



Ivica Gulášová

St. Elizabeth University of Health & Social Sciences,
Bratislava, Slovakia

Lenka Gornerová

College of Polytechnics, Jihlava, Czech Republic

Ján Breza jr.

Urology Clinic and Centre for kidney transplantations, L. Denér
Faculty Hospital, Kramáre, Bratislava, Slovakia

Ján Breza

Urology Clinic and Centre for kidney transplantations, L. Denér
Faculty Hospital, Kramáre, Bratislava, Slovakia, Faculty of
Medicine of Comenius University, Bratislava, Slovakia
Slovak Medical University, Bratislava, Slovakia

Historical milestones of hospice nursing care

Abstrakt

Authors of this article describe the history of hospice care and community nursing. They define hospice nursing care according to the criteria of the World Organization of Home and Hospice Care. They point to the importance and role of community nursing in that area. Further they analyze the difficulties of hospice nursing care. The conclusion is based on the rights of dying patients, where the main goal of palliative care is to maintain the patient's physical and psychological well-being, pain-free state and dignified and peaceful death.

Key words: hospice nursing care, community nursing, holistic philosophy in nursing

INTRODUCTION

Treatment of the terminally ill and dying is besides the extraordinary intensity and difficulty also relatively expensive and often constitutes ethical dilemmas. At a time when we are everywhere looking for possible savings in health expenditures while seeking to preserve the quality of health care, this issue is put into the fore. This problematic is complex but and has impact to different sectors of society. Surveys show undignified conditions of dying in hospitals, sanatoriums, social institutions, but also in home environment. One of the many solutions to this problem is to introduce new approaches in community care of terminally ill. Yet most effective approach, characterized by a new quality of care, is the hospice program that currently successfully extended and applied throughout the civilized world. Where is this program implemented at the appropriate level, the question of euthanasia becomes pointless.

HISTORY

The roots of hospice care reach into the ancient history of mankind. Ashoka, the ruler of India based in r. 238 BC in Varani the refuge for vagrants, poor and abandoned, who came here to die with the fact that their ashes will be dumped into the sacred Ganges, in order to be freed from the circle of death.

In the Age of Christianity is the image of the Good Samaritan, xenodocheion (place for a foreigner), as well as the Christian idea of doing good, as states evangelist Matthew (Mt 25, 35): „... for I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me“. St. Basil of Caesarea based refuge for the sick in Cappadocia in the 4th century. These were (in those times) new facilities of new quality, on this model were gradually based others, especially in cities where were residing bishops. They can be viewed as a nucleon of new approach of Christian civilization to health services in general. In the times of Crusades in seventh century was established the military and hospital Order of the Knights of St. Lazarus of Jerusalem with its hospices for lepers. It pushed forward the concept of hospice care by providing physical care in spiritual order. It's a new quality of compassionate care, the source of contemporary hospice philosophy. Nowadays, especially in developed countries the Order extended care to patients with cancer, and still build new hospices on all continents. In the 16th century joined the spread of hospice care St. John Goths who was highlighting cleansing of the soul (confession) and unseparatedness of physical care: the pain of dying has mental and physical components. In the 18th century are in the care of dying involved nursing charities. In the 20th century Irish Sisters of Charity opened in London St. Joseph's Hospice. Christian charitable organizations are still active in the implementing compassionate care services all over the world. Charity as an expression of Christianity had, has, and always will have a vital role to play.

ST. CHRISTOPHER'S HOSPICE

In 1967 based Cecily Saunders in London Hospice St. Kitts - St. Christopher's Hospice, which has become a model center for the whole world hospice movement. It has a new ecumenical philosophy of the approach, which draws from the traditions of the past. Holistic approach in a new quality, without an ideological and religious undertone respects the present and gives space to diverse communities in society. It is a unifying platform of acceptable concept. It wants to protect and assist, not to rescue. According to this model acts work today in the world more than 3,000 hospices.

PALLIATIVE CARE

In December 1988 in Milan the group of experts established the European Association of Palliative Care (European Association for Palliative Care – EAPC) to support the dissemination and development of palliative care as it is conceptually formulated by the World Health Organization (WHO). EAPC raised the issue of a comprehensive and acceptable solution to care for terminally ill.

The word hospice comes from the Latin word *hospitium* and is derived from the word *host*, what is the international term for a home for the sick or shelter for those in need. The Slovak translation means hospitality or inn. Hospice is an organizational structure and program of team care for patients in the terminal stage of their illness. Hospice also provides assistance to the families and survivors of the patient. Patients come here so they can live fully until their last moment. And since their time is framed by the disease limited life, the more weigh every day. They rejoice in the little and apparent things that healthy people consider as quite ordinary things. Hospice does not promise healing, but does not take away hope. Through hospice program is for terminally ill implemented palliative care, which places greater emphasis on care than on treatment (Hanzlíková, 2004, p. 265).

