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THE ORIGINS AND DEVELOPMENT OF THE MODERN HOSPICE MOVEMENT IN THE CONTEXT OF ONGOING DEMOGRAPHIC AND SOCIAL CHANGES IN THE WORLD¹⁾

ABSTRACT

The modern hospice movement in the world owes its contemporary image to the actions of Cicely Saunders in the 1960s. The initiatives undertaken in the field of palliative care at the time resulted in the development of services supporting dying patients and their families. Hospice care has its origins in the development of the history of societies in ancient times. In successive historical epochs, one can observe specific changes related to society's attitude towards illness, dying, and patients' specific care needs.

The aim of this paper is to present and describe the changes that have occurred within projects related to the implementation of services for the dying and their families. The outline of the historical context will allow us to gain a deeper understanding of the contemporary image of the hospice movement in the world and to understand why current palliative care initiatives support specific groups involved in the so-called limit situations. The presented description is based on the thematic content analysis of domestic and foreign literature and will cover the period from ancient to modern times.

Keywords: hospice care, palliative care, hospice

INTRODUCTION

The aim of the paper is to present the origins of the modern hospice movement in the world, especially in Europe and the United States. More information about this topic is provided on further pages of the paper.

¹⁾ Bibliographical note of the first edition: "Praca Socjalna", 2017, No 2, pp. 155–174.

First, the demographic and social background will be presented as a contributing factor for the present condition of the hospice institution. Second, I will present the current definition of the term „hospice” alongside its historical context. The next part of the paper will outline the characteristics of palliative care in European countries, starting with the activities of Cicely Saunders, through the specificity of the hospice movement in post-communist countries and ending with current activity with the presentation of programmes supporting people and their families. Next, I will discuss the condition and structure of the modern hospice movement in the United States, as well as the vital role of an appropriately selected and professional nursing staff, including social workers. In summary, I will try to summarise the most important aspects and will stress the need for further involvement in palliative care and raising awareness about it.

Most of us associate the term „hospice” with death and with a place where incurably ill people die. In this sense, it is a term that has negative connotations. This is because death is a phenomenon which is suppressed, rejected and therefore unfamiliar, which in turn leads to a feeling of anxiety. As Zygmunt Bauman (1998) suggests, after Edgar Morin, death is a „[...] void, [...] the ultimate absence of ‚non being’”. The conscience of death is, and is bound to remain, traumatic.” Death appears to be a factor or an element that interrupts man’s duration. The perspective of physical departure (if we believe in the afterlife) destroys all efforts and actions of the individual. For everything is „vanity of vanities, all is vanity” (Ecclesiastes 1:2, English Standard Version).

In the United Kingdom, for example, a large part of the population is unaware of the possibility of using social care, which means that the difficulties and sometimes the hardships of dealing with illness and dying concern a very narrow circle of relatives (Dixon, 2015). Also in Poland this situation is not unambiguous, as Piotr Szukalski points out (2013) „due to the natural decline in the domestication of death in the past epochs [...] psychological stress resulting from the loss of a loved one has not decreased, but on the contrary – it is growing. The stress is probably significantly greater also for dying people whose last days and hours of life more and more often pass in an unfamiliar environment.” Due to the fact that the place where people die most often is hospital (50.6%) and this is an upward trend compared to previous years (ibid.), we are dealing with the phenomenon of dying devoid of any quality and emotional comfort. This phenomenon increases the ignorance of the functionality and usefulness of

the hospice institution, including hospice at home services, also when palliative care is needed for the terminal patient.

The visible destruction of the human body is an additional and undeniable sign of the approaching death (Bauman, 1992). Institutions for people with infirmities are places that present a picture of old and ill people. It causes fear and ignorance about these institutions, which in turn leads to the fact that hospices are rarely spoken of, if not at all.

