Euthanasia and the Needs of the Terminally Ill

Merits and Risks of Voluntary Workers in Hospices

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Abstract

The aim is to look into the issue of euthanasia and its perception. What benefits can volunteers offer to improve the time spent by the hospice patients. The issue of euthanasia is broad, gaining lots of both supporters and opponents. This paper describes the issue from the logotherapeutic perspective. The opinion of patients on what may ease the stay in hospice is also taken into account. The main method used is the method of clinical cases, i.e. qualitative methodology, however, observations and conversations are effective methods as well. The method of conversation can only be utilized with communicative patients. The issue of euthanasia is highly sensitive. Its supporters perceive it as a humane way to terminate human life. However, the clinical cases show that on condition the patients are provided good care, i.e. their biological, psychological, social as well as spiritual needs are saturated, the do not tend to think about euthanasia as an option. The patients appreciate the comfortable atmosphere of the hospice. On condition the communication is satisfactory, they do not tend to think about euthanasia as an option. It is essential to cover all kinds of needs of the terminally ill. The calm hospice atmosphere benefits the patients, and the appreciate it very much on condition the communication is easily accessible.

Keywords: euthanasia; volunteer; hospice; dying

1. Introduction

The term euthanasia has not been truly thoroughly explored and evaluated in Czech society or elsewhere.

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Discussions among laymen and specialists are continuing as to whether it is right that individuals should be allowed at the end of their lives to choose to end those lives “prematurely”. That is either by their own decision and with the help of others to accelerate their death, or if it is meaningful to live, even if in very limited conditions, right up to the last “natural” breath. Is it ethical to keep a person alive who is already in a vegetative state and is not conscious of the world around him, himself or others? This paper focuses on the connection between the issues of euthanasia and the meaning of voluntary work in a hospice. The thing is that voluntary workers are often targeted by the patients with a request for help to “terminate” their life prematurely. However, the day-to-day experience shows that the request for euthanasia often correlates with insufficient attention to patients’ needs.

Before we join the discussion on euthanasia we should define what precisely it means. Often it is presented as death on request.† According to the World Medical Association – euthanasia is the conscious and deliberate carrying out of an act with the clear aim of ending the life of another person under the following conditions: the subject is a legally competent informed person with an incurable disease, who voluntarily requests that his life be ended; the physician concerned knows of the state of the subject and his wish to die and commits this act with the primary intention of ending his life; and the act is carried out with compassion and not for personal gain.‡

The word euthanasia is derived from the Greek roots eu-thanos, meaning “good death”. But what is a good death? It may be something different for each person. In Ancient Greece a good death meant that a person died in peace, was reconciled, composed and did not suffer: this was one of the reasons why the Ancient Greeks believed it was possible to cut life short. The stoics also sometimes considered it justifiable to shorten life, but believed that death should not be a hasty escape from life. The dying person was supposed to have a chance to bid farewell to his friends, be reconciled with his enemies, and divide his property.§

Currently there is much discussion around the problem of deciding whether treatment – even if well-intentioned – is genuinely bringing the patient some benefit and relief, or is just causing more suffering.**

In today’s world full of technology it can be hard to distinguish between the saving of life and the prolongation of dying. In 1975 a twenty-one-year old girl called Karen Ann Quinlan fell into a persistent vegetative state (PVS). A pallic syndrome or vegetative state (also known as coma vigile or protracted coma) is a peculiar type of breakdown of consciousness. It involves serious damage to the brain cortex or subcortical structures with continuing function of the brain stem. This state is usually irreversible (hence the so-called persistent vegetative state). In 1985 Karen Quinland contracted pneumonia, and died of it. She was not given antibiotics because this would have been qualitatively futile – the physicians could have prolonged her life for several more years, but the quality of her life was rated so low that treatment was judged to be futile. Nobody had any objection to this decision by the doctors. It was very different in the cases of two women who died at 15 and 17 respectively in PVS. The