Basic definition of palliative care by the World Health Organization (WHO, 2002) reads: „Palliative care is the overall treatment and care of patients whose disease does not respond to curative therapy. The most important is the control and treatment of pain and other symptoms, as well as addressing psychological, social and spiritual problems of patients. The aim of palliative care is to achieve the best possible quality of life of patients and their families“ (Vorlíček, 1998).

It is a form of palliative care, which is dominated by a holistic approach and complexity. For this reason, we can not separate the health, social, psychological and emotional components. Holistic care is thus characterized by mutual cooperation. No man can provide holistic care alone, because no one has all the necessary knowledge and detachment. Holistic care can therefore be provided only in a team of people who work together to input their own knowledge, understanding and own personality (O'Connor, 2005). WHO focuses in hospice care only at the patient. According to the World Organization of Home and Hospice Care and the American Association of Pain, this care cover broad specter involving the family and loved ones of dying and his social environment (Hanzlíková, 2004, p. 266).

DEFINITION OF HOSPICE CARE BY THE WORLD ORGANIZATION OF DOMESTIC AND HOSPICE CARE

Hospice care is a centrally managed program of palliative care, which is specifically aimed at the alleviating of the symptoms of severe disease in terminally ill who have likely prognosis for survival up to six months. The philosophy of hospice care is to respect the life and to enable maximum quality of life of a dying man, realized by providing of care and support for the dying and their families. Life is to be lived as fully and without undue suffering as possible. Death is seen as an integral part of every individual's life. Hospice care does not extend death, nor speed up (Hanzlíková, 2006).

THE DEFINITION OF HOSPICE CARE BY WHO

Hospice care is an integrated form of medical, social and psychological care provided to clients of all indications, diagnoses and age groups for which the physician prognoses life expectancy in the range of less than six months. The hospice care is provided only by palliative care (Hanzlíková, 2006).

HISTORY OF HOSPICE CARE

In recent decades, this area has received a major development, mainly thanks to the foresight, activities and commitment of Cecille Saunders. She has dedicated her entire life care for patients with advanced and progressive disease, and she is considered as the founder of modern palliative care. She established St. Christopher's Hospice in London, which was opened in 1967. Patients were provided there with a good reliever treatment and care, and not just from the physical side. Patients could together with their loved ones deal with the various emotional and spiritual problems, rectify discrepancies and conflicts, reconcile with their destiny, and thus relieve the pain - not only the physical one, but also all other sufferings. Furthermore patients saw that they were not a nuisance to others, but that they are loved and extremely important for their loved ones (Munzarová, 2005).

Achievements of the Hospice of St. Christopher in London showed the way to the establishment of other similar facilities all around the world. An important task of the work was to show to all the doctors, nurses and other healthcare professionals the major role and benefits of multidisciplinary palliative care (Vorlíček, 2004).

In Slovakia there is currently institutional hospice in Bardejovská Nová Ves and Catholic charity also began construction of their hospice, but its existence is seriously threatened by a lack of financial resources. In 1997 was established the Hospice department in Michalovce - Strážský and Palliative department in the National Oncology Centre in Bratislava. Palliative care also provides medical center in Humenné (Hanzlíková, 2004, p. 269). In opposite to expression „nothing can be done“ is the belief that, regardless of diagnosis, level of progress and poor prognosis, we can always do something to improve the quality of remaining life (Vorlíček, 2004 p. 20). Hospice care is currently provided by a multi-disciplinary team, and not only by doctors, but also by nurses, clergy or psychologists. Also important is cooperation with families, volunteers and other lay people. And because the number of terminally ill patients continues to increase, the important area of all the ingredients of team is learning.

COMMUNITY CARE

It is care at home, and not only on sick people but also on healthy people in terms of health promotion and disease prevention. It is much less expensive and, moreover, has the advantage that the patient need not be taken out from his home environment (Hanzlíková, 2004, p. 9). Hospice patients also create their own community. Taking care of these people can not be understood only as care that assigns to certain types of facilities and to close eyes in front of it in general practice. It is rather a philosophy that can be applied daily not only in hospices, but also in various hospitals and departments and also at home. It is part of patient care, and we can not look at it as something different - fundamentally different from the current practice. On the contrary, the development of community-based care for hospice patients could have a very positive impact on other forms in the way that it highlights the shortcomings and problems to which is paid so little attention.

One of the basic ideas of community nursing of palliative and hospice patients is

authenticity, as giving false hope means to shorten his time on detachment from earthly world, so he could reach the end unprepared. Since human is the only creature who is fully aware of the disappearance of its being, no one is allowed to do so. Everyone must create its own interpretation of life and death itself. The only human right and the duty of nurse is to accompany and provide support to palliative patients (Čižmáriková, 2005, p. 33).

