to humoral or pharmacological factors,
- determination of acceleration – defined as a periodical, transient increase in foetal heart rate,
- determination of deceleration – defined as a decrease in foetal heart rate. Depending on their nature, the following types of decelerations are differentiated: early, variable, and late.

When interpreting pregnancy cardiotocography outputs, a type of classification methods referred to as nonstress tests (NST) is used. Criteria used to differentiate nonstress tests:

- a reactive result – showing normal heart rate; there are two or more accelerations increasing the heart rate: 15 beats per minute above the baseline rate and lasting for at least 15 seconds, related with the foetus's movements,

- a non-reactive result – no accelerations revealed; it requires its duration to be extended up to 60 minutes (in case of no improvement, a stress test should be done to clarify the clinical situation),
- an uncertain result – revealing an incorrect number of accelerations (fewer than two) or acceleration with abnormal duration and amplitude; requires a repeat after 24 hours.

The following FHR oscillations can be differentiated in obstetrics:

1. marked – when inclinations exceed 25 bpm,
2. fluctuating – when inclinations are between 5 and 25 bpm and reflect the normal physiology of the autonomous nervous system,
3. narrow – the range of inclinations does not exceed 10 bpm,
4. silent – when inclinations do not exceed 5 bpm – the chart looks like a straight line.

Characteristics of silent oscillation:

a) Recorded foetal heart rate: observed inclinations of FHR > 160 bpm, lasting at least 10 min.
b) Interpretation and basis: low gestational age, infection, medications (beta2adrenergic agonists use), mother's diseases, foetal tachyarrhythmia, pregnancy complications, dehydration, hyperthermia, centralization of foetal circulation, related with intrauterine hypoxia. What is more – occurrence of probable acidosis when related with low variability or a lack of it, lack of acceleration.
c) Approach: when the underlying disease is diagnosed, its treatment should commence; stimulation of heart rate acceleration via scalp stimulation means no acidosis in the foetus; in the case of no improvement in the output, the foetus should be delivered.

Recommendations concerning the medical team's action in case of silent oscillation in CTG

- All the medical care should be provided in line with Regulations and other ministerial documents, procedural algorithms, recommendations of medical associations applicable in each country!
- Every effort should be made to make the CTG output as objective as possible (the patient's body position: the patient should by lying on her left side or a wedge should be used to decompress the right hip to minimise the inferior vena cava syndrome; the technical quality of the cardiotocograph should be checked; the patient's data, date and time should be input correctly).
- It must be kept in mind that silent oscillation is the worst type of oscillation!
  - It indicates very poor condition of the foetus that endangers its life!
  - Immediate intervention by a midwife is required – urgent notification of the medical supervision!

- In-depth medical history should be compiled, including information on the patient's health (including in the past), any medications taken and stimulants, current lifestyle, course of the pregnancy, diet (including hydration).
- All potential causes of silent oscillation in each case must be analysed (including maternal and foetal factors) (cooperation of the interdisciplinary team is priceless!).
- The patient should be well-hydrated (orally or intravenously).
- Other necessary medical acts should be taken urgently (cooperation of the interdisciplinary team).

References

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2. Katsuragi S, Ikeda T, Noda S. Immediate newborn outcome and mode of delivery: use of standardized fetal heart rate pattern management. J Matem Fetal Neonatal Med 2013; 26: 71–74.
3. Grivell RM, Alfrevic Z, Gyte GM. Antenatal cardiotocography for fetal assessment Cochrane Database Syst Rev 2012; 2(12): CD007863.

4. Simulation scenarios for selected diseases, non-standard situations in nursing, obstetrics and physiotherapy, considering aspects of multiculturalism and interdisciplinarity

The implementation of medical simulation in medical education standards was revolutionary. These days, learning by experience is not only possible but necessary since it has the support of a ministerial decision.

Clinical medical simulation classes are based on using technologically advanced simulators and hybrid simulations. Training is provided by qualified teachers, and its content is based on previously developed realistic simulation scenarios. Such a modern form of teaching provides a safe space for learning, acquiring skills, and social competences. The repetitiveness of treatments (procedures) and later debriefing allow for reliable and practical learning of how to act in even the most difficult, rare, and non-standard medical cases.

4.1. Database of sample simulation scenarios (health sciences, medical sciences)

SCENARIO 1

TITLE: **Effective interdisciplinary team**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**Effective interdisciplinary team**	
Main clinical problem	Cooperation and communication in an interdisciplinary team	
Setting	A 73-year-old man, admitted yesterday to the general surgery department for elective surgery to remove varicose veins of the right lower limb. He had surgery today. The operation, performed under subarachnoid anaesthesia, proceeded without complications, and the patient was transferred from the operating suite (the postoperative room) to the ward. Five minutes later, the nurse, who entered the room to disconnect the drip and assess the patient's condition, noticed that the patient was very pale and had a low level of consciousness.	
Educational aims	· Effective cooperation in an interdisciplinary team. · Effective communication in an interdisciplinary team.	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Nursing students – 2 persons · Medical student – 1 person
Introductory information given to the participants	**Setting:** Department of General Surgery. You are taking care of a patient who had surgery today to remove varicose veins of the right lower limb. He has just been transported from the operating suite. At 1:00 p.m., you enter the patient's room to disconnect the drip and assess the patient's condition. You find a patient lying in bed. He is pale, verbal contact with him is difficult, his eyes are closed.	
Introduction for the instructor: (significant elements, management, tasks)	· Assessment of the patient's health status · Effective cooperation and communication in an interdisciplinary team – use of ISBAR strategies, "call out" and "check back" · Effective cooperation in an interdisciplinary team.	

Information for the technician (equipment required, preparation of the room)	**Site:** · Patient room at the Department of General Surgery **Clothes and other props:** · Helper in male clothes or a standardized patient. · Right lower limb bandaged with an elastic bandage with a short stretch from the foot to the groin. · Pyjamas **Props:** · Two beds · Phone in the room · Source of oxygen **Medical equipment:** · Cardiac monitor – not connected · Pulse Oximeter · Blood pressure meter · Stethoscope · Resuscitation trolley – equipped with resuscitation equipment and a set for unblocking the airways · Infusion fluids – NaCl 0.9%, Ringer's lactate solution 500 mL · Drip infusion apparatus
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Andrzej Krasicki · Male · Age – 73 years · Height – 179 cm · Weight – 93 kg · Consciousness – decreased consciousness · Respiration – slowed down · Skin – pale · BP – 85/50 mmHg · Pulse – 68 BPM · Chronic diseases – hypertension, status post myocardial infarction (5 years ago)

Course of the scenario	**Site:** · Patient room at the Department of General Surgery **Scenario versions:** Successful completion: · Vital signs – using the monitor to assess vital signs · Call for a doctor (ISBAR strategy) · The use of "call out" and "check back" techniques in communication · Effective cooperation of an interdisciplinary team Probable outcome: · Vital signs · Call for a doctor (the above-mentioned techniques were not used in communication) · Collaboration in an interdisciplinary team at a fairly good level Unsuccessful outcome: · Incorrect assessment of the patient's health status · Sluggishness in calling for a doctor (ineffective communication on the phone) · Poor effective cooperation in an interdisciplinary team
Lifebuoys	· Entrance of the doctor on duty
Spanners in the works	· The doctor on duty is rude during the telephone conversation. He can say: "As always... you bother me with some trifle"
Things to discuss (sum up after the exercise)	**Issues to be discussed:** · importance of cooperation and effective communication in an interdisciplinary team in healthcare
Additional information: This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.	

SCENARIO 2

TITLE: **Cultural awareness in healthcare**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**Cultural awareness in healthcare**	
Main clinical problem	A 24-year-old Muslim woman with back injury	
Setting	Karima, a 24-year-old Muslim woman, was brought to the emergency department at 7 pm by an ambulance, accompanied by her husband. As a result of slipping, she fell down the stairs onto her back. She has suffered general body bruises and severe back pain in the lumbosacral region. Soon after the fall, she started having trouble breathing and difficulty moving, she was also unable to use the toilet (there was a short-term loss of bladder and bowel control).	
Educational aims	· Introducing the concepts of culture and cultural competence and their understanding in the context of medical care. · Understanding other people's religious beliefs and values based on reflective thinking. · Positive attitudes towards other cultures and religions.	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Nursing students – 2 persons · Medical student – 1 person · Emergency medical services student – 1 person
Introductory information given to the participants	**Setting:** You are a resident physician. You are just starting your duty when a female patient (a Muslim) has just arrived at the emergency department and is waiting for you. Dr Zieliński is the only doctor working in the emergency department, and his phone number is on the whiteboard. If you need his help, you can call him. There is a female nurse, male nurse, and a paramedic on duty with you. They are currently busy.	

