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The Beginnings of Hospice Care in the Czech Republic¹

Abstract

The aim of this paper is to review the situation in communist and post-revolutionary Czechoslovakia in the area of palliative care. It will familiarize readers with the enormous efforts of two big personalities in the history of Czech health care: Marie Opatrná and Marie Svatošová, who tried to change the old and inconvenient Soviet health care system and make the care of terminal and dying people more human. At the end, it will present some challenges which the current Czech hospice care is confronted with.

Keywords: Czechoslovakia, palliative care, communism, oncology, hospice, Caritas, funding.

1. Introduction

Although we know that death is an integral part of our life, we are living in a society in which the cult of youth, success and material security rules and

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where death is taboo. The exit from this life is perceived as something inappropriate, as something what does not have a place in the conception of victorious medicine, what is regarded as defeat of doctors too.

According to a research, performed in the Czech Republic in 2013, on a question: where would you like to die?, 78% of respondents answered: in the home environment; and on the question: where do you not want to die?, 69% of respondents answered: in departments of long-term care in state hospitals. In the process of dying the people are most scared of the loss of dignity, i.e. self-sufficiency (47%), pain (41%) and separation from the close people. (STEM/MARK, 2013, pp. 21–22). Unfortunately, the reality is totally different. The majority of people (68%) dies in medical facilities (hospitals and long-term care facilities); 4% in nursing homes (Haškovcová, 2007, p. 35).

The wish to die at home we can interpret as turning away from the so-called institutional model of dying and as a call for return to the home model of dying, i.e. to similar *ars moriendi* which we know e.g. from the environment of rural Europe in the first half of 20th century. What did it mean? To die at home is connected with the idea of being able to dwell in our well-known environment, being surrounded by members of our family who take loving care of us. It represents a model in which death was not made a taboo and everybody involved knew very well what to do and how to behave. The basic scenario of dying was commonly known: The dying person evaluated his or her situation, came to know that their last hour arrived, called together all members of their family, pronounced their last wish and said goodbye to everybody. The relatives subsequently called a priest who provided the dying person with holy sacraments. Then the dying person ordinarily settled down and patiently waited for their death. When they suffered from severe pains, a doctor was exceptionally called who administered a mitigating injection to them. (Haškovcová, 2007, pp. 26–27).

On the other hand we must not idealize this model of dying. It is important to say above all that it was possible for only a thin layer of society, for ruling dynasties and aristocrats in the first place. The majority of people either did not live in a complete and functioning family or was not able to financially afford a doctor. Nevertheless in this *ars moriendi* death and dying represented a social act in which solidarity of all participating persons found expression (Haškovcová, 2007, pp. 27–29).

The institutional model of dying also had its big advantages. The aim of different institutions (almshouses, old people's homes and later hospitals) was to ensure to every person in need a clean bed, hot food and drink, basic sanitary facilities and developing nursing care. The institutional care, whose peak we can date into the 60th of 20th century, was positively accepted by general public

for a long time. Unprecedented care was offered to dying persons in Czechoslovakia already in the first half of 20th century. But they were alone with their suffering – often in the atmosphere of *pia fraus*. In an effort to ensure the dying person the maximum of privacy a practice to install a white divider came into existence in the 20th century. It was abandoned still in its 80th (Haškovcová, 2018, p. 138–139).

Still at the end of 90th of 20th century there was a widespread belief that ill people needed especially strict calm and tidiness. The close family, relatives and friends were *de facto* excluded from the care of the ill and dying person. In Czechoslovakia there were only two days of their possible visit: Wednesday and Sunday afternoon. This time was strictly observed. In the time when an ill person needed support of his or her family it was practically not possible to meet it (Haškovcová, 2007, pp. 30–31).

With the intention to involve into the care of dying persons their family and relatives the modern Hospice movement arose. Following its history we cannot let aside famous names like Cicely Saunders, David Tasma and St. Christopher's Hospice. Also Czech Hospice movement has its famous names and institutions. In the following lines we would like to present the birth of the first hospice in its socio-cultural context.

2. Health care in the communist Czechoslovakia

With the communists coming to power in 1948, Czechoslovakia had to take on the Soviet model of health care. The transformation of the health care system took place step by step in the 1950s according to the so called Semashko model.² The system of health care was centralized, hierarchically organized and financed exclusively with the funds of the state, which controlled it in a totalitarian way. This model was implemented in all lands of Middle and Eastern Europe after World War II. It was distinguished by the following characteristics: all medical facilities were the property of the state, all doctors, nurses and other staff were state employees, professional organizations played only a consultative role, and all types of health care had to be equally accessible to everyone. Despite some advantages (e.g., the mass vaccination against tuberculosis), it had a clearly regressive character. The cause was the ineffective use of funds and their non-transparent distribution (Ivanová *et al.*, 2018, pp. 87–88).