DEMOGRAPHIC AND SOCIAL BACKGROUND

Population of elderly people

It is worth mentioning the growing importance of hospices in the modern world, which is associated with demographic changes. Since the beginning of the 20th century human life span has been growing in most regions around the world. According to expert estimates, this process will continue to progress. The global population of people aged 80 years or over is projected to increase to approximately 400 million in 2050 (WHO, 2012a, p. 10).

Participation in the global society of people aged 65 or older will rise from 7% in the second half of the 19th century to the projected 14% in 2040. During this period, the number of people over 65 years of age is expected to double. These changes will be the fastest in Europe, North America and Central Asia (Kinsella, He, 2009, p. 11).

The population of European Union member states in 2014 amounted to 506.8 million people with 18.8% being people over 65 years of age. In Poland, people over 65 in 2014 represented 14.9% of the population. The average Polish man lived an average of 72.4 years in 2010, and the Polish woman 80.9 (Szukalski, 2013, p. 1). The European country with the highest percentage of aging population was Italy, where the population of people aged 65 years or over was 21.4%. The growth trend in the number of people in this age group is characteristic throughout the European Union (Eurostat, 2014). Moreover, statistics produced by the World Health Organisation indicate that life expectancy, which is 60 years, will extend further, with this process being twice as fast in developed countries as in developing and underdeveloped ones.

Thus, European women are expected to live an average of 23 years longer and men an average of 19 years longer. In America the average number

of years lived by women and men aged 60 years or older will be 24 and 21, respectively (WHO, 2012a).

Morbidity of elderly people and hospice support

The quality of life of people over 60 years of age is a completely separate issue. There are various determinants for this situation: firstly, continuous progress in the field of medicine, and secondly, a continuous increase in chronic conditions, the so-called civilisation diseases.

I would like to point out here that as many as 46% of people in this age group suffer from some kind of disease (WHO, 2012b). Life expectancy with an incurable disease diagnosis also extends over time, which in turn increases the length of hospice service for patients and their families. As shown by NHPCO research conducted in 2012, the number of patients who received hospice help in the United States has increased in recent years. In 2008, an estimated 1.2 million patients received hospice care, whereas in 2012, an estimated 1.6 million people received such care (NHPCO, 2014). The length of hospice service for dying patients also increases. The average length of service in 2010 was 67.4 days, and two years later it increased to 72 days. 11.5% of all patients remained under hospice care for longer than 180 days (*ibid.*).

It should be noted that the main recipients of hospice care in the United States are elderly people. In 2011, 83.2% of hospice patients were aged 65 or older and in 2012, 84.5% (*ibid.*). In Poland, in 2007, there were 130,000 cases of people seeking medical treatment for cancer and 80,000 deaths from cancer. This is an upward trend compared to previous years (Jamel et al., 2007).

The Maria Skłodowska Curie Memorial Cancer Centre in Warsaw presents data which show that three years later, the number of „new” cases was above 155,000. At the same time, deaths from cancer concerned respectively 52 thousand men and 41 thousand women (Wojciechowska, Didkowska, Zatoński, 2013). In addition, as reported by Home Hospice of the Marians in Warsaw²⁾, there are a total of about 400 patients each month under its care, with about 100 patients leaving hospice care in the mean-

²⁾ Its formal and full name is Non-Public Health Care Center Home Hospice Centre of the Marian Fathers' Congregation. The origins of the institution date back to 1989. The hospice has been operating under this name since 1998.

while (<http://www.hospicjum-domowe.waw.pl/o-nas/co-to-jest-hospicjum>). If we multiply the number of all hospice facilities in Poland (their number amounted to 349 inpatient facilities in 2008) by the number of residents, it would turn out that there are almost 140,000 patients in these facilities (http://www.hospicjum.krakow.pl/hospicjum/forum/organizacja_Opie.pdf). However, due to the fact that not all hospices prioritise inpatient hospice support and home support equally, we should be careful when presenting such statistics.