Introduction for the instructor (significant elements, management, tasks)	**Aims for the students:** · Effective communication with the patient and her husband. · Developing cultural awareness in healthcare. · Effective cooperation and communication in an interdisciplinary team
Information for the technician (equipment required, preparation of the room)	**Site:** · Observation and treatment room at the Hospital Emergency Department **Helper:** · Standardized patient – a young woman (Muslim) **Clothes and other props:** · Two beds · Arm model – right upper limb with the possibility of performing the procedure of inserting a peripheral cannula · Chair · Phone in the room · Pictograms **Medical equipment:** · Cardiac monitor · Defibrillator · Resuscitation trolley – complete · Source of oxygen · Blood pressure meter · Stethoscope · Thermometer · Glucometer · Therapy trolley (test tubes for collecting laboratory test samples, needles, peripheral cannulas in various sizes, skin disinfectant, dressings for fixing cannulas – e.g., Venaplast, infusion apparatus) · Painkiller – Paracetamol 10 mg/mL, infusion solution, 100 mL, 1 vial · Hand washing and disinfection station
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Karima Maalouf · Female · Age – 24 years · Height – 164 cm · Weight – 54 kg · No chronic diseases. · No allergies

Initial diagnostic and imaging evaluation	· So far, no laboratory tests have been performed.
Medical history	**Information from the medical rescue team (EMS):** · the patient has suffered spinal injury because of a fall down the stairs. The EMS team has already notified the patient's husband
Initial parameters Information for the technician	· A young woman, brought on a spine board in a spine collar. · She is groaning with pain.
Course of the scenario	**Site:** · Observation and treatment room at the Hospital Emergency Department **Scenario versions:** Successful completion: · Provision of female medical staff – doctor, nurse/paramedic · When this proves impossible, a talk to the patient showing understanding and respect for the corporeal issue. · Avoiding physical contact with the patient or limiting it to the necessary minimum, and if such contact is necessary, explaining its purpose. · Provision of information on all care and treatment activities to the patient and her husband. · Effective intercultural communication: » asking the patient and her husband open-ended questions that would allow to get as much information as possible about their needs and expectations » providing information and asking questions – slowly and clearly, in the most simple and transparent manner, » using a non-verbal method of communication and the "body language" – illustration of the expression with gestures or accessible objects (use of pictograms) » making sure that the patient and her husband understand the recommendations and accept the proposed care plan · Respecting the patient's right to wear a garment that covers the whole body · Placing a peripheral cannula on the right upper limb Probable outcome: · Notifying the doctor on duty of the family's expectations and handing over the patient to him/her

Course of the scenario	Unsuccessful outcome: · Failure to provide female medical personnel (doctor, nurse) and lack of conversation with the patient indicating understanding and respect for corporeal issues · Failure to limit physical contact to the necessary minimum · Failure to provide information on the purpose of physical contact · Provision of care and treatment information to the patient only · Ineffective intercultural communication: » no open-ended questions to obtain as much information as possible about the patient's and her husband's needs and expectations, » providing information and asking questions quickly and unclearly, in a way that is not transparent, without illustrating it with gestures or accessible objects (e.g., pictograms), » failure to use non-verbal methods of communication » failure to verify the understanding of the recommendations and acceptance of the proposed treatment plan · Failure to respect the patient's right to wear a garment that covers the whole body · Placing a peripheral cannula on the left upper limb
Lifebuoys	· The patient and her husband communicate in English at a fairly good level, they communicate poorly in Polish.
Spanners in the works	· The patient and her husband do not understand specialist medical terminology.
Things to discuss (sum up after the exercise)	**Issues to be discussed:** · the importance of developing cultural awareness in healthcare, · the importance of effective intercultural communication, · language barrier in communication with the patient
Additional information: This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.	

SCENARIO 3

TITLE: **Cultural awareness in healthcare – Chinese culture**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**Cultural competence – Chinese culture**	
Main clinical problem	Postoperative pain	
Setting	A middle-aged Chinese patient. He is on day zero after cataract surgery for the left eye. He refused to take painkillers after surgery.	
Educational aims	· Introducing the concepts of culture and cultural competence and their understanding in the context of medical care. · Understanding other people's cultural beliefs and values based on reflective thinking. · Positive attitudes towards other cultures and religions	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Nursing students – 2 persons · Medical student – 1 person
Introductory information given to the participants	**Setting:** There is a middle-aged Chinese patient in the department of ophthalmology. He refused to take painkillers after cataract surgery for the left eye. When asked, he replied that his discomfort was bearable and that he could manage without medication.	
Introduction for the instructor (significant elements, management, tasks)	**Aims for the students:** · Effective communication with the patient · Developing cultural awareness in healthcare	

Information for the technician (equipment required, preparation of the room)	**Site:** · Department of Ophthalmology, patient room **Helper:** · Older man or standardized patient **Clothes and other props:** · A dressing on his left eye. · Peripheral puncture on the right upper limb. · Two beds · Chair · Phone in the room **Medical equipment:** · Blood pressure meter · Stethoscope · Hand washing and disinfection station · Painkiller – Paracetamol 10 mg/mL, infusion solution, 100 mL, 1 vial · Infusion apparatus
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Mao Li Wang · Male · Age – 56 years · Height – 167 cm · Weight – 57 kg · T2D therapy for the last 2 years: Glucophage XR 500 mg, q.d. (in the evening)
Helper's parameters (initial and planned)	**Initial parameters:** · Consciousness: normal (right eye alternately – half closed / open) · Skin – pale, drenched in cold sweat · BP – 145/85 mmHg · Pulse – 100 BPM · Respiratory rate – 16 BPM · Temp.: 36.9°C · The patient is restless, seems to be in pain. **5 minutes after administration of the analgesic:** · Skin – pink · BP – 125/70 mmHg · Pulse – 78 BPM · Respiratory rate – 12 BPM · Temp.: 36.6°C

Course of the scenario	**Site:** · Department of Ophthalmology, patient room **Scenario versions:** Successful completion: · Effective intercultural communication – asking the patient open-ended questions to obtain as much information as possible about his needs and expectations, · re-offering the administration of a painkiller, talking to the patient and explaining to him that one of the most important duties of a nurse is to ensure the comfort of the patient, · administration of a painkiller. Probable outcome: · After the patient's repeated refusal, phone the doctor on duty and hand over the role to the doctor Unsuccessful outcome: · Not very effective intercultural communication with the patient · Lack of further offer of the painkiller, although the patient is restless and uncomfortable
Lifebuoys	· Help from another nurse: "I read that the Chinese are taught to be restrained. In their culture, the needs of the group are more important than those of the individual. In addition, Asians generally find it rude to take something the first time it is offered "
Spanners in the works	· The doctor on duty is not answering the phone.
Things to discuss (sum up after the exercise)	**Issues to be discussed:** · the importance of developing cultural awareness in healthcare · the importance of effective intercultural communication
Additional information: This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.	

Additional information – medical documentation:

- medical history (previous documentation)
- admission card to the ward
- patient record

SCENARIO 4

TITLE: **Cultural awareness in healthcare – Romani culture**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**Cultural competence – Romani culture**	
Main clinical problem	The role of the family in the Romani culture during a relative's serious illness	
Setting	A 73-year-old Romani man has been staying in the Intensive Care Unit for three days. He was admitted with a diagnosis of a sudden cardiac arrest (SCA) during ventricular fibrillation. His condition is very severe, he is intubated and connected to a ventilator. He is on SIMV. His family insists that his relatives always be present.	
Educational aims	· Introducing the concepts of culture and cultural competence and their understanding in the context of medical care. · Understanding other people's religious beliefs and values based on reflective thinking. · Positive attitudes towards other cultures and religions. · Developing cultural awareness in healthcare.	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Nursing students – 4 persons · Medical student – 1 person
Introductory information given to the participants	**Setting:** In the Intensive Care Unit, you are taking care of an elderly Romani man. The patient's general condition is very severe. Three days ago, he suffered from cardiac arrest during VF. He is now intubated and connected to a ventilator (SIMV). He remains in no contact. His family insists that his relatives always be present. Your colleagues in the ward complain about this situation and insist that something be done about it. What do you do?	
Introduction for the instructor (significant elements, management, tasks)	**Aims for the students:** · Effective communication with the patient's family members. · Developing cultural awareness in healthcare.	

Information for the technician (equipment required, preparation of the room)	**Site:** · Intensive Care Unit **Helper:** · An older man **Clothes and other props:** · Intubated with an endotracheal tube, size 7.5 · Central line – right subclavian vein (Dobutamine infusion and 500 mL electrolyte solution) · Intra-arterial puncture – left radial artery · Foley catheter inserted into the bladder · Flocare gastric probe · Two beds · Chair · Phone in the room **Medical equipment:** · Cardiac monitor · ECG apparatus · Defibrillator · Resuscitation trolley – complete · Airway clearance device kit · Infusion pump with Dobutamine (4 mL/hour) · Source of oxygen, air, and vacuum · Ventilator · Blood pressure meter · Stethoscope · Suction tube · Therapy trolley · Hand washing and disinfection station
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Andrzej Kwiatkowski · Male · Age – 73 years · Height – 178 cm · Weight – 112 kg · Hypertension, type 2 diabetes mellitus · No allergies · SIMV – mechanical ventilation · Skin – pale · Consciousness – unconscious · BP – 115/55 mmHg · Pulse – 79 BPM · SpO2 – 94% · Respiration rate – 14 per minute · Body temperature – 36.5°C

Course of the scenario	**Site:** · Intensive Care Unit **Scenario versions:** Successful completion: · Effective intercultural communication – asking the family open-ended questions to learn more about their needs and expectations · Showing patience and empathy in contact with the patient's family. · Agreeing with the family on convenient visiting hours for the patient so that they can spend as much time with him as possible Probable outcome: · Effective intercultural communication – asking your family open-ended questions to learn more about their needs and expectations · Notifying the doctor of the family's expectations and handing over the patient to him/her. Unsuccessful outcome: · Poor communication with the patient's family members (no open-ended questions that would allow to get as much information as possible about their needs and expectations) · Failure to understand family members' needs – the need to spend as much time as possible with the patient
Lifebuoys	· A departmental nurse enters and engages in conversation with the family.
Spanners in the works	· Distress of the family after receiving information that there are specific visiting hours in the ward and only then they can stay with the patient.
Things to discuss (sum up after the exercise)	**Issues to be discussed:** · the importance of developing cultural awareness in healthcare
Additional information: This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.	

