Third-wave Public Health?  
Compassion, Community, and  
End-of-life Care

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ABSTRACT

Clinical approaches to end-of-life care often extend their practise into community care, but frequently that practise has been under-recognized and under-theorized. A seamless practise connection with community approaches to end-of-life care is crucial to a total healthcare response to death and loss. One-on-one practises find their greatest therapeutic and aftercare support in a complementary community approach to that care. What public health models might we adapt to assist the psychological professions to support a community response to death and loss? This article reviews recent World Health Organization (WHO) work in community development, in particular the “Healthy Cities” projects. From this review, a “Compassionate Cities” framework is suggested as one fruitful way forward to address issues of prevention, health promotion, and aftercare in a holistic approach to end-of-life care.

Key words: community, compassion, end-of-life, healthy cities, palliative care, public health

THE CONTEMPORARY CONTEXT OF BEREAVEMENT CARE

The year 2002 witnessed two major reviews of the psychiatric contribution to bereavement care. These international review articles, in the US journal *Death Studies* by Parkes (2002) and in the UK journal *Mortality* by Stroebe (2002), follow hard on the heels of the US bombing events of September 11, 2001. What was striking about the content of the articles vis-à-vis the nature of recent international terrorist events is how markedly contrasting, even unrelated, they seem to one another.

Stroebe (2002) spends most of her article celebrating how Bowlby’s attachment theory saved psychoanalysis from being “discredited.” Much of her reflection details the development of psychological models of coping and the
role of child development in grief responses. Stroebe (2002) sees the future of bereavement research in terms of attempting to understand grief across the lifespan and in refining our personal models of coping. There is little mention of research or practise models that employ social or cultural processes to support grieving.

Parkes (2002) reflects on the conceptual and empirical emphases between normal and complicated grief. He observes that it was Lindemann, in 1944, who expressed the rather progressive view at the time that normal grief work could be done in “8 to 10 interviews” by “non-psychiatrists.” However, it was only in 1965 when Parkes himself recalled that he could not identify any systematic studies of normal or uncomplicated grief at the time. Like Stroebe, Parkes (2002) celebrates the one-to-one practise models, the studies of widow or childhoo d bereavement, and the rising importance of counseling in our midst.

Parkes (2002) goes further than Stroebe (2002) by devoting part of his review to acknowledging the role of the social sciences to grief theory, the broader significance and interconnections of grief with bereavement, posttraumatic stress, disenfranchised grief, and losses beyond death such as amputation and adoption. But as he pauses to reflect about the future he returns to stress the primacy and importance of the counselor “in a world in which many people can no longer rely on their own families to provide them with emotional support, non-judgmental acceptance, and tolerance, there will continue to be a need for counselors who will do just that” (Parkes, 2002, p. 381). But do casework interventions exhaust our professional responses to grief and loss? What, for example, have been the cultural and social responses to 9/11?

Newspapers carry full-page stories, not simply about the actual deaths, but containing tributes to individuals who have died, as well as their families. Telethons hold fund-raising programs with titles like “Americans Unite.” Memorial services are held in baseball or football grounds that hold more than 100,000 seats. Politicians attend memorial services with communities in several capital cities. Newsreaders wear black clothing and pin flowers to their collars. National days of mourning are declared. Scarcely a word is mentioned about “counseling” and the minute’s silence held for the dead at racing and sporting venues is equaled only by the silence of reflections on the practise implications of these social and cultural processes in facilitating and supporting normal grief. Where is the interdisciplinary public health interest, for example, in this form of end-of-life care?

As a sociologist I am unsure about the accuracy of Parkes’ (2002) assertion that “people can no longer rely on their families for support.” But they can certainly rely on their communities for support in national disasters (Raphael, 1984). Workplaces, recreational clubs and events, media outlets, churches, governments, charities, and other people’s families (if not your own) are certainly ready to recognize grief, offer support, and provide non-judgmental...
acceptance. True, these are deaths in the context of some declared national disaster, but they do highlight several important practice issues for anyone with a professional interest in end-of-life care.

First, family support is only one kind of support and other social supports are frequently recognized to be, if not equally important, then perhaps of complementary importance to the grieving process. Second, social and cultural recognition is at least important in mitigating or protecting against the possibility of “disenfranchised grief” – the grief caused by poor or absent recognition of important losses (Doka, 1989). Third, communities can and do have a record of mobilizing to support people in their grief, and many useful observations about these structures and experiences may help to strengthen a public health knowledge as this is expressed in community psychiatric practise.