Transformation of social bonds and family support

As I have already pointed out, the prospect of living longer with an incurable disease diagnosis is a consequence of broadly understood advancements in the medical field, availability of modern treatment methods and tools, universal access to health care, as well as preventive actions and the dissemination of knowledge about health-promoting activities (Jack et al., 2014, p. 136). Particularly noteworthy are hospice at home services. The transformation of social bonds is evidenced by such phenomena as:

- an increase in the number of small households;
- migrations (more frequent) of family members (i.e. people who could possibly care for a dying loved one);
- the pursuit of a career among younger family members;
- an increasing number of divorces.

This, in turn, encourages providing the best possible care conditions for dying people and family carers (ibid.). We have been observing a decline in the number of people getting married in the European Union, with a double increase in the number of divorces in recent decades and labour migration flows mainly among people under 35 years of age (2,320,000 Poles stayed temporarily abroad in 2014, which is an upward trend compared to previous years). All this together means that families and thus naturally designated carers are dispersed (CSO, 2015, p. 2). The bond between family members relaxes, which makes it necessary to use the resources of palliative care institutions, including in particular home hospices. According to research, people at the end of their lives express a wish to die at home (Clark, Centeno, 2006, p. 199). In the further part of the paper, the stages of hospice activity will be presented with special emphasis on initiatives that took place at the beginning of the second half of the 20th century. For starters, let's look at the definition of „hospice”.

Definition of the term „hospice”

This term „hospice” had or has several meanings. Its key meaning in this field has remained unchanged over the centuries and has been functioning in inter-social communication to the present day. Over time, the term evolved and changed its meaning. It originally meant a shelter for pilgrims in the Middle Ages. These days, „hospice” refers primarily to a medical facility. Both meanings, however, have a certain common characteristic – the hospice has always meant safety and a shelter for those in need (Krakowiak, Modlińska, 2008, pp. 35–43).

Next, I refer to several dictionary definitions of „hospice” [*hospicjum*]. According to the Great Dictionary of Polish Language, it is:

- a) health care facility – a health care facility that provides medical and nursing care for terminally ill people living in a building designated for them or staying in their own houses;
- b) building – a place where the hospice is located, a health care facility;
- c) a lodging for pilgrims: an institution that offers hospitality to pilgrims or other people who stay outside their place of residence;
- d) building – a place where the hospice is located – an institution that offers hospitality (www.wsjp.pl).

The Dictionary of the Polish Language gives the following definitions:

- a) a facility for terminally ill patients;
- b) *archaic*: a guest house;
- c) *archaic*: student accommodation (www.sjp.pwn.p).

Although the cited definitions are clear, coherent and transparent, the discourse on this topic uses „hospice” (according to the World Health Organisation) interchangeably with terms such as „palliative care” and „hospice care”, which reflect the activities of this facility (Łuczak, 2013, p. 1). So we have „hospice” and „pallum” – two terms that make up a coherent whole (Kurczewska, Jasińska, Orszulak-Michalak, 2010, p. 94).

The International Health Organisation (WHO, 2012b) emphasises the importance of the three overarching elements that form a complete definition of palliative or hospice care:

1. providing the patient with care as early as possible, preferably during the course of treatment dedicated to extending his/her life (active);
2. pain relief;
3. expanding the list of patients eligible for HHC.

On this basis, it should be stated that hospices are aid institutions for people with a cancer or chronic disease diagnosis. Eligibility for hospice care also includes dysfunctions resulting from central nervous system diseases, HIV, myocardial conditions, respiratory failure and decubitus ulcers (Regulation of the Minister of Health of 2009). Hence, the aim of hospices is to relieve pain and to provide comprehensive support guaranteeing the highest possible standard and quality of life at its end related to the above-mentioned conditions.