Additional information – medical documentation:

- prescription sheet
- history of current Illness

SCENARIO 5

TITLE: **Interdisciplinary communication and patient safety**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**Interdisciplinary communication and patient safety**	
Main clinical problem	Ineffective communication in an interdisciplinary team.	
Setting	Parents and their 17-year-old daughter come to the Hospital Emergency Department. Parents believe their daughter has overdosed on Apap. The girl has overdosed on medications before and is under the care of a psychiatrist. The patient claims that she only took a few tablets because of the headache, and the remaining tablets scattered on the floor, so she threw them in the bin. According to information from parents, the daughter took the tablets about 6 hours ago.	
Educational aims	Effective cooperation and communication in an interdisciplinary team	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Nursing students – 4 persons · Medical student – 1 person
Introductory information given to the participants	**Setting:** You work in the Hospital Emergency Department. You receive an order from the doctor on duty to urgently measure the concentration of paracetamol and salicylates in the blood in a 17-year-old girl, who may have taken the entire package of Apap about 6 hours ago. You ask the laboratory to call you back with the results as soon as they are ready.	
Introduction for the instructor (significant elements, management, tasks)	**Aims for the students:** · Effective cooperation and communication in an interdisciplinary team.	

Information for the technician (equipment required, preparation of the room)	**Site:** · Observation and treatment room at the Hospital Emergency Department **Clothes and other props:** · One bed · Two chairs · Phone in the room **Medical equipment:** · Cardiac monitor · Source of oxygen, air, and vacuum · Blood pressure meter · Stethoscope · A therapy trolley equipped with equipment for taking laboratory test samples (needles, test tubes etc.) · Box of gloves · Hand washing and disinfection station · Contaminated and municipal waste bin
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Joanna Michnicka · Female · Age – 17 years · Height – 169 cm · Weight – 50 kg · She is treated psychiatrically for depression (pharmacotherapy: Fluoksetyna Egis 10 mg/day + group psychotherapy) · No allergies · Skin – pale · Consciousness – conscious · BP – 120/80 mmHg · Pulse – 79 BPM · SpO2 – 94% · Respiration rate – 14 per minute · Body temperature – 36.5°C
Course of the scenario	**Site:** · Observation and treatment room at the Hospital Emergency Department **Scenario versions:** Successful completion: · During a telephone conversation with a laboratory technician, the nurse uses the "check back" communication technique. · The patient is given a procedure to manage paracetamol overdose.

Course of the scenario	Probable outcome: · The doctor contacts a laboratory technician to confirm the paracetamol concentration. · The patient is given a procedure to manage paracetamol overdose. Unsuccessful outcome: · Ineffective communication on the phone – no verification of the laboratory test result · The patient is not treated for paracetamol overdose.
Lifebuoys	· Help from another nurse: "Did you hear the result correctly? Did you ask the laboratory staff if the level of paracetamol in the blood is 2.15 for sure?"
Spanners in the works	· The laboratory technician does not say if this concentration indicates poisoning and does not check that the nurse understood the telephone message correctly.
Things to discuss (sum up after the exercise)	**Issues to be discussed:** · the importance of effective communication in an interdisciplinary team in preventing adverse events in health care

Additional information:

This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.

SCENARIO 6

TITLE: **Gestational diabetes mellitus in a Hindu patient**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**Gestational diabetes mellitus (GDM) in an Indian patient**	
Main clinical problem	· Intercultural communication · Cooperation and communication in an interdisciplinary team	
Setting	Archina, a 27-year-old Indian woman, who is 20 weeks pregnant, reported to a specialist diabetes and obstetrics clinic to optimize the treatment of gestational diabetes and for diabetes education, including dietary education.	
Educational aims	· Introducing the concepts of culture and cultural competence and their understanding in the context of medical care. · Understanding other people's religious beliefs and values based on reflective thinking. · Positive attitudes towards other cultures and religions. · Effective cooperation and interdisciplinary communication	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Nursing student – 2 persons · Midwifery students – 1 person · Dietetics student – 1 person
Introductory information given to the participants	**Setting:** A 27-year-old Indian woman, diagnosed with gestational diabetes mellitus (GDM), who is in the second trimester of pregnancy, comes to the clinic. The aim of the visit is to optimize her diabetes treatment and provide education on diabetes.	
Introduction for the instructor (significant elements, management, tasks)	**Aims for the students:** · Effective communication with the patient. · Developing cultural awareness in healthcare. · Effective cooperation and communication in an interdisciplinary team	

Information for the technician (equipment required, preparation of the room)	**Site:** · Doctor's office in a specialist diabetes and obstetrics clinic **Clothes and other props:** · Desk · Two chairs · Phone in the room · Diabetes education pictograms **Medical equipment:** · Blood pressure meter · Stethoscope · Thermometer · Glucometer · Hand washing and disinfection station
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Archina Sharma · Female · Age – 27 years · Height – 168 cm · Weight – 54 kg · Family history of T2DM · No allergies
Initial diagnostic and imaging evaluation	· First fasting glucose test – 130 mg/dL (test performed at 16 weeks pregnancy) · Second fasting glucose test – 135 mg/dL (test performed at 18 weeks pregnancy)
Course of the scenario	**Site:** · Doctor's office in a specialist diabetes and obstetrics clinic **Scenario versions:** Successful completion: · Effective cooperation of an interdisciplinary team (effective communication between healthcare professionals – discussing together all issues related to the patient's care plan) · Provision of an interpreter (e.g., support staff) · Discussion of issues related to the optimization and education of the patient in the interdisciplinary team (midwife, educational nurse, and dietitian) · Allowing the woman to consult her husband about the care plan · Considering religious and moral considerations in the diet planned by a dietitian

Course of the scenario	· Effective intercultural communication: » asking the patient open-ended questions to obtain as much information as possible about the patient's needs and expectations, providing information and asking questions – slowly and clearly, in the most simple and transparent manner, » using a non-verbal method of communication and body language, considering the important role of gestures in this culture: - all activities performed by the participants with their right hand (not touching the patient with their left hand), - to draw attention to a point or when discussing care plan avoid pointing with a finger – using a whole hand or chin, - use of pictograms, - showing courtesy when saying hello and goodbye (half-bow with folded hands at heart level and fingers pointing up), » making sure that the patient and her husband understand the recommendations and accept the proposed care plan. Probable outcome: · Poor cooperation of an interdisciplinary team · Ineffective intercultural communication Unsuccessful outcome: · Lack of cooperation between the members of the interdisciplinary team in discussing the therapeutic management of the patient. · Ineffective intercultural communication: » no open-ended questions to obtain as much information as possible about the patient's needs and expectations, » providing information and asking questions quickly and unclearly, in a way that is not clearly visible, without illustrating the expression with gestures or accessible objects (e.g., pictograms), » failure to verify the understanding of the recommendations and acceptance of the proposed treatment plan.
Lifebuoys	· The mother tongue of the patient and her husband is Hindi, but they speak and understand English.
Spanners in the works	· The patient and her husband communicate poorly in English. They have trouble understanding specialized medical phrases.

Things to discuss (sum up after the exercise)	**Issues to be discussed:** · the importance of developing cultural awareness in healthcare, · intercultural communication, · language barrier in communication with the patient.
Additional information: This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.	

Additional information – medical documentation:

- maternity notes
- referral to the clinic
- fasting glucose test results

SCENARIO 7

TITLE: **Religious awareness in healthcare – Hinduism**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**Salty lotus**	
Main clinical problem	Natural labour management in a Hindu patient – a lotus birth	
Setting	· There is a patient in the delivery room during natural labour. Cervical dilation – full, the amniotic fluid is leaking out, contractions of the uterus are vigorous, contractions last 50 seconds at 2-minute intervals. · FHR (+) of approx. 145–160 BPM. · The labour is going on with no complications.	
Educational aims	· Introducing concepts related to Hinduism and specifying what medical staff should be aware of in the context of this religion. · Understanding other people's religious beliefs and values based on reflective thinking. · Positive attitudes towards other cultures and religions. · Developing cultural awareness in healthcare.	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Midwifery students – 3 persons
Introductory information given to the participants	**Setting:** In the delivery room, you are taking care of a woman giving birth in the second stage of labour. The patient declares herself to be Hindu. She is dressed in garments in accordance with the assumptions of the Hindu religion. She wishes to give a lotus birth. She is accompanied by her husband. Her vital signs are normal.	
Introduction for the instructor (significant elements, management, tasks)	**Aims for the students:** · Effective communication with the patient. · Knowledge and implementation of the rules of conduct in the case of a patient of different faith. · Constant monitoring of vital parameters. · Maintaining verbal contact with the patient. · Developing cultural awareness in healthcare.	