Lastly, the role of psychiatry and psychoanalysis in helping to create healthy community grieving seems under-recognized in recent reviews and yet community development and supports have been of interest and use in social and community psychiatry (Raphael, 1984). Models of community and social psychiatry provide continuity of care as well as alternatives to casework in partnership with community responses to death, dying, and loss. Are there promising directions or models for a public health approach to end-of-life care that include the four above-mentioned concerns and which have the potential to create partnerships across the community and all health services? The WHO “Healthy Cities” programs and policies, with some modifications, may indeed hold some promise in these ways.

HEALTHY CITIES AND THE NEW PUBLIC HEALTH

The “Healthy Cities” projects were developed by the World Health Organization as one way to implement the Ottawa Charter for Health Promotion (WHO, 1986). Action strategies are designed for the health of whole communities across a diverse range of sectors – workplaces, recreational sites and events, schools and universities, nursing homes and hospitals, and in churches, local government, and voluntary organizations.

This intersectorial approach to public health draws heavily on the idea that our personal experience of health depends on strong and sustainable social foundations – partnerships, community involvement and supports, reorientation of health services, and the development of personal skills for all citizens. The premier assumption of this public health approach is that health is not merely the absence of disease. In a parallel way, quality of life is not merely the absence of problems.

But, notwithstanding these worthy ideas about health and quality of life, the experience of death, dying, and loss is largely absent from the language, theory, and policy direction of “Healthy Cities.” Ironically, the earlier idea of death-as-failure so characteristic of medical thinking in the middle of the twentieth
century seems to suggest itself in current health promotion theory and policy (Kellehear, 1999, pp 14–15).

According to Ashston et al. (1986) the very origins of the first wave of public health initiatives can be traced to health promotion activities developed in eighteenth- and nineteenth-century cities. The squalor, undernourishment, and infectious diseases responsible for the mortality and morbidity of those periods led directly to the establishment of municipal public health departments. In the late twentieth century, the growing disillusionment with the costs and effectiveness of direct medical services and the therapeutics industry led to a recent revival of interest in public health ideas. This second-wave public health, sometimes called the “New Public Health” (Baum, 1998) took the view that public health was more than ensuring clean water, sewerage, and control of infectious diseases. Health is always linked to settings both physical and social.

The psychiatrist and public health worker Leonard Dahl (Aicher, 1998) contributed writings that examined and developed ideas towards holistic and systemic approaches to health. In 1984 a major public health conference was held in Toronto, Canada, to explore ecological and holistic approaches to health policy and it was at this forum that Dahl coined the phrase “healthy cities” (Aicher, 1998, p. xii).

Taking the view that health was a quality of life inexorably linked to “habitats” – to the immediate, physical, and social environments of organisms, including human organisms – seemed like a good idea. This was especially viewed well given the likelihood that by 2000 almost half the world’s population will live in cities. The idea of the city as a primary site for strategic health policy approaches also seemed appropriate because cities are the most basic political and administrative level for assembling political and financial resources, and for engaging participation and intersectorial cooperation.

From this academic and policy pressure to view health in these wider and more interdependent relationships several other initiatives were developed and coincided. In 1986, the WHO published the Ottawa Charter for Health Promotion. This consisted of five important principles for the environmental support of health:

- Building healthy public policies.
- Creating supportive environments.
- Developing community action.
- Developing personal skills.
- The reorientation of health services.

Also in 1986 the Lisbon Symposium on Healthy Cities took place, with participants from 21 cities attending it. Drawing from the WHO policy statements on Health for All and the Ottawa Charter, this conference began to establish some of the first definitions and action statements about the idea of healthy cities. In
1987, healthy cities was established as an actual policy program of the WHO European Regional Office (Baum, 1998, p. 445).

Since these beginnings, healthy cities programs have been established worldwide. By 1992, the WHO office worked directly with 35 cities. The 20-step booklet that outlines the initial steps for the establishment of a healthy city program has been translated into over 20 languages. Since 1995, healthy cities programs have extended into eastern and central Europe and Asia, with cities cooperating with each other on specific health promotion campaigns (Tsouros, 1995).