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women died after long-drawn out court cases when hydration and feeding of the organism was discontinued. The ethical question is one centred on the question of whether hydration and artificial feeding using a tube is or is not obligatory care in such cases.‡‡

The problem of dysthanasia is one of care that is bad for all concerned, although worst of all for the patient. For example, cardiopulmonary resuscitation, when undertaken for a much longer time than it should be, causes broken ribs, with endo-tracheal intubation which can damage the trachea, and other serious problems. If the patient is under very heavy medication, which clouds his mind, or unconscious, what is known as “over-treatment” can be dehumanising. It means we are not dealing with the patient as someone who needs our help, but as a body, or part of a body from which we are expecting a certain effect – heartbeat, movement of the lungs to initiate breathing, hydration and nourishment of the organism. §§

If the relatives of a dying person tell the health staff, “Do everything, anything to save our loved one”, they may in fact be putting their loved one in a situation where they are abusing him through their unrealistic hopes. If someone is being given aggressively life-preserving treatment, it is psychologically harder to accept the subsequent deterioration of his state or his death. If professionals have not spoken honestly with relatives or the patient himself this can raise hopes that may lead him or his family to ignore or brush aside the fact that the treatment is no longer effectual. Health professionals unwittingly support this approach by a commitment to the idea that the prolongation of life is the fundamental goal, and that the fight with disease is always the most important priority; they thus encourage a “fighting spirit” or unjustified optimism. Yet there are approaches which would benefit the patient more in these situations. In the first place there is healthy communication between all concerned, then mutual support based on frankness and lastly others such as correct information, palliative care and enough love.

Superfluous and inappropriate care causes what is known as moral distress in all those involved. Moral distress arises in situations when people know or sense what ought to be done, but some external factor does not permit it; for example an institution is not willing or able to look after the patient in the way required. This is not just a matter of bad feelings, but can find expression in unsuitable behaviour to the patient or family, loss of patience, or even the development of burn-out syndrome. A situation in which someone does not do what he internally feels to be right may have an impact on his health, self-conception, spirituality, personal relations and the quality of his work. The American Medical Association describes futile treatment as a method involving aggressive treatment of an individual simply directed to preserving a life that is likely to end naturally anyway. ***

2. Arguments for and against euthanasia

2.1. Arguments for euthanasia†††

1. Everyone has the right to decide when and in what way he or she will die. If someone wants in his sphere of freedom to do something affecting him alone, and not thereby endangering another person, there is no reason to prevent him from doing so. The right to die is the moral right of every human being and no one has the right to impede his decision.


2. People own their own bodies. A person’s body is his property, and so the individual may do whatever he considers right with his body. Especially if that body is sick, decrepit, painful and uncontrollable.

3. Each person knows best whether or not the pain he is suffering is unbearable. Only the individual concerned can judge what pain he can or cannot bear any longer, and whether he would not rather die.

4. Euthanasia is a dignified death. One may die well or badly. And a bad death is not heroism. Every individual has the right to choose which death he prefers, and it is not shameful to choose a death that is good, quick, painless etc. Better a dignified death using euthanasia than a long and agonising death in a hospital or at home.

5. Supporters of euthanasia base their arguments on a hedonistic or utilitarian ethic. If the recipe for a happily lived life is the optimisation of pleasure and minimisation of pain over the long-term, then euthanasia is justifiable, because there is no reason to linger when the pain so much exceeds the pleasure. If a patient knows that he will not be rising from his bed, and is only waiting for death here and will never again encounter anything pleasant or any fine experience, there is no reason to wait for the natural arrival of death.

6. Euthanasia can be an act of mercy. There are countries, such as the United States or Great Britain, where citizens can be prosecuted for not shortening the life of a suffering laboratory animal but prosecuted for shortening the life of a suffering human being, yet the experience of pain is not so different for animals and people. What is considered key here is an act of mercy, intended to spare the suffering individual unbearable pain.

7. Euthanasia may be essential for the just distribution of medical care and resources. Every financial resource that is invested in dying people and patients whose deaths are long-drawn-out, will not be available for example for acute cases.