Information for the technician (equipment required, preparation of the room)	**Site:** · delivery room in secondary referral hospital **Clothes and other props:** · A woman in labour · A woman dressed in garments in accordance with the assumptions of Hindu religion · Delivery bed **Medical equipment:** · Next to the bed – a cardiotocograph · Cardiac monitor · Hospital phone in the room · Adult Ambu bag · Nasal cannula/oxygen mask · Source of oxygen, air, and vacuum · Blood pressure meter · Stethoscope · Therapy trolley · Labour kit (tools, kortland, clothes for the new-born) · Liquid for disinfecting the skin and mucous membranes · Sterile gloves (2 pairs) · Swabs, compresses · Source of spotlight · Screen · Pillowcase, pillow · Hand washing and disinfection station · Medical scrubs, disposable mask, protective glasses, · Linen soaker pads/tetra diaper · Medical sieve · Deep bowl · Saline solution
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Kanak Sharma · A woman in labour – 2nd stage of labour (labour with no complications) · Age – 28 years · Height – 150 cm · Weight – 69 kg · No allergies · Skin – pink · Consciousness – conscious · BP – 115/75 mmHg · Pulse – 76 BPM · SpO_2 – 98% · Respiration rate – 16 per minute · Body temperature – 36.2°C

Patient characteristics 2 minutes after the beginning of the scenario	• Skin – pink • Consciousness – patient conscious • BP 110/75 mmHg • Pulse – 100 BPM • SpO_2 – 98% • Respiration rate – 22 per minute • Body temperature – 36.8°C Natural labour takes place in the supine position on the birthing bed. The patient is dressed in clothes compatible with her religious affiliation. After the baby is born, the father initiates the first religious rite – a jatakarman – he utters the words of a special mantra into the new-born's ear – a request for long life and wisdom, then touches the baby's forehead. The new-born is placed on the mother's breast to accelerate the detachment of the placenta. When the placenta is born, it is placed in a bowl, gently rinsed with warm water, blood clots are removed, and gently dried. The placenta is then placed on a sieve with a tetra diaper, then in a deep bowl filled with saline solution.
Course of the scenario	**Site:** • Labour ward **Scenario versions:** Successful completion: • Effective action in accordance with the applicable Standards of Perinatal Care in Poland, considering the wishes of the patient and husband regarding the management of a lotus birth. • Showing patience and empathy in contact with the patient. • Showing respect for a Hindu patient, her beliefs, values, and independent decisions regarding her own health and life. • Respect for human dignity regardless of religion, race, and personal beliefs. Probable outcome: • Effective communication with the patient. • Undertaking activities aimed at informing the doctor on duty about the patient who is of different religion – including the clothes in which she is giving birth in. • Lack of knowledge about the lotus birth. • Waiting for the doctor to contact the staff.

Course of the scenario	Unsuccessful outcome: · Lack of knowledge and skills when taking care of a religiously different patient: » Lack of knowledge about the lotus birth. » Poor communication with the patient. · Lack of understanding of the patient's individual decisions and values; failure to respect the dignity of a religiously/culturally different patient: » Contradicting/negating patient's individual decisions regarding the labour.
Lifebuoys	· A medical doctor comes in, who supports the woman in labour, her beliefs, and behaviours.
Spanners in the works	· The dominance of the patient's husband in the delivery room. · Patient's reluctance to have an internal examination (cervical check) performed by the midwife.
Things to discuss (sum up after the exercise)	**Issues to be discussed:** · the importance of developing cultural awareness in healthcare, recommended conduct of a midwife in the case of a labour by a religiously different patient.
Additional information: This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.	

Additional information – medical documentation:

- prescription sheet
- maternity notes
- previous CTG records

After recording the content of the scenario on the audio-video carrier, a narrative will follow, in which the details of the scenario will be explained (patient's behaviour / staff behaviour / medical actions taken).

SCENARIO 8

TITLE: **Religious awareness in healthcare – Hinduism**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**Silent Edha**	
Main clinical problem	Rehabilitation after Covid-19 (so-called post-covid rehabilitation)	
Setting	In the gynaecological room, there is a patient diagnosed with HSIL (acc. to Bethesda scale) and with post-COVID-19 complications manifested as breathing difficulties.	
Educational aims	· Introducing concepts related to Hinduism and specifying what medical staff should be aware of in the context of this religion. · Introducing the principles of performing medical, rehabilitation and physiotherapeutic procedures in the case of post-COVID-19 complications. · Understanding other people's religious beliefs and values based on reflective thinking. · Positive attitudes towards other cultures and religions. · Developing cultural awareness in healthcare.	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Nursing student – 1 person · Physiotherapist – 1 person
Introductory information given to the participants	**Setting:** In the gynaecological room, you are looking after a patient with the following initial diagnosis: HSIL – for further diagnostic evaluation The patient had had Covid-19 two months earlier. Until now, she has been experiencing the complications of the disease. She complains of the following: · difficulty breathing, · dyspnoea, · voice problems (irritation of the vocal cords and larynx), · difficulty swallowing solid and liquid foods. Her vital signs are normal.	

Introduction for the instructor (significant elements, management, tasks)	**Aims for the students:** · Undertaking activities for effective communication with a patient. · Adopting a professional attitude towards the implemented physiotherapeutic methods. · Teaching the patient the positions to alleviate shortness of breath. · Teaching her breathing techniques. · Teaching the basic exercises recommended by the WHO. · Teaching how to deal with voice problems and techniques to improve difficulty swallowing food. · Knowing and implementing the rules of conduct in the case of a patient declaring to be Hindu. · Monitoring of vital parameters. · Maintaining verbal contact with the patient. · Developing cultural awareness in healthcare.
Information for the technician (equipment required, preparation of the room)	**Site:** · Gynaecological room in secondary referral hospital **Clothes and other props:** · a woman suffering from gynaecological diseases, history of Covid-19 two months earlier. **Medical equipment:** · hospital bed, · disposable gloves, · access to the source of oxygen, · oxygen mask/nasal cannula, · pulse oximeter.
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Edha Gupta · A woman suffering from gynaecological problems · Age – 50 years · Height – 155 cm · Weight – 74 kg · No allergies · Skin – pink · Consciousness – conscious · BP – 125/80 mmHg · Pulse – 84 BPM · SpO_2 – 94% · Respiration rate – 24 per minute · Body temperature – 36.6°C

Patient characteristics 2 minutes after the beginning of the scenario	· Skin – pale · Consciousness – patient conscious · BP 125/80 mmHg · Pulse – 72 BPM · SpO_2 – 98% · Respiration rate – 16 per minute · Body temperature – 36.8°C Implementation of physiotherapeutic exercises aimed at the elimination of post-COVID-19 complications.
Course of the scenario	**Site:** · Gynaecological room **Scenario versions:** Successful completion: · Effective implementation of physiotherapeutic activities. · Taking all possible actions to initiate and maintain the best possible communication with the patient. · Showing patience and empathy, and above all support in contact with a gynecologically ill patient, burdened with complications of the post-COVID-19 respiratory system. · Showing respect for a Hindu patient, her convictions, values, and individual decisions concerning the aspect of her own health and life as well as the life of the child. · Respect for the patient's religious needs. · Respect for human dignity regardless of religion, race, and personal beliefs. Probable outcome: · Effective communication with the patient. · Undertaking physiotherapeutic activities aimed at the elimination of post-COVID complications. · Lack of substantive knowledge and skills to improve the function of the respiratory system. · Waiting for the doctor to contact the staff. Unsuccessful outcome: · Lack of knowledge and skills in the case of improving the patient's respiratory system after Covid-19: » poor communication with the patient, » passive attitude as a physiotherapist. · Lack of understanding of the patient's individual decisions and values; failure to respect the dignity of a religiously/culturally different patient: » denying/negating the patient's individual reactions.

Lifebuoys	· A nurse enters and establishes contact with the patient, provides support, encourages her to take up physical activity.
Spanners in the works	· Lack of cooperation between the patient and the medical staff, no willingness to communicate. · Patient's reluctance to follow the exercises or follow the instructions of the physiotherapist. · No faith in the sense of pulmonary rehabilitation.
Things to discuss (sum up after the exercise)	**Issues to be discussed:** · the importance of developing cultural awareness in healthcare, · recommended physiotherapeutic treatment in the case of a gynaecological patient with post-COVID-19 complications.
Additional information: This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.	

Additional information – medical documentation:

- prescription sheet
- medical documentation – internal medicine documentation

After recording the content of the scenario on the audio-video carrier, a narrative will follow, in which the details of the scenario will be explained (patient's behaviour / staff behaviour / medical actions taken).

SCENARIO 9

TITLE: **Religious awareness in healthcare – Islam**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**The power of maternity**	
Main clinical problem	Natural labour management in a Muslim patient	
Setting	There is a patient in the delivery room during natural labour. Cervical dilation – full, the amniotic fluid is leaking out, contractions of the uterus are vigorous, contractions last 50 seconds at 2-minute intervals. FHR (+) of approx. 140–150 BPM. The labour has no complications.	
Educational aims	· Introducing concepts related to Islam and specifying what medical staff should be aware of in the context of this religion. · Understanding other people's religious beliefs and values based on reflective thinking. · Positive attitudes towards other cultures and religions. · Developing cultural awareness in healthcare.	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Midwifery student – 1 student
Introductory information given to the participants	**Setting:** In the delivery room, you are taking care of a woman giving birth in the second stage of labour. The patient declares herself to be Muslim. She is dressed in Muslim garments. Her vital signs are normal.	
Introduction for the instructor (significant elements, management, tasks)	**Aims for the students:** · Effective communication with the patient. · Knowledge and implementation of the rules of conduct in the case of a patient of different faith. · Constant monitoring of vital parameters. · Maintaining verbal contact with the patient. · Developing cultural awareness in healthcare.	