What is a healthy city? The WHO summarized the most important characteristics of healthy cities into nine principles (WHO, 1996, p. 15):

- Has a clean, safe physical environment.
- Meets the basic needs of all its inhabitants.
- Has a strong mutually supportive, integrated non-exploitative community.
- Involves its community in local government.
- Offers inhabitants access to wide variety of experiences, interactions, and communications.
- Promotes and celebrates its historical and cultural heritage.
- Provides easily accessible health services.
- Has a diverse, innovative economy.
- Rests on a sustainable ecosystem.

The underlying concepts of the healthy city then are:

- Health is a positive concept – it is not simply the absence of disease.
- Health is a holistic concept.

In other words, establishing and maintaining good health depends on the nurturing role of the physical, social, political, economic, and spiritual environment, and not simply on the quality of direct health services alone. Health is an ecological idea, not a medical one. Lastly:

- Healthy cities must always be concerned with inequalities in health.

Health, like wealth, is unevenly distributed in the population and any genuine concern about health must address the differential way in which health distributes itself among those of different ages, genders, ethnicity, and social classes (Hancock, 1993).

The reader will note that the words death, dying, and loss are absent from these otherwise admirable public health principles. If death or bereavement appear as concepts at all in current health promotion literature they do so as experiences to be avoided or perhaps as the very reason itself for health promotion activities.
Death and loss, certainly early or unnecessary death and loss, are targets for prevention and early intervention. There is no recognition that death and loss are universal experiences sooner or later in recent public health literature. The idea that there are matters to do with death, dying, and loss that are preventable within these experiences themselves remains foreign. The spiritual, psychological, or social morbidity associated with living with a life-threatening illness or loss are not explicit targets of current health promotion thinking.

But, recognizing that despite our best efforts all communities will have to cope with a certain burden of death and loss we are able to revise “Healthy Cities” ideas and practises into compassionate ones. I have called compassionate public health “Third-wave Public Health” because it is an incorporation of the experiences of death, dying, and loss into our formulations of health and because it is inclusive of the idea of compassion into our health policy and practises (see Kellehear, in press). Both of these policy and practise initiatives are new to current public health ideas and analyses.

THIRD-WAVE PUBLIC HEALTH: THE DEVELOPMENT OF SOCIAL MODELS OF COMPASSION AND END-OF-LIFE CARE

The word compassion means to pity, to share, or show mercy and sympathy in another person’s suffering. The term “compassionate” is to have this quality of attitude and action. It is a commiseration – a joint journey of sharing with another. Funk and Wagnell’s (1963) New Standard Dictionary of the English Language observes that the term “compassion” derives from two Latin root words: cum meaning “together” and patior meaning “suffer.”

But under the terms “compassion, compassionate”, Origins: A Short Etymological Dictionary of Modern English (Partridge, 1958, p. 113) provides the intriguing advice “See patience.” Under this term, we learn that Latin prefix-compounds such as pati, which are root origins for compassion and compassionate, are Old French terms adopted from Late Latin. This root suggests a sharing with another’s suffering; to be patient in another’s suffering, to bear and support suffering. This pati root also has another etymological life as the basis for the English term “patient” – a person who shows patience, presumably in his or her own suffering.

The theoretical reason for the choice of the term “compassionate” is to signal a number of ethical and policy distinctions that the current term “health” does not seem to make in the current public health or health promotion discourse. These are, first, that compassion is an ethical imperative for health. Compassion is the human response, the tender response aroused by the distress and suffering of others. It is the moral, social, political, and physical basis of our attempts to give aid and support in a time of difficulty. A healthy person without compassion is a potentially dangerous person to the health and safety of other people.
Second, health is a positive concept that can coexist in the presence of disease, disability, or loss. The WHO stresses that health is not simply the absence of disease. On the contrary, for most of us, disease is ever-present. No conception of health makes sense without acknowledgment that, to more or less extent, diseases such as atherosclerosis, arthritis, hypertension, diabetes, and many others singly or together affect most of the population. Disabilities in mental health, movement, sight, hearing, or touch are endemic. Indeed, chronic illness and disability are so widespread that any definition of health that excludes these experiences promotes an unnecessarily idealistic—in fact, unrealistic—idea of health. Disease is not the opposite of health—death is.

Third, compassion is a holistic or ecological concept just as much as are current public health conceptions of health. Compassion must express itself not simply in an individual attitude but in changes in the workplace, churches, human services, and schools. Death and loss must be recognized as universal experiences that we all share and provision for these experiences must be integrated in policies and practises at those sites.