² Nikolai Aleksandrovich Semashko (1874–1949) was the first Russian Minister of Health (People's Commissar of Public Health) after 1917. He also held the post of professor of Social Hygiene at Moscow State University.

The poor state budget was insufficient to provide expensive medical apparatus and finance modern drugs, and new therapeutic methods were usually delayed. Everything was decided “from above”; personal initiative was undesirable in most cases. State employees decided about the allocation of money and its utilization; medical staff were not responsible for such decisions. The result was that staff were unmotivated, felt undervalued and were not willing to debate delicate questions in public. The non-transparent funding also presented a fertile ground for corruption and a shadow economy. The distribution of scarce, above-standard health care was not controlled by an independent board; it was fully due to the competence of doctors. The consequence of this *status quo* was the “collective irresponsibility” which had an impact on the population: people put minimal stress on preventive supportive programs (Šimek and Špalek, 2002, pp. 6–8).

It is understandable that the Czechoslovak Faculties of Medicine offered no course on medical ethics. Instead, it was obligatory to pass an exam from the History of International labor movement, Political economy or other “socialistic sciences”. At the end of their studies, medical students had to pass a state exam in Scientific Marxism-Leninism since 1981. The so-called scientific worldview (materialistic seeing of the world) influenced doctors, nurses and patients for several generations until the fall of the regime in 1989. Only in 1992 was the “socialist health care system” replaced by general health insurance. However, the thinking and behavior of people remained the same for a long time.

In most cases, patients were seen purely in a biological dimension. It was not appropriate that they expressed their opinions because the communication was led exclusively by their doctor. The infaust prognosis was systematically withheld from patients, the result of which was that the patient, their doctor and their fully informed family played a game: they pretended not to know anything and left the patient to unmerciful loneliness and anxiety. An unproductive man was regarded as a ballast to society. Patients in the terminal stage of disease were hidden behind a white divider and abandoned until death. Windows were opened in severe cold during the winter or nurses took them directly to baths in cold water. The journalist Eva Maraulasová stated the following: “When I was on business in one hospital, I experienced a literally terrifying event for my character here. At the Intensive Care Unit, there was an about 5-year-old boy lying in a small bed near to the window. He was undressed, curled up, a real crestfallen – and behind the windows it was snowing, since it was February. I asked the nurse performing her service, how it was possible that a child was lying naked under the slightly opened window here, that he would catch a cold, that... ‘He doesn’t care about it anymore; he will die

of leukemia anyway.' Why add to it? Maybe only so much that I can see the boy till today [...]" (Maraulasová, 1991, p. 6).

On the other hand, dehumanization in medicine has deeply affected a number of health care professionals, both human-minded and Christian-minded in particular. They did not agree with the socialist view of a man and this health care system and desired a change. One of these was the young doctor Marie Opatrná at the beginning of 1980s.

3. First attempts for establishing a hospice

Marie Opatrná graduated from the Faculty of Medicine at Charles University in Prague in 1981 and immediately began working full of enthusiasm at the Department of Oncology, Kladno Hospital (Central Bohemia). Assisting dying individuals, she was shocked by the way in which they passed away. She found very quickly that they not only needed surgery, radiotherapy, chemotherapy, or hormonal manipulations but also another kind of care: psychological and spiritual support. Using the time of duties in the afternoons and evenings for interviews with patients, she was confronted by their existential, spiritual, and religious needs. Despite the omnipresent socialist ideology, some of them longed for a meeting with a catholic priest and to receive holy sacraments. However, it was very risky to contact a priest or a pastor; Marie knew that such a step was illegal and if she did it, she could be denounced and punished. After receiving her postgraduate certification in radiotherapy (of the first grade) in 1988, the management of the hospital announced that she was politically unreliable and that it would not give her permission to apply for postgraduate certification of the second grade.

Marie decided to leave Kladno Hospital and started working in Prague at a newly established out-patient oncology center. The problem was that this center lacked an in-patient department, and thus there was no continuity of care. As a result, Marie was confronted with a new challenge: How to take care of pre-terminal and terminally ill patients? Most of them had no one to take care of them at home, and hospitals also did not want to accept them. At that time, Marie learned for the first time how people can pass away with dignity in the West: she learnt about hospices.