8. Euthanasia has always been practiced, for example by administering overdoses of morphine, and so it would be best to regulate it by law, clearly establishing what is and is not permitted.

Concrete case study: Chantal Sebire, a 52-year-old French teacher, was so facially disfigured by a particular form of cancer that she no longer wanted to live. She publicly asked the French government, specifically President Nicholas Sarkozy, to allow her death by euthanasia. The government responded that euthanasia was illegal in France. Mme Sebire reacted by taking a large dose of barbiturates, and died on the 19th of March 2008. Had euthanasia been legal, Mme Sebire would have been able to die in a deep sleep, or at least to carry out assisted suicide under the supervision of a doctor.

2.2. Arguments against euthanasia

1. There is no right to euthanasia. All so-called human rights (right to property, freedom of expression and so on) are based on the premise that human beings have an interest in maintaining their existence, and that the individual is most concerned about his right to life, to self-preservation. The right to life is then the basis of all the others. The right to death is not then comparable to other human rights and is not defensible. Jan Sokol sees “rights” in terms of reciprocal responsibilities to others. The right to life can therefore be understood as the imperative “Do not kill!”, and the right to property as the imperative, “Do not steal!”. If we accept this concept of rights, then notions like “animal rights” collapse, because animals cannot be said to have responsibilities. In any case, according to Jan Sokol, the idea that we have fundamental rights “from nature” or “from birth” is far from self-evident. More and more rights are being defined, but the question of where these rights come from and who accords them to individuals remains unanswered.

*** In order to present the opinions for and against euthanasia in an even-handed way, this section will be based on the same book, i.e. see Vácha, M. Eutanazie. In: Vácha, M. O.; Königová, R.; Mauer, M. Základy moderní lékařské etiky. 1st edn. Praha: Portál, 2012, pp. 250–256.
2. There is a clear danger of abuse. There are cases of patients where it is hard to see a reason against the use of euthanasia. At the end of the sub-section "Arguments against Euthanasia" we have given the case of Mme Sevire. We could find other similar cases. On the other hand, a particular case and a law applicable to all citizens of the Czech Republic are two different things. It is hard to imagine how any kind of legal norm would prevent the abuse of euthanasia. If this law was unfolded as an umbrella for everyone, I do not believe that we are ready to carry this responsibility, and sooner or later there would be serious abuse. A dying patient, lacking physical and mental resources, dependent on those around him and sometimes suffering mental disorder or depression, can be very vulnerable to pressure. Especially patients who have earlier lived very active lives can start to feel guilty about their complete dependence on those around them. Under the pressure that their new “role” exerts on them, they may fall prey to feelings that are not grounded in reality; they may all too easily believe themselves to be a burden and ask for euthanasia, but after a few months feel differently. Nor, of course, can we forget the financial aspect; a patient may feel a burden for members of the family and health staff, and it might even be insinuated to him that others might choose euthanasia, and that he is lingering on for selfish reasons, etc. Those of us with any knowledge of long-stay wards full of elderly people, whose children come and visit them just for the sake of money, will be all too aware that this could be a slippery slope to the abuse of euthanasia. The legalisation of assisted suicide or euthanasia may at first glance look like an enlargement of civic rights, but there is a risk of a slippage from the “right to die” to the “duty to die”.

3. It cannot be wholly accepted that every person has a right to decide when and how they die – euthanasia is not just a private agreement between patient and doctor, and more people are always involved in the whole situation. Euthanasia affects doctors and the relatives of the patient, and shows society the kind of value publicly attributed to human life.

4. The argument that everyone owns his own body and may do with it as he wishes can be countered by another form of categorical imperative: “Act in such a way that you use the humanity, both in yourself and in the person of another, always as an end and never purely as a means.” If an individual rejects the body whenever it causes pain, he is treating it as a means and not an end in itself.