THE DEVELOPMENT OF THE MODERN HOSPICE MOVEMENT

Cicely Saunders' work

The term „hospice” was used in the past in relation to a broad spectrum of activities meant not only for terminally ill people, but also for young students or travellers seeking shelter and rest. Nevertheless, the modern meaning of this term evolved from the aforementioned traditions. Usually, the purpose of church-based hospitals (just like the purpose of modern hospices) was to provide help and support for those in need. The term „hospice” was more and more commonly used to describe a health-care facility looking after dying patients, and it entered common usage in about the mid-1960s. At the time, the first palliative care units were established all over the world, serving as a model for the next ones. The institution of hospice is supposed to provide a ready but, above all, appropriate solution that meet a terminal person's emotional, psychological and medical needs (De Walden-Gałuszko, 2007, p. 37).

The birthplace of current standards of palliative care is thought to be Great Britain where in 1967 in Sydenham the first modern hospice was established: Saint Christopher's. Its founder was Cicely Saunders, who at the end of the 1940s was trying to implement the guidelines underlying the framework for action for hospice facilities (Ostrowska, 2005, p. 178).

Cicely Saunders spoke about the beginnings of her project at OFRH³⁾ congress in Cracow in 2000 in these words: „For us, at St. Krzysztof, history began in 1948, inspired by conversations or publications on hospice and palliative care, and understanding that the right moment has come to create a proper center. He is associated with the person of Dawid Taśma,

³⁾ The National Forum of the Hospice Movement. The forum discontinued its activities in 2009.

a Jewish refugee from Warsaw who died of cancer in a London hospital. As a social worker, I visited David almost every day during the last eight weeks of his life. He needed more and more care in connection with the growing symptoms of the disease, but even more needed to talk about his life and his feelings that he could do so little with him. During many of our meetings, we discussed our vision of a place where people could be helped by providing them with a more humanized type of help than in a crowded surgical ward of a hospital surgery" (Stokłosa, 2014).

The facility which was opened less than 20 years after the events described above, served as a model for the next facilities of this kind. After the first hospices were founded, palliative care was divided into home care and external round-the-clock care (24, Górecki, 2000). As a result of this division, the patient had, depending on his/her preferences and health condition, as well as his/her social situation, a broad spectrum of choices regarding the place in which he/she wished to stay as an inpatient.

In 1975, another breakthrough occurred which initiated an in-patient and an outpatient approach. St. Luke's hospice in Sheffield (<http://www.stlukeshospice.org.uk/about-us>) was the first hospice which undertook this initiative. It allowed families of terminally ill patients to get a bit more space for their personal lives and to distance themselves from the situation in which they had found themselves. At the same time, the initiative allowed patients to be in constant contact with other members of society. In the same year, the term „palliative care" was officially introduced to the public discourse and has been in use until now to refer to the management of pain, in particular cancer pain, but not only (Krakowiak, Modlińska, 2008, pp. 19–21).

Pain relief has since then been one of the priority objectives of the hospice movement policy. This objective found expression in the publication of the World Health Organisation document „Cancer pain relief" mainly in terms of the organisation of nursing staff, who since then was to provide the patient with an active, ongoing and professional support in the medical, psychological, spiritual and social fields (WHO, 1986).

The development of the hospice movement in the United States

The US hospice culture evolved and was inspired to act by the palliative care project proposed by Cicely Saunders. In 1963, she gave a speech at Yale University on specialised care for the terminally ill (<http://www.nhpco.org/>

history-hospice-care). Although the American hospice model differed in several aspects from the European model, the basic underlying ideas and principles were the same. One of the pivotal moments for the hospice movement in the United States was the publication of Elisabeth Kübler-Ross's groundbreaking book „On Death and Dying” in 1969. On the basis of interviews carried out with dying patients, she analysed and summarised the conditions in which these patients lived until then. At the same time, she pointed out the inefficiency and ineffectiveness of the services necessary for the normal psychophysical state of individuals staying in nursing homes. She stressed the importance of patient participation in decision making about his/her future and the need to deinstitutionalise the dying process. [She pointed to the constructivism of introducing the subject of home hospice] with the involvement of the family, availability of professional medical staff, and the provision of emotional, spiritual and financial support (Kübler-Ross, 1997, p. 48).