After the fall of regime in November 1989, Marie immediately began to set-up the first inpatient hospice in Czechoslovakia. She addressed the leading specialists in the area of oncology: Prof. Josef Koutecký, Prof. Jiří Zámečník and espe-

cially Prof. Pavel Klener, the first post-revolutionary Minister of Health, who all stood up for Marie's idea. Klener approved her project in January 1990.

Marie, along with some other enthusiasts, founded the *Christian Association for Helping Cancer Patients*, of which members the first palliative team was born. She also got in touch with Olga Havlová, the first wife of President Václav Havel, and former Olympic champion Věra Čáslavská, asking them for support. To raise some money, she began organizing benefit concerts. These concerts took place predominantly in Prague catholic churches. In particular, two artists participated: organ and cembalo player Marie Šestáková and trumpeter Ladislav Kozderka. Thanks to foreign contacts of Prague Bishop František Václav Lobkowitz, a significant sponsor from the USA was found who promised to finance the equipment for the entire workplace. Thanks to the generosity of one Belgian hospital where Marie was able to study for a short time, the future hospice gained a donation in the form of medical material and clothes for the staff.

At the same time, Marie prepared for her postgraduate certification (of the second grade) in clinical oncology. In 1991 she submitted a written work entitled *The Hospice Movement* (Opatrná, 1991), in which she presented her project. Her main idea was to establish an in-patient hospice that would be part of the oncology center. She intended to offer oncology patients continuous therapy and care until their natural demise. With her idea she was ahead of time. E.g. the European Society for Medical Oncology began promoting the full integration of clinical oncology and palliative care in its program only in 2003.

There was an old building of the former maternity and gynecology hospital in Prague 6, at Rooseveltova street. As it was missing most of the modern technical and laboratory facilities, it had to be closed. Marie proposed reconstructing it into an in-patient hospice and to realize her project here. For this idea, she had to win over the management of the District Institute of National Health (DINH), members of the District National Committee (DNC) of Prague 6 and also the project and construction company, with which the DINH made a contract and which was commissioned to achieve the redevelopment. Arduous expert, technical and organizing negotiations followed, during which each part tried to push through its own opinion.

Two reconstruction projects were finally accepted: a very expensive and many times reworked project of the company Puroklima and a very cheap student project of the Faculty of Civil Engineering of Czech technical University in Prague, worked out free of charge – by students under the tutelage of associate Prof. Karel Bloudek, who was seriously ill at that time. Puroklima made a commitment to finish the reconstruction and modernizing works by 31st Decem-

ber 1992. During these works, the DNC found out that the proprietary rights to the building were not clear, that it was protected by preservationists and that the design documentation of Puroklima was insufficient. Despite this, the DINH enforced further cooperation with this company. In February 1991, the house remained without a roof so was exposed to negative weather conditions. In summer 1991, Marie unofficially heard that the project would no longer continue, but this was only officially confirmed to her in September 1991. Instead, she received another proposal from the DNC: to realize her project in one of the buildings of a former day nursery. In November, a totally exhausted Marie fell seriously ill and the house in the Rooseveltova street had to be pulled down, which meant the factual end of her project.

The reasons why this project failed were the following: the aversion of Prague society to seriously ill and dying persons and persisting communist thinking; incomprehension of the DNC³; irresponsibility of the management of the DINH; the arrogance and reluctance of Puroklima to follow the basic requirements so that the facility met the standards of an inpatient hospice, associated with a non-transparent increase of financial costs; and the irresponsibility of preservationists and an unresolved proprietary relation of Prague 6 to the building.

4. Origin of the first hospice

In the first years after the Velvet revolution (1989) there was a very optimistic atmosphere in the Czech Republic: real joy from the newly obtained freedom, the opening of borders across the world for unexpected possibilities, but also the challenge of using freedom responsibly in a democratic society. In this atmosphere, another doctor tried to change the way in which dying people passed away and to enable a lot of families to look after their members late in life: Marie Svatošová.