Information for the technician (equipment required, preparation of the room)	**Site:** · Delivery room in secondary referral hospital **Clothes and other props:** · A woman in labour, · A woman dressed in Muslim garments, · Delivery bed. **Medical equipment:** · Next to the bed – a cardiotocograph, · Cardiac monitor, · Hospital phone in the room, · Adult Ambu bag, · Nasal cannula/oxygen mask, · Source of oxygen, air, and vacuum, · Blood pressure meter, · Stethoscope, · Therapy trolley, · Labour kit (tools, kortland, clothes for the new-born), · Liquid for disinfecting the skin and mucous membranes, · Sterile gloves (2 pairs), · Swabs, compresses, · Source of spotlight, · Screen, · Pillowcase, pillow, · Hand washing and disinfection station, · Medical scrubs, disposable mask, protective glasses.
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Karima Haddad · A woman in labour – 2nd stage of labour (labour with no complications) · Age – 31 years · Height – 170 cm · Weight – 66 kg · No allergies · Skin – pink · Consciousness – conscious · BP – 110/75 mmHg · Pulse – 84 BPM · SpO_2 – 98% · Respiration rate – 16 per minute · Body temperature – 36.5°C

Patient characteristics 2 minutes after the beginning of the scenario	· Skin – pink · Consciousness – patient conscious · BP 110/75 mmHg · Pulse – 100 BPM · SpO_2 – 98% · Respiration rate – 22 per minute · Body temperature – 36.8°C The patient gives birth by natural labour in a squatting position with use of a delivery chair available at the labour room. She is dressed in clothes compatible with her religious affiliation.
Course of the scenario	**Site:** · Labour ward **Scenario versions:** Successful completion: · Effective action in accordance with the applicable Standards of Perinatal Care in Poland. · Showing patience and empathy in contact with the patient. · Showing respect for a Muslim patient, her beliefs, values, and independent decisions regarding her own health and life. · Respect for human dignity regardless of religion, race, and personal beliefs. Probable outcome: · Effective communication with the patient. · Undertaking activities aimed at informing the doctor on duty about the patient who is of a different religion – including the clothes in which she is giving birth. · Waiting for the doctor to contact the staff. Unsuccessful outcome: · Lack of knowledge and skills when taking care of a religiously different patient: » Poor communication with the patient. · Lack of understanding of the patient's individual decisions and values; failure to respect the dignity of a religiously/culturally different patient: » contradicting/negating patient's individual decisions regarding the labour.
Lifebuoys	· A medical doctor comes in, who supports the woman in labour, her beliefs, and behaviour.

Spanners in the works	• The patient doesn't feel comfortable in front of the midwife, she is embarrassed and frequently covers up her private parts. • Patient's reluctance to have an internal examination (cervical check) performed by the midwife.
Things to discuss (sum up after the exercise)	**Issues to be discussed:** • the importance of developing cultural awareness in healthcare, • recommended conduct of a midwife in the case of a religiously different patient in labour.
Additional information: This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.	

Additional information – medical documentation:

- prescription sheet
- maternity notes
- previous CTG records

After recording the content of the scenario on the audio-video carrier, a narrative will follow, in which the details of the scenario will be explained (patient's behaviour / staff behaviour / medical actions taken).

SCENARIO 10

TITLE: **Religious awareness in healthcare – Islam**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**A stone**	
Main clinical problem	Mobilizing of a puerpera on day "0" post CC.	
Setting	There is a puerpera in the maternity ward on day "0" after the caesarean section (elective).	
Educational aims	· Introducing concepts related to Islam and specifying what medical staff should be aware of in the context of this religion. · Introducing the rules of medical procedures in the patient's maternity ward on day "0" after caesarean section. · Understanding other people's religious beliefs and values based on reflective thinking. · Positive attitudes towards other cultures and religions. · Developing cultural awareness in healthcare.	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Midwifery student – 1 student · Physiotherapist – 1 person
Introductory information given to the participants	**Setting:** In the maternity ward, you are looking after a puerpera on day "0" after a caesarean section. The patient has made a few attempts to become mobile with midwife's assistance but to no avail. She reports severe pain and fear of falling and excessive body movement. A physiotherapeutic consultation has been ordered. · Patient's vital signs are normal. · Obstetric status parameters: » height of the bottom of the uterus – one transverse finger above the navel, » hard, spherical uterus with prominent edges, » scant lochia » dressing on the postoperative wound clean and dry.	

Introduction for the instructor (significant elements, management, tasks)	**Aims for the students:** · Undertaking activities for effective communication with the patient. · Adopting a professional attitude towards the patient's attempts to maintain a sitting position on the bed, standing up and moving. · Implementing anti-oedema and anti-coagulant exercises. · Teaching the patient how to correctly cough, sneeze, and defecate. · Knowing and implementing the rules of conduct in the case of a Muslim patient. · Monitoring of vital parameters. · Maintaining verbal contact with the patient. · Developing cultural awareness in healthcare.
Information for the technician (equipment required, preparation of the room)	**Site:** · Maternity room in secondary referral hospital **Clothes and other props:** · A female patient – day "0" post CC **Medical equipment:** · Maternity bed, · Disposable gloves, · Access to the source of oxygen, · Oxygen mask/nasal cannula
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Abu Rahid · A puerpera on day "0" post CC. · Age – 30 years · Height – 165 cm · Weight – 58 kg · No allergies · Skin – pink · Consciousness – conscious · BP – 110/80 mmHg · Pulse – 76 BPM · SpO_2 – 98% · Respiration rate – 16 per minute · Body temperature – 36.2°C

Patient characteristics 2 minutes after the beginning of the scenario	· Skin – pale · Consciousness – patient conscious · BP 100/70 mmHg · Pulse – 72 BPM · SpO_2 – 98% · Respiration rate – 16 per minute · Body temperature – 36.8°C With professional physiotherapeutic instruction, the patient tries to become mobile.
Course of the scenario	**Site:** · Maternity room **Scenario versions:** Successful completion: · Effective implementation of physiotherapeutic activities to mobilize the patient. · Taking all possible actions to initiate and maintain the best possible communication with the patient. · Showing patience and empathy, and above all, support in contact with the patient, who has many fears related to standing upright, defecation etc. · Showing respect for a Muslim patient, her convictions, values and individual decisions concerning the aspect of her own health and life as well as the life of the child. · Respect for the patient's religious needs. · Respect for human dignity regardless of religion, race and personal beliefs. Probable outcome: · Effective communication with the patient. · Undertaking activities aimed at helping the patient become mobile. · Lack of substantive knowledge on the implementation of exercises in a patient on day "0" post CC. · Waiting for the doctor to contact the staff. Unsuccessful outcome: · Lack of knowledge and skills when taking care of a religious patient: » Lack of knowledge on the implementation of exercises in a patient on day "0" post CC. » poor communication with the patient, passive attitude as a midwife. · Lack of understanding of the patient's individual decisions and values; failure to respect the dignity of a religiously/culturally different patient: » denying/negating the patient's individual reactions.

Lifebuoys	· A midwife enters and establishes contact with the patient, provides support, encourages her to take up physical activity.
Spanners in the works	· Lack of cooperation between the patient and the medical staff, no willingness to communicate. · Patient's reluctance to follow the exercises or follow the instructions of the physiotherapist.
Things to discuss (sum up after the exercise)	**Issues to be discussed:** · The importance of developing cultural awareness in healthcare. · Recommended physiotherapeutic management in the case of a patient on day "0" after caesarean section and a patient of different religion/denomination.
Additional information: This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.	

Additional information – medical documentation:

- prescription sheet
- obstetric medical records

After recording the content of the scenario on the audio-video carrier, a narrative will follow, in which the details of the scenario will be explained (patient's behaviour / staff behaviour / medical actions taken).

SCENARIO 11

TITLE: **Religious awareness in healthcare – Catholic Christianity**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**So silent, so sad**	
Main clinical problem	· Foetus diagnosed with malformation syndrome and foetal lethal abnormalities. · Management of natural childbirth in a Catholic patient.	
Setting	There is a patient in the delivery room at 24 weeks pregnancy. Contractile activity initiated by drip with 0.9% NaCl and 10 IU Oxytocin i.v. Cervical dilation to 7 cm, regular contractions of the uterus.	
Educational aims	· Introducing concepts related to Catholic religion and specifying what medical staff should be aware of in the context of this religion. · Presentation of the principles of medical procedures in the delivery room in relation to the conduct and delivery of a foetus with diagnosed malformation syndrome. · Understanding other people's religious beliefs and values based on reflective thinking. · Positive attitudes towards other cultures and religions. · Developing cultural awareness in healthcare.	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Midwifery students – 2 persons · Physician – 1 person

Introductory information given to the participants	**Setting:** In the delivery room, you are taking care of a woman giving birth at 24 HBD. Prenatal diagnostics (including a genetic test) revealed malformation syndrome and foetal lethal abnormalities. The patient was referred for pregnancy termination. The patient declares herself to be Catholic. She has hearing impairment. She gives birth by natural labour to a stillborn foetus. She is not accompanied by anyone close to her. Cervical dilation to 7 cm, clear amniotic fluid is leaking out, contractions of the uterus are vigorous, contractions last 40 seconds at 2-minute intervals. She is receiving a drip with 0.9% NaCl and 10 IU Oxytocin i.v. Patient's vital signs are normal.
Introduction for the instructor (significant elements, management, tasks)	**Aims for the students:** · Undertaking activities for effective communication with a patient giving birth to a foetus with lethal defects. · Adopting a professional attitude towards delivery of a foetus with lethal defects. · Knowledge and implementation of the rules of conduct in the case of a Catholic patient. · Constant monitoring of vital parameters. · Maintaining verbal contact with the patient. · Developing cultural awareness in healthcare.
Information for the technician (equipment required, preparation of the room)	**Site:** · Delivery room in tertiary referral hospital **Clothes and other props:** · A woman in labour, · Delivery bed. **Medical equipment:** · Next to the bed – a cardiotocograph, · Cardiac monitor, · Hospital phone in the room, · Adult Ambu bag, · Nasal cannula/oxygen mask, · Source of oxygen, air, and vacuum, · Blood pressure meter, · Stethoscope, · Therapy trolley, · Labour kit (tools, kortland) · Liquid for disinfecting the skin and mucous membranes, · Sterile gloves (2 pairs), · Swabs, compresses, · Source of spotlight,

Information for the technician (equipment required, preparation of the room)	· Screen, · Pillowcase, pillow, · Hand washing and disinfection station, · Medical scrubs, disposable mask, protective glasses, · Linen soaker pads/tetra diaper, · Holy water.
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Maria Mackiewicz · A woman in labour – 1st stage of labour, 24 hbd., FHR (+) · Age – 40 years · Height – 160 cm · Weight – 58 kg · No allergies · Skin – pink · Consciousness – conscious · BP – 120/75 mmHg · Pulse – 76 BPM · SpO_2 – 98% · Respiration rate – 16 per minute · Body temperature – 36.2°C
Patient characteristics 2 minutes after the beginning of the scenario	· Skin – pink · Consciousness – patient conscious · BP 110/75 mmHg · Pulse – 100 BPM · SpO_2 – 98% · Respiration rate – 22 per minute · Body temperature – 36.8°C Natural labour takes place in a supine position on the birthing bed. The foetus is born giving clear signs of life. At the patient's request, the midwife gives the sacrament of baptism and gives a name previously agreed on with the mother in accordance with the child's gender.