The development of the hospice movement in post-communist countries

The European hospices can speak about the renaissance of their activities in the 1990s. Their numbers increased at the time. In accordance with the objectives of the hospice institution, its main ideas included:

- an approach in which we treat the patient first of all as a human being, not as a patient⁴;
- the participation of patients' families in the disease process;
- constant support for patients and their families (Ostrowska, 2005, pp. 198–199).

During this period, special attention was given to the necessity of dissemination and implementation of palliative care objectives in Central and Eastern Europe countries. Most of these countries, due to their political

⁴ The distinction between “patient” and “human being” lies in the recognition of a broad range of the patient's needs (which I mentioned earlier), respect of his/her autonomy and the provision of not only medical support. In that respect, the dying person is not treated instrumentally, as an individual who receives only medical support, and the patient is treated as someone who needs to be administered an appropriate dose of medicine. The phenomenon of the humanisation of death guarantees the patient his/her intimacy and respect for his/her will and feelings. More about hospice care for the terminal patient can be found in A. Ostrowska, 2005, pp. 198–199.

system at the time, didn't take part in the development of the hospice movement. Among the satellite states⁵⁾, Poland was the precursor of activities for dying patients, followed by Hungary and then other countries (Janowicz, Krakowiak, Stolarczyk, 2015, pp. 40–41). While gathering data on hospice activities in these countries, it was found that

- the palliative care policy varies from country to country;
- the hospice activity remains underdeveloped;
- the number of hospice facilities is grossly insufficient for the number of people who need them (Clark, Centeno, 2006, pp. 18, 199).

Due to the need to catch up in these areas, the European Commission of the European Parliament prepared a strategy for palliative care in 2005. It focused on the need to address and improve the following aspects:

- specific diseases, e.g. cancer;
- professional care of older people;
- exchanging information on best practices;
- training for healthcare professionals;
- networking of organisations (ibid.).

Selected projects on palliative care in Europe

In addition, the Council of Europe took many initiatives aimed at improving the effectiveness of activities meant for terminally ill people. Within over two years of setting up a committee of experts, its report containing a set of guidelines on the humanitarian and comprehensive care of patients with an end-stage disease was adopted in 2003 ([www.coe.int/T/E/Social_Cohesion/Health/Recommendations/Rec\(2003\)24.asp](http://www.coe.int/T/E/Social_Cohesion/Health/Recommendations/Rec(2003)24.asp)).

The report highlighted the need to support families in the face of their loved ones' dying. In addition, it stressed the role of patients' choice of a place where they, depending on their condition and needs, should and would like to stay, as well as the need to employ highly qualified staff (Clark, Centeno, 2006, p. 199).

In 2004 the European Federation for Older People launched a campaign to make palliative care a priority. Specialists from 33 European countries

⁵⁾ A satellite state is a country that is under the influence of another country (a great power); the sovereignty of a satellite country is limited. In this case, the term refers to the countries in the Soviet sphere of influence in the years 1945–1989.

took part in the project. It was declared that modern palliative care should be based on the following values:

- human rights and patients' rights;
- democracy;
- solidarity, human dignity;
- equal gender opportunity;
- social cohesion;
- participation and freedom of choice (Davies, Higginson, 2004).

Current condition of palliative care in Europe

A common feature of the above-mentioned activities was the recognition of territorial diversity as a determinant of the nature of hospice care. Implementing new initiatives became a demanding task, especially in Central and Eastern Europe countries, which was the legacy of the socialist system. It should be noted that the offer of palliative care services is still insufficient in relation to the number of people waiting for hospice care. A similar situation occurs in Western Europe. This is evidenced by the results of the analysis of the number of beds dedicated to hospice patients carried out in 2005.