5. Case studies from the Netherlands show that the slippery slope is no fantasy. The Remmelink Committee first drew attention to situations in which patients had been killed without an explicit request for euthanasia. The Brongers affair showed that a patient could be killed just for reason of age and weariness of life, without a concrete diagnosis. Another case given publicity: Chabot – here euthanasia was carried out on a 50-year-old woman with depression, which is not a terminal diagnosis. In the period 1997–2005 Dutch doctors admitted granting a “merciful death” to 22 children, and none have been charged. All these causes demonstrate that our society is already on the slippery slope, as is evident from sentiments now voiced in debates: that killing can be a good deed, that suicide is actually the rational solution to certain problematic situations, that natural death is undignified and euthanasia by comparison dignified, and the care for people who are too old, handicapped or otherwise disqualified or dying is an excessive burden which exhausts our emotional, human and financial resources.

6. The carrying out of euthanasia without an explicit request is problematic. If the element of active request for euthanasia is absent, the act is one of killing not euthanasia. Euthanasia means that the individual is aware of his state and does not wish to endure it further, but if for various reasons he does not ask for euthanasia and his life is nevertheless terminated this is not euthanasia. Doctors argue that patients are no longer able to indicate their wishes, but that if they were able to do so they would definitely request euthanasia. The ethical problem remains, however, that if the wish is not uttered (and in any case it may not be clear that it is uttered freely), nobody can presume to know what the particular person would or does wish internally, and to guess his wish in this most important matter – to end or not to end life – is at the very least unprofessional and unethical.

7. People mistakenly believe that “euthanasia is the solution to long and painful dying” and that it is the only way to escape pain and an agonisingly prolonged exit from life. There are possibilities, however, that can entirely
replace euthanasia and still ensure dignified dying and then a dignified death. These are palliative medicine and hospice care. If we consider the word dignity to be a value, something noble, exceptional and so on, then it is possible to die with dignity regardless of the “form” of dying. Dying in the circle of one’s loved ones or in a hospice facility with loving and kind staff is certainly dignified.

8. Against the argument that euthanasia can be an act of mercy stands the fact that man is the only being that seeks and can find meaning in his suffering. It is just because animals are not people that we can kill them so as to end their suffering, for an animal does not seek or find meaning in its own suffering. There is a qualitative difference between men and animals. A cube is in two dimensions just a square, but it has another dimension. Man is not just aggressive but expresses his feelings far more deeply. He can hate and love. An animal can then be killed to relieve its suffering, but with a human being the problem is much more complicated.

9. The law always applies to all and laws for all cannot be created just on the basis of individual concrete cases, however persuasive.

10. Some supporters of euthanasia argue that euthanasia is a just act in view of the need for an equal distribution of medical care, but the life of every person is precious, regardless of age. If this principle is not honoured, ageism will be encouraged. Every person has his dignity and as citizen has a right to palliative care. The Parliamentary Assembly of the Council of Europe passed a recommendation (no. 1418) in 1991 that stated in Article 8: The Assembly recommends that the Committee of Ministers appeals to all the Member States of the Council of Europe to respect and protect the dignity of terminally ill or dying individuals in all respects, by recognising and defending the right of terminally ill or dying people to comprehensive palliative care and by adopting the relevant measures:
   - to ensure that palliative care be recognised as an individual’s legal right;
   - to ensure that all terminally ill or dying persons should be accorded equal access to appropriate palliative care. Every patient should then have the right to palliative care and every patient should have equal access to it. It cannot then be argued that money invested in palliative care for old people should be invested elsewhere, for one could argue that about any kind of medical care – for handicapped individuals, children, alcoholics, people with mental disorders etc.

11. Against the argument that euthanasia has always in practice happened, and so it is better to regulate it by law, stands the fact that crimes like murder or theft have always occurred, but this is not held to be a reason for permitting them in certain circumstances. The murder of the innocent is always wrong. It remains then to consider to which category euthanasia belongs.