Course of the scenario	**Site:** · Labour ward **Scenario versions:** Successful completion: · Effective action in accordance with the applicable Standards of Perinatal Care in Poland. · Taking all possible actions to initiate and maintain the best possible communication with the patient. · Showing patience and empathy, and above all, support in contact with a patient who gives birth to a foetus with malformation syndrome. · Showing respect for the patient who declares Catholic faith, her convictions, values, and individual decisions concerning the aspect of her own health, life, and life of the child. · Respecting the patient's religious needs in relation to faith and the sacrament of baptism. · Respect for human dignity regardless of religion, race, and personal beliefs. Probable outcome: · Effective communication with the patient. · Undertaking activities aimed at informing the doctor on duty about the patient of a different religion. · Lack of knowledge regarding the management and delivery of a foetus with lethal defects. · Waiting for the doctor to contact the staff. Unsuccessful outcome: · Lack of knowledge and skills when taking care of a religious patient: » lack of knowledge regarding the management of birth of a foetus with lethal defects, » poor communication with the patient, passive attitude as a midwife. · Lack of understanding of the patient's individual decisions and values; failure to respect the dignity of a religiously/culturally different patient: » contradicting/negating patient's individual decisions regarding the labour.
Lifebuoys	· A midwife enters and establishes contact with the patient, provides support and shows her empathy.

Spanners in the works	· Lack of cooperation between the patient and the medical staff, no willingness to communicate. · Patient's reluctance to have an internal examination (cervical check) performed by the midwife.
Things to discuss (sum up after the exercise)	**Issues to be discussed:** · The importance of developing cultural awareness in healthcare, · Recommended conduct of a midwife in the case of a labour by a religiously different patient. · The rules of conducting and accepting the delivery of foetuses with lethal defects, · Methods of cooperation with a patient giving birth to a foetus with malformation syndrome.
Additional information: This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.	

Additional information – medical documentation:

- prescription sheet
- maternity notes
- obstetric medical records
- genetic diagnosis documentation

After recording the content of the scenario on the audio-video carrier, a narrative will follow, in which the details of the scenario will be explained (patient's behaviour / staff behaviour / medical actions taken).

SCENARIO 12

TITLE: **Religious awareness in healthcare – Jehovah's Witnesses**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**I feel red**	
Main clinical problem	Postpartum haemorrhage in patients declaring themselves to be Jehovah's Witnesses	
Setting	There is a patient in the delivery room after natural labour. The baby was born 10 minutes ago. Due to breathing disturbances, the neonate was just transferred to the neonatal unit. The patient is now reporting a distinct feeling of warmth in the perineum.	
Educational aims	· Introducing concepts related to Jehovah's Witnesses and specifying what medical staff should be aware of in the context of this religion. · Understanding other people's religious beliefs and values based on reflective thinking. · Positive attitudes towards other cultures and religions. · Developing cultural awareness in healthcare.	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Midwifery students – 2 students
Introductory information given to the participants	**Setting:** In the delivery room you are taking care of a woman who has just given birth by natural labour. The crotch is uninjured. Due to breathing disturbances, the neonate was transferred to the neonatal unit and is not a participant in the simulation. On admission to hospital and delivery room, the patient declared that she is a Jehovah's Witness. She does not wish to have blood, blood products, and blood substitutes transfused. She has also submitted a written refusal to consent to blood transfusion, a form for appointing a medical representative, and a care plan in the form of a personal document: "Orders and power of attorney regarding health care". Vital parameters are within normal limits. Obstetric condition parameters are also normal.	

Introduction for the instructor (significant elements, management, tasks)	**Aims for the students:** · Effective communication with the patient. · Knowledge and implementation of the rules of conduct in the case of postpartum haemorrhage diagnosis: 1. call for assistance, 2. performing Crede's manoeuvre on the uterine muscle, 3. administration of medications: · 5 units of Oxytocin i.v. + 0.9% NaCl (bolus), · 1 amp. of Methergine i.v. + 0.9% NaCl (bolus), · 1 amp. of Pabal i.v., · 0.9% NaCl 500 mL i.v. 4. constant monitoring of vital parameters, 5. maintaining verbal contact with the patient. · Developing cultural awareness in healthcare.
Information for the technician (equipment required, preparation of the room)	**Site:** · Delivery room in tertiary referral hospital **Helper:** · A woman just after natural labour, · A cellulose dressing for the perineum, · Intravenous line in the left arm **Clothes and other props:** · Delivery bed **Medical equipment:** · Next to the bed – a cardiotocograph, · Cardiac monitor, · Hospital phone in the room, · Adult Ambu bag · Nasal cannula/oxygen mask, · Source of oxygen, air, and vacuum, · Blood pressure meter, · Stethoscope, · Therapy trolley, · Kit for perineal, vaginal, and cervical check-up after delivery (in a sterile drape: a linen or disposable sterile pad for under the buttocks, speculum, several pair of bullet forceps, sponge holding forceps, anatomical or surgical tweezers, sterile gauze), · Liquid for disinfecting the skin and mucous membranes, · Sterile gloves (2 pairs), · Swabs, compresses, · Source of spotlight, · Screen,

Information for the technician (equipment required, preparation of the room)	· Pillowcase, pillow, · Hand washing and disinfection station, · Apron, disposable mask · Medications: » Oxitocin 2 amp., » Methergine 2 amp., » Pabal 1 bottle, » 0.9% NaCl 500 mL, » small, disposable ampoules of 0.9% NaCl, · Needles (7,8,9), syringes (5/10/20 mL) · Pink cannulas, · Cannula fixators.
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Anna Nowak · A woman just after natural labour (labour with no complications) · Age – 35 years · Height – 170 cm · Weight – 66 kg · No allergies · Skin – pale · Consciousness – conscious · BP – 110/75 mmHg · Pulse – 84 BPM · SpO_2 – 98% · Respiration rate – 16 per minute · Body temperature – 36.5°C
Patient characteristics 2 minutes after the beginning of the scenario	· Skin – pale · Consciousness – patient conscious · BP 75/55 mmHg · Pulse – 120 BPM · SpO_2 – 98% · Respiration rate – 18 per minute · Body temperature – 36.8°C Very profuse vaginal bleeding. The bottom of the uterus is barely palpable – atonic and soft uterus with undetectable edges.

Course of the scenario	**Site:** · Labour ward **Scenario versions:** Successful completion: · Effective action in line with the recommendations of the Polish Society of Gynaecologists and Obstetricians; implementation of Crede's manoeuvre on the uterine muscle; initiation of pharmacotherapy. · Showing patience and empathy in contact with the patient. · Showing respect for a Jehovah's Witness, the patient's beliefs, values, and independent decisions regarding her own health and life. · Respect for human dignity regardless of religion, race, and personal beliefs. Probable outcome: · Effective communication with the patient. · Undertaking activities aimed at informing the doctor on duty about the occurrence of an obstetric emergency. · Waiting for the doctor to contact the staff. Unsuccessful outcome: · Lack of knowledge and skills to deal with a perinatal emergency such as postpartum haemorrhage: » Poor communication with the patient. · Lack of understanding of the patient's individual decisions and values; failure to respect the dignity of a religiously/culturally different patient: » contradicting/negating the patient's personal decisions regarding the transfusion of blood and blood products/blood substitutes.
Lifebuoys	· The entry of a midwife who declares her personal affiliation with the Jehovah's Witnesses and who supports the patient.
Spanners in the works	· Initially loud and clear agitation from the patient regarding the prohibition of transfusing blood, blood products, and blood substitutes. · The patient's anxiety about the threat to her own health. · Asking many questions – each time, about intravenously administered medications. · Complete lack of contact with an obstetrician (including by telephone) due to an emergency, medical life-saving operation in a separate operating theatre.

Things to discuss (sum up after the exercise)	**Issues to be discussed:** · The importance of developing cultural awareness in healthcare, · Recommended behaviour from the midwife in the event of an emergency such as a postpartum haemorrhage.
Additional information: This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.	

Additional information – medical documentation:

- prescription sheet
- refusal of consent to blood transfusions
- a form for appointing a medical attorney and a care plan in the form of a personal document: "Orders and power of attorney regarding health care"

After recording the content of the scenario on the audio-video carrier, a narrative will follow, in which the details of the scenario will be explained (patient's behaviour / staff behaviour / medical actions taken).