The United Kingdom and Norway were in the best situation at the time, with more than 18,000 and 23,000 specialist palliative care beds for patients, respectively. The worst conditions in this regard existed in Hungary, Ukraine, Slovakia and Lithuania. In these countries approximately 100,000 dying patients waited for a bed and in Lithuania more than 116,000 patients. Poland placed on the fifth position with an average number of hospice beds of 1 per 27,000 patients in need of palliative care (Gronemeyer et al., 2005).

Currently, the most common form of care for terminally ill patients is home hospice (Jack et al., 2014, p. 132). More and more attention is given to promoting awareness of the development of the hospice movement. In order to implement the most effective activities, theoreticians and practitioners in the field take into account the potential and limitations of a given region. International Observatory on End of Life Care (IOELC) links the development of palliative care services in individual countries with the following issues:

- current services;
- reimbursement and funding;
- opioid availability and consumption;

- national and professional associations;
- palliative care ‘coverage’;
- palliative care workforce capacity;
- healthcare system issues;
- partnerships and international collaboration;
- material on ethics and narrative-based accounts from activists (Clark, Centeno, 2006, pp. 198–200).

The development of hospice infrastructure in the United States

The first support center for terminal patients in the United States was established in the mid-1970s. The facility was founded by Florence Wald (Adams, 2008). The hospice movement began to expand its activities throughout the entire country. With time, more and more precise legal regulations were designed describing basic principles and a mission for this kind of institution. Soon after, a consultation team was formed for terminal patients at the St. Luke’s Hospital in New York, where it was possible to carry out medical procedures without the need to hospitalise the patient (<http://www.nhpco.org/history-hospice-care>). This initiative allowed patients to spend more time in a friendly environment, e.g. at home. It also gave families relief from watching over their loved ones who needed attention and care. At the same time, the introduction of this solution was a great way to prevent the social exclusion of these people. Because of their infirmities, they were until then isolated from other members of society.

The palliative care policy of the United States relies heavily on the guidelines issued by the International Health Organisation (WHO). WHO since the 1980s has been working on a project for cancer pain relief. For this purpose, it created a framework “How to relieve pain?” (<https://www.nhpco.org/history-hospice-care>). Pain relief has become one of the primary goals of the hospice movement in the United States.

Hospice services became a guaranteed benefit under Medicare in 1993 (ibid.). At the end of the 1990s, campaigns were launched to make the American public more aware of the importance of the quality of the dying man’s life and the need to educate medical staff about the European experience in the field of palliative medicine.

Since the beginning of the hospice movement in the United States, the number of hospices caring for patients at the end of their lives increased as did the number of people who required palliative care. The number of

people receiving hospice care grew to over a million in 2004. Two years later, the palliative care branch was officially recognised as one of the medical specialties, which only highlights the scale and importance of this issue (NHPCO, 2014, p. 4).

A careful analysis of research results for the United States found that patients who received hospice services lived on average 29 days longer than those who did not receive hospice care (*ibid.*). From our point of view, the period of less than a month seems to be a short time, not worth the effort. However, for a person who is aware of dying, each additional moment of life becomes unique and important. As long as the dying person is accompanied by a loved one during this period, and his/her pain is relieved, it was worthwhile to improve the quality of life of the palliative care patient.

In the United States, hospice services are currently provided by a team of professionals that usually consist of

- volunteers
- physicians
- clergy or other spiritual counsellors
- bereavement counsellors
- home health aides
- therapists
- nurses (Kurczewska, Jasińska, Orszulak-Michalak, 2010, p. 94).

In total, an estimated 1.5 million people received palliative care, including 36.9% of patients with cancer diagnoses in 2012. The average length of stay for hospice patients was almost 73 days. The report presented by the National Hospice and Palliative Care Organisation reveals that 66% of patients received home hospice care, whereas 41.5% and 18.6% of patients received care in private residence and in hospice inpatient facilities, respectively.

The largest available category of hospice agencies in the United States are independent, freestanding institutions. They represent about 57% of agency type. The remaining agencies are either part of a hospital system (20.5%) or nursing home (16.9%) (NHPCO, 2014).