12. It is very hard for a dying person to freely and autonomously decide on the question of his being or ceasing to be. The sick person usually stands outside all rational argumentation of the kind possible in lecture-rooms or textbooks, treatises on ethics, and the theoretical discussions of people who are healthy. The dying person is in most cases at a clear disadvantage; he is dying, and even if his physical pains are alleviated with drugs, this does not mean that his autonomy is not influenced by psychological social or spiritual disequilibrium. Temporary pressure may induce a patient to make a decision that they would not make under more normal circumstances.

13. Euthanasia may lead to a slackening of efforts to find new types and treatments for the terminally ill and could become an economical solution for hospitals. In the worst-case scenario doctors might be pressured by hospital managements or insurance companies to try and persuade patients of the benefits of euthanasia, not because they considered it the best solution for the patients, but to save money.

14. The question remains as to whether one group should have the right to kill another group. Doctors do not study in order to terminate lives, but to save them. Recently there has been some discussion on the theme of whether euthanasia should not be carried out by someone other than a doctor – by someone specially trained. Furthermore, that if or just the patient asks for euthanasia does not mean that he genuinely wants it. If someone talks about suicide it does not mean that he wants to die, but that he needs help.
Concrete case: It is worth mentioning the case of Diana Pretty in 2001. Mrs. Pretty, 42 years old, was suffering from MND – motor neuron disease – and was paralysed from the neck down when she asked for euthanasia. Her paralysis meant that she could not commit suicide herself and she asked her husband Brian to kill her. He was willing to do this, but by British law he would be liable to up to 14 years in prison for murder. He asked for permission to carry out euthanasia, but the government refused it. Mrs. Pretty accused the British government of violation of her rights and brought a case against it at the European Court. The European Court of Human Rights in Strasbourg ruled that no such “right to death” existed, and supported the British government. The court expressed its sympathy for Mrs. Pretty, but stated that there was no legal right to die by the hand of another person or through assisted suicide. Mrs. Pretty died in May 2002 in a hospice facility, and her husband was with her to her last moments.

There is a thin borderline between euthanasia and insufficiency of attention to patient’s bio-psycho-spiritual needs. Of course, the care about the terminally ill is focused on their biological needs - the right temperature, pain management, good bowel movement and urination, the right humidity of mucosa, adequate nourishment, prevention of dehydration, etc. However, psychological and spiritual needs play just as important role in the life of a terminally ill as the biological ones. The correct psychological intervention and stimulation of spiritual needs are often the best means to eliminate anxiety and confusion. Open and honest communication is an inseparable part of quality care. Even in a hospice there are patients targeting the workers with a request to help them “terminate” their lives. When such a request is examined, it usually shows absence of something that can be replenished, such as unfinished matter with a relative, inability to forgive, a lack of contact or just a lack of open supportive communication with the patient. That is why the hospice workers should be sympathetic people who are able to provide understanding for the clients and their situations, and who are able to provide the best possible approach.

This role is irreplaceable, no matter whether provided by professionals or interns or volunteers. All these people affect the patient in a certain way and thus can motivate the client to bear the burden of their illness bravely, or, at least to bear it at all. Our aim was to find out how patients perceive the volunteers in the hospice. That is why a survey was carried out in St. Agnes’ of Bohemia Hospice in Červený Kostelec.

3. Methodology

3.1. The main and partial aims of the survey

The aim of the survey is to analyze the system of internship in a hospice by interviewing and observing the terminally ill patients.

3.2. Partial aim was defined as:

Analyze and reflect the present state of internship in St. Agnes’ of Bohemia Hospice in Červený Kostelec.

- Organize and record individual dialogues between a hospice client and a student
- Analyze the current state within the hospice by the means of observation and interviews
- Facilitate the direct contact between the clients of St. Agnes’ of Bohemia Hospice in Červený Kostelec and the interns
- Help the clients of the hospice to articulate their needs that can be saturated by the students
- Bring up inspiration for improvements in the hospice care
3.3. The selected survey methodology and its reasoning

A moderated, half-structured interview was selected as the most fitting method to obtain a detailed overview and insight into the internship state in a hospice. A certain pattern and questions created a framework for the interviews.