SCENARIO 13

TITLE: **Religious awareness in healthcare – Christianity, Orthodox**

PROJECT NUMBER: KA203 nr 2019-1-PL01-KA203-065205

PROJECT TITLE: Interdisciplinarity, multiculturalism and non-standard situations – use of medical simulation as an educational tool in medical sciences and health sciences

PREPARED BY: University of Opole

Name of the scenario	**Eyes wide open**	
Main clinical problem	Management of a stillbirth by natural labour in a patient with hearing impairment. The patient is an Eastern Orthodox Christian.	
Setting	There is a patient in the delivery room during natural labour. Cervical dilation – full, green amniotic fluid is leaking out, contractions of the uterus are vigorous, contractions last 60 seconds at 2-minute intervals. She is receiving a drip with 0.9% NaCl and 5 IU Oxytocin i.v. FHR (-).	
Educational aims	· Introducing concepts related to Eastern Orthodox Christianity and specifying what medical staff should be aware of in the context of this religion. · Introducing the rules of performing medical procedures in the delivery room to a patient with hearing impairment. · Introducing the rules of medical procedures performed in relation to a patient giving birth to a stillborn foetus. · Understanding other people's religious beliefs and values based on reflective thinking. · Positive attitudes towards other cultures and religions. · Developing cultural awareness in healthcare.	
Participants	**Staff from the Centre for Medical Simulation:** · technician, instructor	**Target group (participants):** · Midwifery students – 2 persons · Physician – 1 person

Introductory information given to the participants	**Setting:** In the delivery room, you are taking care of a woman giving birth to a stillborn foetus (2nd stage of labour). 40 hbd., FHR (-). The patient declares herself to be an Eastern Orthodox Christian. She has hearing impairment. She gives birth by natural labour to a stillborn foetus. She is not accompanied by anyone close to her. Cervical dilation – full, green amniotic fluid is leaking out, contractions of the uterus are vigorous, contractions last 60 seconds at 2-minute intervals. She is receiving a drip with 0.9% NaCl and 5 IU Oxytocin i.v. Her vital signs are normal.
Introduction for the instructor (significant elements, management, tasks)	**Aims for the students:** · Undertaking activities for effective communication with a patient with hearing impairment. · Adopting a professional attitude towards the conduct and delivery of a stillbirth. · Knowledge and implementation of the rules of conduct in the case of a patient of different faith. · Constant monitoring of vital parameters. · Maintaining verbal contact with the patient. · Developing cultural awareness in healthcare.
Information for the technician (equipment required, preparation of the room)	**Site:** · Delivery room in secondary referral hospital **Clothes and other props:** · A woman in labour, · Delivery bed. **Medical equipment:** · Next to the bed – a cardiotocograph, · Cardiac monitor, · Hospital phone in the room, · Adult Ambu bag, · Nasal cannula/oxygen mask, · Source of oxygen, air, and vacuum, · Blood pressure meter, · Stethoscope, · Therapy trolley, · Labour kit (tools, kortland, clothes for the new-born), · Liquid for disinfecting the skin and mucous membranes, · Sterile gloves (2 pairs), · Swabs, compresses, · Source of spotlight, · Screen,

Information for the technician (equipment required, preparation of the room)	· Pillowcase, pillow, · Hand washing and disinfection station, · Medical scrubs, disposable mask, protective glasses, · Linen soaker pads/tetra diaper
Preliminary characteristics of the patient (sex, age, medical history, etc.)	· Name and surname – Zoja Iwanienko · A woman in labour – 2nd stage of labour, 40 hbd., FHR (-) · Age – 22 years · Height – 160 cm · Weight – 53 kg · No allergies · Skin – pink · Consciousness – conscious · BP – 115/75 mmHg · Pulse – 76 BPM · SpO_2 – 98% · Respiration rate – 16 per minute · Body temperature – 36.2°C
Patient characteristics 2 minutes after the beginning of the scenario	· Skin – pink · Consciousness – patient conscious · BP 110/75 mmHg · Pulse – 100 BPM · SpO_2 – 98% · Respiration rate – 22 per minute · Body temperature – 36.8°C Natural labour takes place in the supine position on the birthing bed.
Course of the scenario	**Site:** · Labour ward **Scenario versions:** Successful completion: · Effective action in accordance with the applicable Standards of Perinatal Care in Poland. · Taking all possible actions to initiate and maintain the best possible communication with the patient. · Showing patience and empathy, and above all, support in contact with a patient who gives birth to a stillborn foetus. · Showing respect for an Eastern Orthodox Christian patient, her beliefs, values, and independent decisions regarding her own health and life. · Respect for human dignity regardless of religion, race, and personal beliefs.

Course of the scenario	Probable outcome: · Effective communication with the patient. · Undertaking activities aimed at informing the doctor on duty about a patient of a different religion. · Lack of knowledge regarding the conduct and management of stillbirth, · Waiting for the doctor to contact the staff. Unsuccessful outcome: · Lack of knowledge and skills when taking care of a religiously different patient: » lack of knowledge regarding the conduct and management of stillbirth, » poor communication with the patient, passive attitude as a midwife. · Lack of understanding of the patient's individual decisions and values; failure to respect the dignity of a religiously/culturally different patient: » contradicting/negating patient's individual decisions regarding the labour.
Lifebuoys	· A midwife coordinating the Delivery Block enters and establishes contact with the patient, provides support and shows her empathy.
Spanners in the works	· Patient's reluctance to maintain eye contact with the duty midwife. · Patient's reluctance to have an internal examination (cervical check) performed by the midwife.
Things to discuss (sum up after the exercise)	**Issues to be discussed:** · The importance of developing cultural awareness in healthcare, · Recommended conduct of a midwife in the case of a labour by a religiously different patient. · The rules of conduct and management of stillbirth, · Methods of cooperation with a patient giving birth to a stillbirth.
Additional information: This scenario can be the basis for creating new scenarios with different or additional training aims. Changing this scenario requires careful consideration of what activities and procedures are to be demonstrated by the trainees, and what changes should be made to the training aims and the structure of the scenario.	

Additional information – medical documentation:

- prescription sheet
- maternity notes
- previous CTG records

After recording the content of the scenario on the audio-video carrier, a narrative will follow, in which the details of the scenario will be explained (patient's behaviour / staff behaviour / medical actions taken).

5. Instructional videos

Instructional videos made during medical simulation to tackle the issues of multiculturalism, interdisciplinarity, and non-standard situations:

1. Birth of the lotus (childbirth) – Hinduism religion

2. Bleeding after birth – religion of Islam

3. Woman after eye surgery (eye ward) – Chinese culture

4. The dying person (intensive care unit) – Roma culture

5. Woman after a car accident (rescue service) – religion Islam

6. Emergency birth – visually impaired woman on the street

7. Under the forces of nature

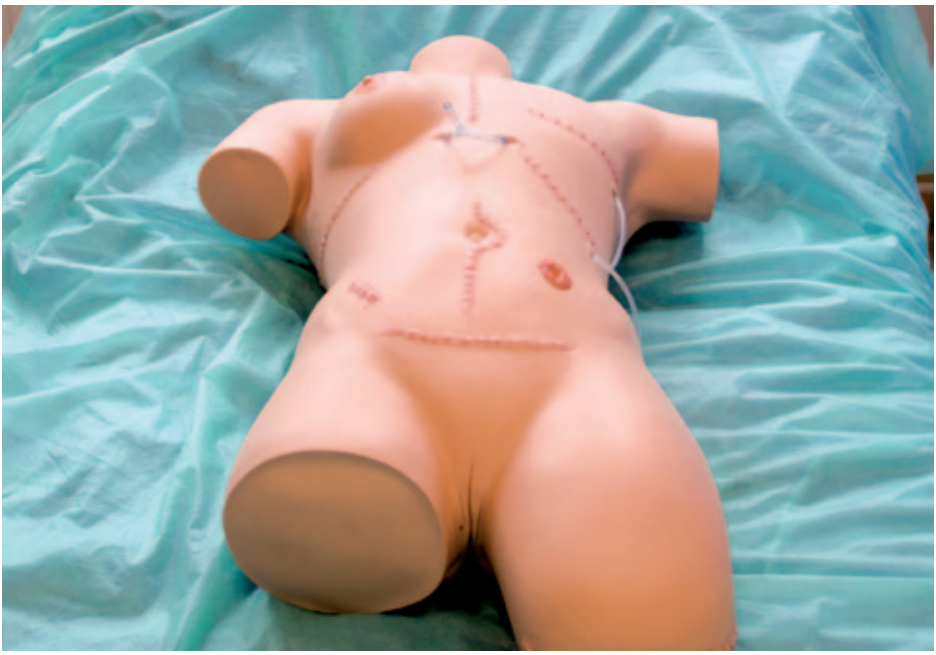
8. Roma culture in the face of a newborn child