She was born in a small village Hlavňov (East Bohemia) in 1942. Her parents were catholic; her father worked as a teacher at the local elementary school. The catholic faith caused large problems for little Marie. As a child, she wanted to become a nurse, but the director of the elementary school did not submit her application form in time. In fact, as a catholic, she was considered politically unreliable. Despite this, she successfully graduated from the Secondary Nursing School

³ The only person who understood the vision of Marie was a deputy mayor, a woman, who lost one of her parents because of a tumour-associated illness. She knew very well what it meant in the current circumstances...

as one of the top students; however, she was not allowed to carry on at the Faculty of Medicine. The reason was the same: she was catholic and not a member of the communist party. After one year of service as a nurse in Hradec Králové, she was admitted to the Faculty of Medicine in the same town and graduated in 1968. Afterwards, she began working at the Department of Medical Ward of the Hospital in Semily (Central Bohemia); three years later she moved to Prague where she received a place as a company doctor of the factory AVIA and later of the Public Transit Company. During her service as a general practitioner, she realized many times how insufficient the care was for old and ill people, that conditions for dying with dignity were not ensured and that the social system did nothing for families who would like to serve their closest members until their death. Marie wanted to help families who wanted to stay with their dying relatives, but she also realized very well the danger of the possible subsequent legalization of euthanasia in the Czech Republic and decided to avert it.

The real impulse for the radical change in her life came in 1988 when she got a samizdat issue of the journal *Salus* in which she read an article about Cicely Saunders, about the existence of the Hospice St. Christopher's in London and about the Hospice Movement in general (Sandersová, 1988, pp. 15–17). The official media did not broadcast information of this art and it was not easy to come by it in a totalitarian state which had the monopoly on everything. Every official attempt to change this *status quo* was illegal...

Immediately after November 1989, Marie handed in her notice in the health care sector, became an employee of the emerging Czech Catholic Caritas and began going around the republic, giving lectures about dying with dignity and seeking co-workers. Her first question was: what should we start with? Is it real to push through the idea of a hospice in the current medical facilities? To begin with, she concentrated on the financially less demanding home and family-centered care. In association with Caritas, she successfully mobilized tens of nurses and trained other caregivers, who were enthusiastic about the idea of hospice, and were ready to help families of patients with an infaust prognosis. Thanks to her contacts of friends working in the Ministry of Health (e.g., Václav Filec) and especially thanks to the positive attitude of the Minister of Health, Prof. Pavel Klener, these activities were legalized in the form of a two-year experiment in 1991. At the same time, Marie also received the first state subvention for it. It was in the period before the first health insurance companies were created. In 1993, a network of 41 fully functional centers of Caritas Nursing Care (CNC) was established. Their nurses looked after ill people with an infaust prognosis in the first place, meaning that they *de facto* supplied the missing home hospice care.

The problem was the financing of the CNC, because the newly-emerged insurance companies refused to pay them; e.g., the top management of the General Insurance Company stated in one negotiation with Marie: “If you do not care for the ill persons, they will die and we will not pay anything for them.” For many years, no payment regulation existed and nurses working in the CNC received many nonsense tasks from the insurance companies. With the justification that there was a need to normalize the work first, the nurse had to gauge on a stopwatch how many seconds she needs to take up medicine into a syringe, how much disinfectant agent she needs for disinfection of the skin before the injection, etc., which cost a lot of precious time. Nevertheless, the insurance companies were not satisfied and gave back the work to rework. The home care appeared on the list of payment regulations only after several years. The CNC survived through the most difficult period exclusively thanks to the selflessness of their employees and the financial support of some donors (Svatošová, 2018, pp. 132–133).

In 1993, Marie abandoned Caritas and exclusively pursued hospice care. For this reason, along with two colleagues, Jiří Černý and Alice Hložková, she founded the citizen’s association *Ecce homo*, whose goal it was to ensure hospice care for 10 million citizens of the Czech Republic. The strategy of this association was as follows:

1. Public talking about dying and death,
2. Building the first inpatient hospice,
3. Sharing the experience from the hospice in the form of lectures, seminars etc.,
4. Promoting the idea of hospice in all locations where people die (Svatošová, 2006, pp. 9–10).

Marie also searched for help abroad. A certain religious sister, Florence, whose contact information was unfortunately lost, came to the Czech Republic from the USA for some months at the invitation of the Ministry of Health. Florence was convinced in the beginning that there was no need to have an inpatient hospice in a country which provides a well working network of home hospice care – similar to Great Britain. However, another argument and social background convinced her after some months to change her mind: the Czechs need both. Thanks to a Czech emigrant Zuzana Poláková and a Jesuit priest Jan Lang in London, Marie and her co-workers Miroslav Wajsar and Božena Špuláková spent three weeks in several hospices in London (including St. Christopher’s) in 1994, where they got to know in more detail how an inpatient hospice works. Wajsar then became director of the first Hospice in Červený Kostelec (North-East Bohemia) and Špuláková worked as a nurse in the same facility for about 20 years.