3.4. The description of the facility

The survey was carried out in a particular hospice - St. Agnes’ of Bohemia Hospice in Červený Kostelec. This non-state health and social facility provides care for the terminally ill, namely those with oncological diseases in the latest stages. It also serves as a model facility, providing experience for those interested, both from the Czech Republic and from abroad. It provides individual, compact care and palliative treatment with accent on quality of patient's life; further it offers consulting services and a medical aid rental.

The building of the hospice is in a symbolic shape of a boat, and is situated not far from the city center of Červený Kostelec at the address of 5. května 1170. The building is in the open space, barrier-free, with a lot of resting places and an indoor garden. There is a fountain in the lobby and a tea room where the patients and their families and companions can have a sit-down. This place is also a venue of many cultural events. The total of 20 rooms is situated on two storeys, providing the capacity of 30 beds (14 single-bed, 4 double-bed and 2 four-bed rooms).

The aim of the institution is also presented on their website§§§: “Our activities are based on the concept of uniqueness of everyone and of respect to their personalities. We are convinced that human life in any form is a precious gift, thus worth appreciation and protection. While taking care of terminally ill we try to fulfil the whole range of their needs for their dignified and full-bodied life. We strive to fulfil the days of the patient with life, by the same token, however, we respect the death as a part and parcel of natural life. Our activities consist of:

• endeavour to reduce physical and spiritual pain
• endeavour to respect human dignity
• offer of close personal relation”

Voluntary work and internship is highly appraised. The system and the organization seem elaborated.

3.5. The course of the survey

The survey was carried out between April and June 2015 during pre-arranged visits. The senior doctor or matron selected patients that were able to communicate. Each patient was asked whether he or she minded participation in the survey. The interviews were recorded with a sound-recording device and subsequently they were literally transcribed into electronic text form. The interviews were held in the natural atmosphere of hospice, either by the patient’s bed or in the common spaces of the hospice.

3.6. Method of data analyzing

Before the interviews were held, a set of questions was created that was used in each interview along with other, developing, additional questions that were supposed to clarify the core questions. Based on transformation of partial aims into suitable form, the obtained information from all eight interviewees was subsequently sorted.

§§§ www.hospic.cz
4. Results

First of all it is inevitable to point out some pitfalls and limitations of this survey. Firstly, the results are limited by a rather low number of respondents. The quality of the conclusion is influenced by the extent of openness, sincerity and verbal abilities of the patients. The survey reliability may be undermined by the assumed distrust of the respondents. However, we cannot see a reason why the respondents should not answer truthfully. What seemed notable was the ease with which the trust and friendship were established. Nevertheless, the individual answers are subjective ones, thus it is not possible to generalize the results, yet.

4.1. Hospice clients

Patients’ responses were divided into 3 categories: firstly describing personal background, secondly describing patient’s attitude to the hospice and its atmosphere, thirdly describing patient’s attitude to the internship.

4.2. Personal background questions

While asking personal questions, we tried to induce atmosphere of trust and openness. We were interested in what disease brought the respondents to the hospice. The result corresponded with the republic statistics, i.e. most hospice patients are ill with an oncological disease. Another personal question concerned patient’s family and whether the family visits them. The survey showed that despite most patients had a family, some members did not visit them regularly. All patients showed a tendency to advocate for them rather than to feel grudges for the lack of interest. “Yes, she comes, she sure does. She used to. The granddaughter has some exams now, so she isn’t coming now and I don’t want to force her.” [Interview 4, 2015] A female respondent in Interview 5 stated, that she is visited by her son, however, being asked whether her grandchildren visit her too, she forgivingly commented the situation: “... they are grown up, they turn up when they need something from Grandma or when they need advice. They have their families, so they come just when they need something.”

When asked whether they chose the facility themselves, most respondents answered that they either had heard about it and consequently they found it, or had been recommended.