Social Workers

I would like to bring a number of observations about social workers' activities in palliative care. These activities are so specific that they differ considerably from services delivered for other needy social groups. In this case,

social workers should be flexible in their activities and provide services concerning

- evaluation of a given issue and an attempt to solve a practical problem (e.g. help in doing the shopping);
- providing necessary and broadly understood information in the field of law, rules and regulations which allow the patient to function properly in society (Jaroszyk, 2015).

The role of social workers in this particular situation is to provide support wherever it is not possible for other staff taking care of the dying person and his/her family, or simply it is not in the scope of their duties. In order for the cooperation between the social worker and his/her client to be the most constructive, he or she is expected to have appropriate knowledge.

The social worker

- is familiar with the concept of social work;
- is able to communicate freely with the patient and his/her family;
- meets cultural needs of patients and supports families during bereavement;
- recognises the needs and expectations of those under his/her care (Bosma et al., 2008).

The social worker providing hospice care should be endowed with such values as respect for the patient, empathy and helpfulness, as well as consistency in pursuing his/her objectives and commitment (ibid.). The role of the social worker is important and useful for maintaining the proper functioning of the patient and his/her family. To what extent does the social worker participate in the patient's life? What is the actual area of care provision? I leave these questions open, highlighting the need to do empirical research on this issue in order to be able one day to lay the groundwork for the most useful model of care for the patient and his/her family.

Patients, depending on their capabilities and limitations they face due to their health condition, receive four general levels of hospice care:

- hospice care received at the place the patient resides;
- hospice care provided by professional medical staff;
- hospice care for pain management;
- respite care offering short-term relief to caregivers (American Cancer Society, 2014).

It should be noted that since 2008 the number of hospice programmes in the United States has increased from 4,850 to 5,560 in 2012. Of particular significance is volunteers' involvement in the hospice movement. There

were about 400,000 hospice volunteers in 2012. They donated more than 19 million hours a year, which accounted for 5% of all clinical staff hours (NHPCO, 2014). Hospice volunteers provide care mainly in the following areas:

- spending time with patients and families
- clinical support
- fundraising efforts (*ibid.*, 2014, pp. 11, 12).

In reference to these issues, it should be noted that patients, if possible, want to stay as long as possible in the familiar territory of home, where they feel more confident, calmer, simply better. The possibility of using continuous home care provided by professional medical staff during periods of crisis makes such a choice more and more often possible.

SUMMARY

The modern hospice movement in both the United States and Europe has grown from Cicely Saunders' initiative. It has given rise to current hospice practice. The aim of the paper is not to assess or compare these two territorially diverse trends. I wanted to sketch out the nature of palliative care projects which are either proposed or present in the policy of a given region.

The history of the hospice movement in Europe has a rich tradition. Today, its development is related to the increasing number of older people around the world (with the exception of a few regions), which means that more and more people are living longer. The number of cancer cases is growing too. WHO predicts that in 2025 an estimate of 14 million people all over the world will be diagnosed with cancer and by the year 2030, the global burden is expected to rise to 19 million (2014). The growing polarisation of society into poor and rich people, the widespread phenomenon of the so-called social callousness and the reformulation of the functions of the family (some researchers point to the disintegration of the basic social unit) (Witkowski, 2011), call for the need of an urgent comprehensive action plan for hospice patients.

All of the practices discussed in the paper are aimed at providing high-quality humanitarian care to palliative care patients. Constant hospice intervention is still indispensable. Implemented requirements and projects are, however, disproportionately low in relation to the number of people who need end-of-life care. However, since the problem has been noticed and the activity in the field is not declining, there is hope that the pallia-

tive care policy will still be developing dynamically in the future, if only because each of us will become ill and die one day. That is why today we should participate in activities expanding our knowledge and improving our skills to support people affected by the suffering of their loved ones.

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Transl. Anna Treger