One of the things that the Czech delegation changed after they returned home was the design of the first hospice. It was planned for 52 patients who were accommodated in 26 double-bedded rooms. At the recommendation of English colleagues the project was changed and a single room was assigned to each patient. The other bed was replaced by an extra bed for a family member of the patient. Although this change meant a decrease in the capacity of the facility, which was not easy from an economical point of view, it was shown to be a fortunate solution. The future patients unequivocally preferred their privacy in single rooms with the possibility of accommodating their relatives and the possibility of spiritual talks on very private topics.

On 8th December 1995, the first inpatient Hospice of St. Agnes of Bohemia was opened in Červený Kostelec. This event presented a real breakthrough in the care for terminally ill and dying individuals in the Czech Republic. With the financial support of the state, sponsors and donors, other hospices followed very quickly: Strasbourg in Prague (1998), Lazarus in Plzeň (1998), St. Joseph in Rajhrad (1999), St. Stephan in Litoměřice (2001), Hospice on the Holy Hill near Olomouc (2002) and many others.

In the 1990s, they were regarded as “examples of good medical practice” for other health care facilities in the introduction of continual pain therapy, and in the usage of modern tools of nursing, including adjustable hospital beds, anti-decubitus mattresses etc. The first Hospice of St. Agnes of Bohemia welcomed several excursions every week in the first years of its functioning. It attracted not only medical staff members, but also different politicians who wanted to be inspired by it.

Marie Svatošová still works as a tireless promoter of the hospice movement, and has received some significant honors and decorations: Medal of Merit (Third Grade) in 2002, St Wenceslas Medal in 2008 and Medal of Merit for the State in 2015. In 2020, she was dubbed “Knight of the Czech Medical Profession”

5. Some current challenges

Currently, there are 18 inpatient hospices in the Czech Republic; the construction of the 19th is also underway. Their providers are catholic Caritas (4 hospices), Diaconia of the Evangelical Church of Czech Brethren (1 hospice) and various associations – mostly citizen’s associations (13 hospices). In 2005, their representatives united their forces and formed the *Association of Hospice Palliative Care Providers* (AHPCP).

A large challenge for the whole hospice movement in the Czech Republic is the unresolved legislation and financing connected with it. The Czech legislation (Act No. 372/2011 Sb.⁴) has not known the term “hospice” until recently. After its amendment in 2017 (Act No. 290/2017 Sb.), “hospice” is defined as follows (sec. 44a): “(1) With hospice, a provider is understood to provide health services to incurably ill patients in the terminal stage in special inpatient health facilities of hospice type or in the own social milieu of the patient. (2) The hospice ordinarily provides patients and their close relatives with other consequential services according to other legal regulations.”

Palliative care includes services on different levels and is characterized by a multidisciplinary approach. At least two levels are distinguished here: general and specialized palliative care. While general palliative care is provided by medical staff members within the purview of their expertise, specialized palliative care is more dimensional and requests the existence of a multiprofessional team (Tomeš *et al.*, 2015, pp. 24–25; Záleská, 2018). It is linked to the fundamental question: who will finance it? The Czech law (Act No. 372/2011 Sb.) defines palliative care as “the care whose aim is the alleviation of pain and the maintenance of quality of life of the patient who is suffering from an incurable disease.” (sec. 5. 2h). However, the precise definition of general and specialized palliative care, which is crucial for payment from insurance companies, cannot be found in the Czech legislation to date. Therefore, the provision of specialized palliative care, within the purview of the care paid by insurance companies, is *de facto* not possible in the Czech Republic (Tomeš *et al.*, 2015, p. 25).⁵

Hospice facilities are recognized as non-state medical facilities in the Czech Republic. The funding from health insurance is not sufficient for hospices to fulfil their mission. They are financed unsystematically, from other sources, with some uncertainty surrounding whether they will receive the required financial sum to pay for the services offered (Tomeš *et al.*, 2015, pp. 62–63). The working of hospices is currently financed from: insurance companies (55%), state subventions, grants and donations (20%), and state benefits – social insurance (8%), collections (10%) and participation of clients (7%). About 20–40% of the total costs of hospices have to be arranged from donations and collections (Tomeš *et al.*, 2015, pp. 31–32). On the topic of hospices’ funding their long-term development

⁴ ‘Sb.’ stands for the Collection of Laws of the Czech Republic. Czech legislation has been retrieved from www.beck-online.cz.