4.3. Relation to the hospice

When asked how they perceive the quality of this facility, the respondents stated that they liked it there. A female respondent’s answer in Interview 7: “I do like it here, there are nice and helpful people here.” All patients unanimously agreed that the hospice care is far better than in medical facilities (hospitals), where they had been treated. “Well, it is like day and night. I’ll tell you - the factory that calls itself a hospital can’t stand in comparison with this. I signed the waiver in the hospital to get out.” [Interview 1, 2015]. “It (hospice) has nothing to do with hospital. Well, it is so nice in here, it is incomparable.” [Interview 2, 2015]. “It is impossible (to compare). First I was in hospital in Náchod, it was terrible; and then in Broumov, and it was terrible as well. It is incomparable.” [Interview 5, 2015].

Further the respondents appreciate positives such as a larger staff in hospice, which allows the nurses pay attention not only to patients’ bodily needs but also to their well-being. “One has more privacy; and the nurses and assistants are more careful. There aren’t so many of us here and there are different workers for each shift who take care of us.” [Interview 3, 2015].
When asked whether the respondent had any complaints about the hospice, most replies were in favor of hospice. “Everything is excellent; the food is delicious.” [Interview 5, 2015]. Just two (out of eight) patients complained about noise and chattering. “Yes, they do their best. The only thing I mind is the noise. There are many people speaking loudly. Many people here have bad hearing, but with me it is the other way round. For example the talks outside - I hear everything. The talks are spinning around diseases, which is not my cup of tea.” [Interview 8, 2015]. Another complaint from Respondent 1 was: “Do you know what is terrible? The bursts of loud laughter! It is outrageous and improper for this place.” Generally it can be stated that patients prefer peace and quiet over bustling atmosphere.

4.4. The interns and the likes

There was agreement over the issue of presence of interns. To the question that was formulated: “There are students doing their internship here, have you noticed that?” the respondents mostly replied that they were not sure whether those people were students or whether they belonged to the staff. Just two of them knew exactly who is who. “It is easy to say who everyone is - they introduce themselves. It is the ethics here - whoever enters, introduces himself or herself. I have seen several of them.” [Interview 3, 2015]. Others do not find it important to distinguish between a student and the staff. “Well, I don’t know if there are any. I say that the nurses are very nice and the atmosphere as well. Whenever you ask they will ride you out.” [Interview 5, 2015]. Despite the introduction the patients do not tend to remember their names. Patient 4 apologized himself that he does not remember such things due to his illness. “...they wear the uniform apparel, so I do not know. They introduce themselves, but as I say, I am confused. My wife also tells me something and I do not remember it in half an hour.”

Generally all respondents value the staff as nice and helpful. Some respondents were even more specific, sharing encounters that made impact on their memory: “There was a student - a guy. A nice chap. He sat down to me and we had a chat. ...And the black-haired lass - I don’t know if she is a student or a nurse - she is wonderful, very nice. Other students just look around to get a glimpse what it looks like here.” [Interview 5, 2015].

Some respondents also mentioned their appreciation regarding services that the students (they assume these people to be students) provided: “...they do everything - give me a bath, care for me.” [Interview 5, 2015].

Respondents also unanimously agreed that they did not mind being cared for by students that had not finished their training. Among responses supporting this issue can be mentioned these: Respondent 8: “No, of course not. They couldn’t get experience otherwise.” Respondent 4: “Well, I don’t mind them being here. They do for me everything I need - give me a bath, care for me.” Respondent 3 stated he liked any change in the routine: “Of course not. I love people and there is no life without change. Those people coming here are mostly nice and polite.”

4. Discussion and Conclusion

It is understandable that due to the low number of interviews it is impossible to generalize the findings presented in this paper. Nevertheless, they do provide a certain insight into the issue. Furthermore, more detailed research would be needed to uncover all aspects of internship in a hospice.