Community care is care that is focused on specific care in different communities, in this case about hospice and palliative patients, which is focused on relevant aspects such as holism and holistic approach, respecting the rights of patients, the application of modern methodologies and differentiation on the basis of classification symbols, such as age, gender, ethnicity, type of disease and others. Particularly difficult group are hospice and palliative patients in the community care. The main goal of palliative care is to maintain the patient's physical and psychological well-being, state without pain and dignified, peaceful death.

IN IMPLEMENTING OF SUCH CARE SHOULD BE NURSING CARE BASED ON THE RIGHTS OF THE DYING:

- I have the right to be treated as a living man until my death,
- I have the right to keep hope, no matter what it is focused at,
- I have the right to receive the care provided by people who are able to maintain my hope, whatever the situation changes,
- I have the right to express my feelings about the impending death, in my own way,
- I have the right to participate in decisions concerning care of myself,
- I have a right to expect continuing medical and nursing interest in myself, even if the „medical“ aims are replaced by pursuing of the objectives of maintaining my „well-being“,
- I have a right not to die alone,
- I have the right to be free from pain,
- I have a right to honest answers to my questions,
- I have the right not to be lied about anything,
- I have the right to me at the moment when I realize impending death, help my family and support was also provided to my relatives,
- I have the right to die peacefully and with dignity,
- I have the right to retain my individuality and not to be judged for my decisions which may be in contrary to the opinions of others,
- I have the right to talk and spread my religious or spiritual views regardless of what they mean to others,
- I have a right to expect that the inviolability of the human body will be respected after my death,
- I have the right to be cared for me by sensitive, caring and experienced people who will try to understand my needs and will bring them some gratification for their conduct when they face certain death (Kozierová, 1995).

CONCLUSION

The solution for many of the problems with hospice patients in community care system is a “good angel” system. This non-profit organization has been founded three years ago in partnership with pediatric oncology Kramáre. It provides financial assistance to patients and families of patients at regular monthly intervals of around about 130 euros. Good Angel financially assisted hundreds of families with children in Slovakia.

LITERATURE

- CINOVÁ J., MAGUROVÁ D. Sestra a umierajúci pacient [The nurse and the dying patient]. In: Sestra a lekár v praxi. No. 7–8. Vol. VII., 2008. ISSN 1335-9444, p. 44.
- ČIŽMÁRIKOVÁ I. Psychológia umierajúceho [Psychology of dying]. Sestra a lekár v praxi, No. 9, Vol. IV., 2005 ISSN 1335-9444, p. 32–33.
- FARKAŠOVÁ D. ET AL. 2005. Ošetrovatel'stvo – teória [Nursing – Theory]. Martin: Osveta, 2005, 216 p. ISBN 80-8063-182-4.
- HANZLÍKOVÁ A. ET AL. 2004. Komunitné ošetrovatel'stvo [Community nursing]. Martin: Osveta, 2004, 279 p. ISBN 80-8063-155-7.
- HANZLÍKOVÁ A. ET AL. 2006. Komunitné ošetrovatel'stvo [Community nursing]. Martin: Osveta, 2006, 279 p. ISBN 80-8063-213-8.
- JELČOVÁ L. Vždy potrebovala a chcela pomáhať [She always needed and wanted to help]. In: Sestra a lekár v praxi, No.9–10, Vol. VIII., 2009 ISSN 1335-9444, p. 15.
- KOZIEROVÁ B., ERBOVÁ G, OLIVIEROVÁ R. 1995. Ošetrovatel'stvo I. [Nursing Vol. I]. Martin: Osveta, 1995, 1474 p. ISBN 80-217-0528-0.
- KOZIEROVÁ B., ERBOVÁ G, OLIVIEROVÁ R. 1995. Ošetrovatel'stvo II [Nursing Vol. II]. Martin: Osveta, 1995, 1474 p. ISBN 80-217-0528-0.
- MUNZAROVÁ M. 2005. Eutanázia, alebo paliatívni péče? [Euthanasia or palliative care?] Praha: Grada, 2005, 108 p. ISBN 80-247-1025-0.
- NEMEČKOVÁ M. ET AL. 2004. Práva pacientov [Rights of patients]. Martin: Osveta, 2004, 214 p. ISBN 80-8063-162-X.
- O'CONNOR M., ARANDA S. 2005. Paliatívni péče pro sestry všech odborů [Palliative care for general nurses]. Praha: Grada, 2005, 324 p. ISBN 80-247-1295-4.
- PAVLÍKOVÁ S. 2007 Modely ošetrovatel'stva v kostce [Models of nursing in a nutshell]. 1. Issue. Praha: Grada Publishing, 2007, 141 p. ISBN 978-80-247-1918-4.
- VORLÍČEK J., AMAM Z., POSPÍŠIOVÁ Y. ET AL. 2004. Paliatívni medicína [Palliative Medicine]. Praha: Grada, 2004, 540 p. ISBN 80-247-0279-7.
- VORLÍČEK J., AMAM Z. ET AL. 1998. Paliatívna medicína [Palliative Medicine]. Praha: Grada, 1998, 466 p. ISBN 80-7169-347-1.