⁵ For more about the current Czech palliative care in the different context, see: Vorlíček, J., Adam, Z., Pospíšilová, Y. *et al.* (2004) *Paliativní medicína*, 2. ed., Praha: Grada; Bužgová, R. (2015) *Paliativní péče ve zdravotnických zařízeních. potřeby, hodnocení, kvalita života*, Praha: Grada; Ratislavová, K. (2016) *Perinatální paliativní péče*, Praha: Grada; Bužgová, R., Sikorová, L. *et al.* (2019) *Dětská paliativní péče*, Praha: Grada.

depends, especially important is the question of the possible extension of offered services.

Another big challenge is the absence of rules for continuous health care in different medical facilities. There is a certain kind of rivalry among hospices, departments of long-term care in state hospitals and health insurance companies. The oncology patient cannot choose where they will stay for the rest of their life. In-patient hospices accept clients in the last stages of life. If the state of health of these patients improves, they are transferred back to state hospitals. The reasons for this are the rules surrounding the funding of beds and pain therapy. However, complex care is not provided in departments of long-term care. The employees of hospitals also behave differently. We cannot meet the social and spiritual services here as we know them from in-patient hospices (Tomeš *et al.*, 2015, pp. 51–53).⁶

Except the challenges of the legislative-financial framework the Czech hospice movement has to face the whole range of myths and fables which circulate among the people. Let us mention only the best-known of them:

1. Hospice is a house of death,
2. Hospice fits for every dying person,
3. Hospice is a luxury medical institution for long-term ill patients,
4. Hospice is only for believers (Haškovcová, 2007, p. 76–77),
5. Hospice is only for old people.

Doctors and persons actively involved in the palliative care take these prejudices into account and try to raise public awareness of the real role of hospices and of the principles of palliative strategies.⁷

6. Conclusions

The example of two big personalities of Czech medical care regarding the end of human life, Marie Opatrná and Marie Svatošová, shows that at the beginning of the hospice care era in the current Czech Republic, there was a non-profit seeking desire of two enthusiastic doctors who had their eyes opened, who perceived the needs of dying patients very well and who wanted to change the cur-

⁶ The issues of spiritual support in the context of hospice care in the Czech Republic is treated here: Svatošová, M. (2012) *Víme si rady s duchovními potřebami nemocných?*, Praha: Grada. See also: Opatrný, A. (2017) *Spirituální péče o nemocné a umírající*, Červený Kostelec: Pavel Mervart.

⁷ As a particular act of the health education director of the Czech Television Adéla Komrží produced a documentary *Jednotka intenzivního života* in 2020. It gives insight into the first Clinic of the Palliative Medicine in the Czech Republic. This clinic is situated in Prague and was founded by doctors Kateřina Rusínová and Ondřej Kopecký on 1st January 2021.

rent inconvenient health care system into another, more human one: all at the expense of immense personal sacrifice, their own health included. Both ladies are still getting involved in the health education; each of them in her field of interest.

When Marie Opatrná got seriously ill, she met the other side of Czech health care. At once she did not stand at the bed of an ill person as a doctor but she herself was in bed as patient. She met both selflessness of her colleagues and nurses and arrogance and ruthlessness of the medical staff. In this situation she made a firm resolution: if she succeeds in getting out of the illness, she will teach and train future nursing staff, how to come up to ill people, how to communicate and how to deal with them (Opatrná, 2008, p. 9). She is still active as a teacher and she engages especially in the field of hospital chaplaincy.

Marie Svatošová spent an essential part of her life at the beds of dying and terminally ill persons. She gained an immense quantity of experiences. Travelling around the whole Czech Republic and giving lectures about the hospice movement and the palliative care she spoke about the art of accompanying the patients. To accompany a person means according to her to go a part of journey with him or her. Even if it is only a very short period of life, it can pose very much especially for a person who feels totally abandoned from the others. Dying with dignity is then closely connected both with an effort to bring more expertise into the home care and to involve the family and close friends in the hospital care – closer to the suffering person. If this goal is not possible to achieve at home or in a hospital, it will surely be accomplished in an inpatient hospice (Svatošová, 1995, p. 19).

Concluding we would like to state that the quality of the care at the end of human life in general consists in particular people. It is not important who is the founder of an inpatient hospice or of another palliative care facility but who is just on duty at my bed. In other words: if I am treated with respect which belongs to me as to a unique human being.

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