The analysis of interviews regarding the internship in St. Agnes' of Bohemia Hospice in Červený Kostelec revealed certain benefits both for the patients and the interns. The interns appreciate the positive acceptance from the patients. Patients, on the other hand, appreciate the changes brought about by the interview, especially the changes of the position in bed during the interview. They, however, prefer peace and quiet, not preferring talks about health matters. The patients seldom distinguish between interns and nurses although the interns introduce themselves. This fact does not seem important to the patients. What the patients remember though, is how they appear, how they act, whether they help them, do something unusual (e.g. a trip to the shops) or just fulfil their request. They also appreciate when they find something they have in common, something to talk, even laugh about.
The interns are more touched by the emotional aspect although they learn something about nursing, too. The environment and atmosphere of the hospice have positive impact on both the patients and interns, evoking the feelings of friendliness, peace and quiet.

Appendix A. Example interview

Respondent 1 - M. G.

Hello,
We are holding interviews regarding the internship here and you - the patients.

What was your occupation? Well, in fact I’ve had 2 jobs. I studied education and then I taught 8 years. Then I left for Norway. I lived in Norway and got a state job there. It was in 1973, when crude oil was discovered offshore Norway which required a lot of labour force, so there was not great demand for state jobs. I was the only applicant for the job - Rehabilitation, retirement and pensions - I was in the department of the working environment diseases.

How long have you been in the hospice? 3 weeks.

How are you doing? Well, if I got back home, it would be my end. I expected better food, though. There are little vegetables, a poor variety. I wish we had more easily digestible food. I know, it’s hard. Today’s breakfast was a roll and butter and cocoa. I know - there are people who would be over the moon for this, but me, on the other hand... well..

How long have you been back in the Czech Republic? When I was 60 I quit because I knew I would have a sufficient widow’s pension. That’s why I didn’t wait until 67 to be entitled for retirement pension and it was good. I was 28 when I left for Norway.

Do you have any children? My daughter died as an infant. There was an outbreak of encephalitis in Oslo and there was no medication. Then I had another baby - extrauterine pregnancy - he died, too.

So there is no-one to wait for you in your home in Jilemnice? I have siblings. My sister lives just next door. She is nearly 80 and has a deaf husband, so she has enough of her problems. And I have a brother.

Why did you decide to come back from Norway? I was lonely. But as I say, you have to stay there long enough. When you are a team it is always better. In all aspects. A sole person - it’s a kind of a pit.

How long have you been in the Czech Republic, then? Since I was 60, that has been for 15 years. I didn’t finish the contract. Because I knew I needed to be registered as a permanent resident. There was needed 40 years time of insurance. And I didn’t have that.

How long have you know about your disease? Since 2008. I have large intestine cancer. I believed I got over it, but in 2012 I got yellow.

You were in a hospital before, can you compare it? I was in Hradec. Well, it is like day and night. I’ll tell you - the factory that calls itself a hospital can’t stand in comparison with this. I signed the waiver in the hospital to get out.
You have been here for three weeks you say. Have you met any interns? Oh, I don’t know whether they are interns. I only know about one - she stated that - it was last week.

What does she do here? Helps the nurses with procedures - medication...

How do you perceive her? I don’t mind her. What I mind - there is a lady - staff, I think, you know their bursts of loud laughter! It’s inappropriate for this place.

What do you mind about that? You know, it’s fine when one is happy, but you must control your laughter. It’s just individuals, though.

Once I found it so uncomfortable that I asked them to close the door and control themselves a bit. And the guy didn’t tell them. So I had to repeat that and then it was better.

There are also volunteers, how do you perceive them? As a charity. I haven’t been here that long. Well, there was a lady from the seniors’ home, but I said I didn’t want it any more. It was just rubbish. Well, had we talked, for example, about her grandkids, it would be something else. And there was a psychologist here, too. It was completely a different league. Firstly she said it benefits her occupation and secondly it explains to me a lot of things from the psychological point of view which makes sense.

I feel I need to get back in and move a little. Although the senior doctor discourages me from that. But stay here and slowly ... well, not at all.

References


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