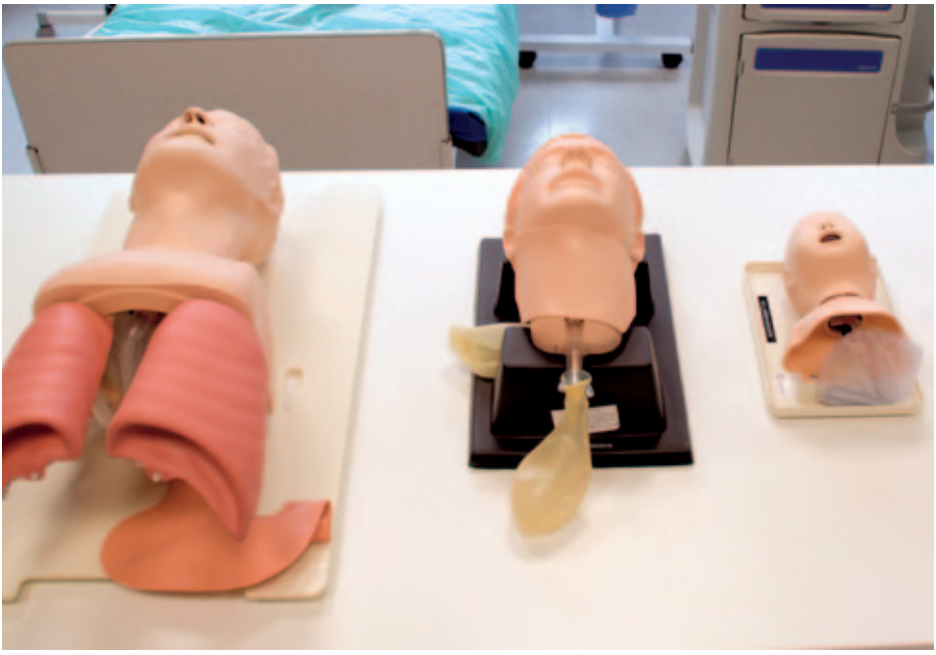
9. The birth in the Roma culture

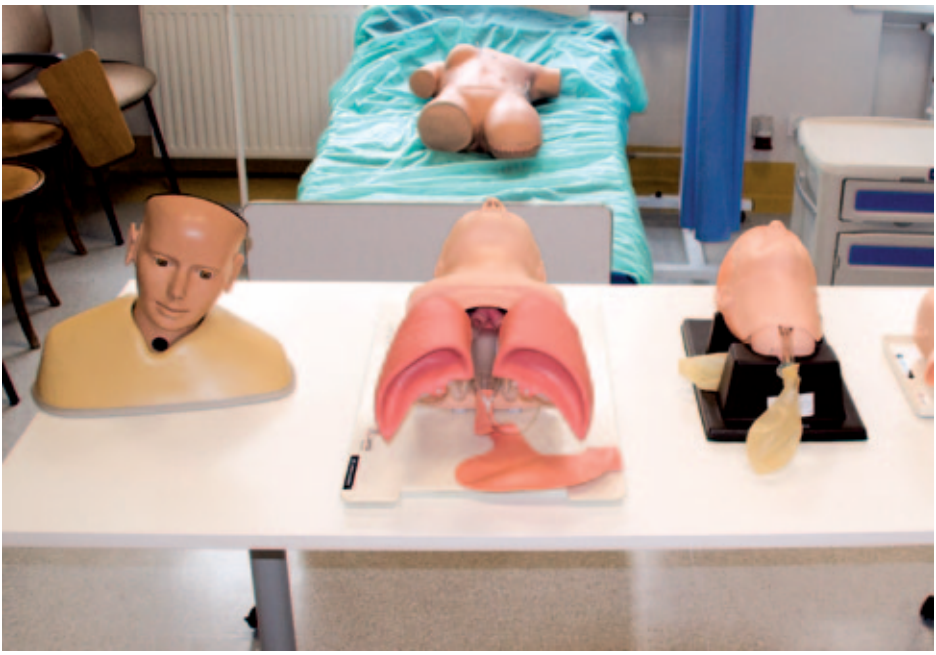
10. Under the influence of drugs, interdisciplinarity and communication

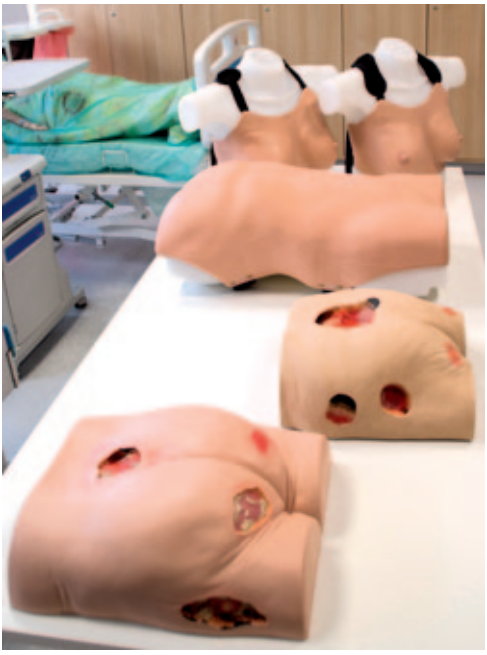
11. World languages and religion and culture

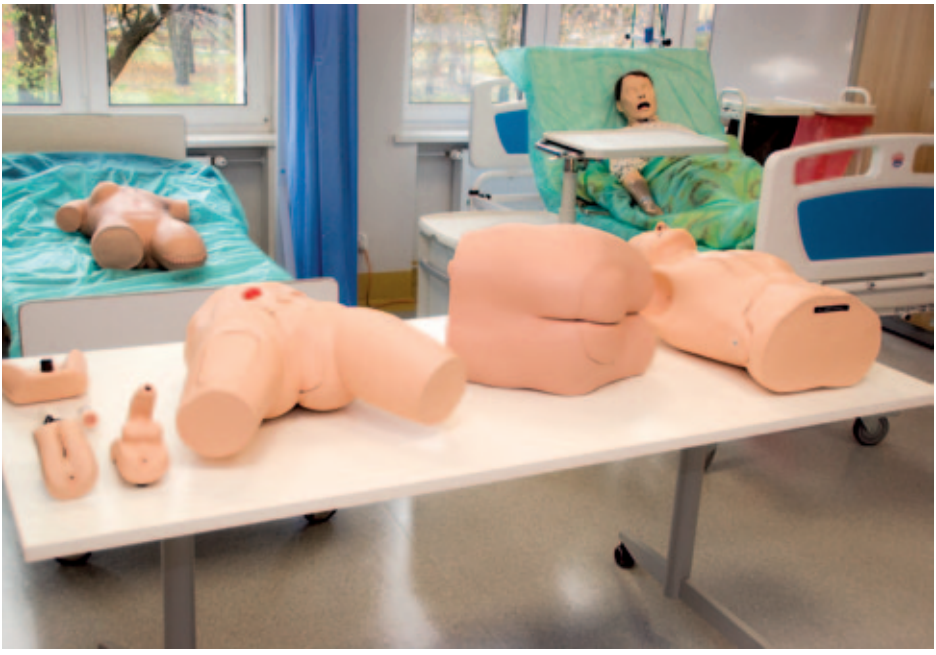
6. Gallery of the Medical Simulation Centre of the Faculty of Health Sciences, University of Opole

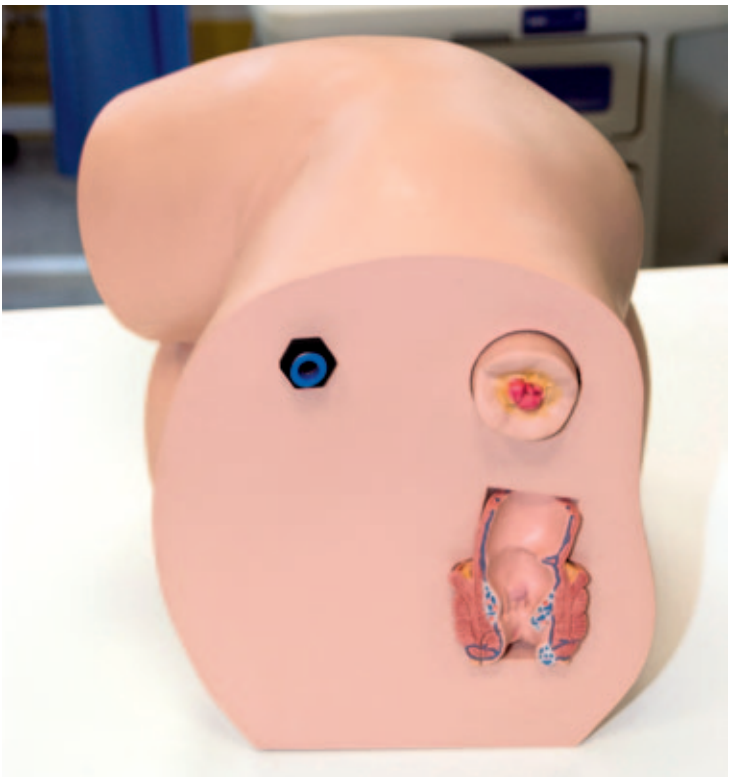


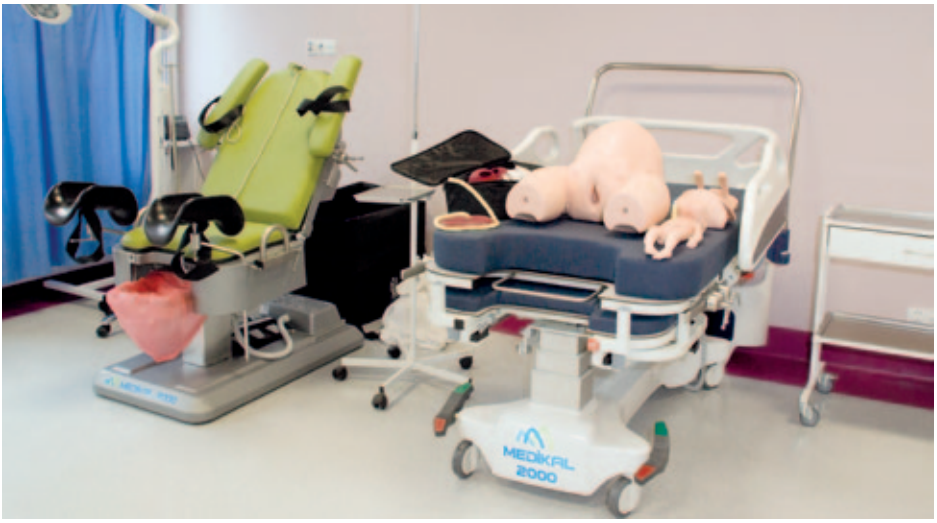








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