Finally, compassion necessarily implies a concern with the universality of loss. Loss can result from terminal illness (cancer, AIDS, motor neuron disease, etc.) but also from violence (victims of crime and abuse). The forced separation of peoples from their land or their cultural traditions and identity (refugees, indigenous peoples, and international adoptions) must make dispossession equal to bereavement as a compassionate concern for end-of-life care. This pivots our attention from the meaning of the term “end” in this phrase, as a biographical and physical end of “an individual life” to a wider understanding of loss and identity as connections to a broader community life within and outside ourselves.

In the above context, of course, social and physical rejection (from racism, sexism, ageism, disability, relationship disintegration, or unemployment) is equally a concern, not only because these concern all healthy cities as issues of inequality but also as compassionate issues. They are compassionate issues because they create death and loss in others in their social, symbolic, and sometimes even physical lives. They are risk factors in the identification and control of dispassionate (heartless) attitudes, values, and policies by individuals and governments. They are legitimate concerns of a compassionate city approach to public health policy and practise.

Central Concepts of Compassionate Cities

- Compassion is an ethical imperative for health.
- Health is a positive concept even in the presence of disease, disability, or loss.
- Compassion is a holistic or ecological idea.
- Compassion implies a concern with the universality of loss.
How do these central concepts of the compassionate city translate into defining characteristics? There are nine characteristics that define a compassionate city and these should be read together with the nine WHO-defined characteristics of healthy cities. These are as follows.

Compassionate cities have local health policies that recognize compassion as an ethical imperative. There must be a public debate about the value and need for compassion to be an ethical imperative in their environments and for health to take up the hard challenge of genuinely viewing health away from physical experience. We must make and debate the practical links between ethical choices and supportive health-promoting environments.

Compassionate cities also meet the special needs of their aged, those living with life-threatening illness, and those living with loss. There must be new connections forged between experiences of mortality, health, and quality of life that are now frequently viewed as counterintuitive. There can and should be an acknowledgment that death and loss are predictable and permanent experiences and that we can and should strive for quality of life rather than denial in their shadow. Compassionate cities as healthy cities also have a strong commitment to social and cultural difference. There can be no safety and therefore no guarantees for health in a community that does not passionately advocate tolerance and embrace difference. While we live in a time and a place where only some people are viewed as deserving of all the rights and privileges of community support, no one is safe.

Compassionate cities also involve the grief and palliative care services in local government policy and planning. No planning, policy development, or set of action strategies can be designed or implemented without the experience and insights of those who have made a professional life studying and caring for those facing death and loss. Compassionate cities must also offer their inhabitants access to a wide variety of supportive experiences, interactions, and communication. Unless, people who face death and loss are unable to see themselves, or see their own experiences reflected in the face of their own community, in the local media, marginalization, alienation, and despair will always be unshared, private experiences.

Compassionate cities also promote and celebrate reconciliation with indigenous peoples and the memory of other important community losses. We will not understand the cultural and existential basis for loss while we continue to see this experience in the narrow and confined terms of bereavement. Death and loss have a wider meaning beyond disease, and these experiences and consequences need to be recognized and understood to create inclusive policies on loss that mean the most to most people.

Compassionate cities also provide easy access to grief and palliative care services. Because many of these services are historically new they play a major role in current support of people facing death and loss, and they have created a
cutting edge body of knowledge for those of us in public health who would take end-of-life care forward and beyond those services. Compassionate cities also recognize and plan to accommodate those disadvantaged by the economy, including rural and remote populations, indigenous people, the unemployed, the disabled, and homeless, and in these ways again, compassionate cities as healthy cities concern themselves with inequalities.

Finally, a compassionate city preserves and promotes a community’s spiritual traditions and storytellers. Beyond mere social and health beliefs, the spiritual traditions of a community – in particular, its religions and cosmic belief systems – are a treasury of ideas about death, suffering, and loss, and will be instrumental in the provision of support and comfort. Compassionate cities are not only mindful of public health ideas, they are respectful and supportive of diverse religious beliefs – their direction, desire, and when relevant, their absence.

**Defining Characteristics of a Compassionate City**

- Has local health policies that recognize compassion as an ethical imperative.
- Meets the special needs of its aged, those living with life-threatening illness, and those living with loss.
- Has a strong commitment to social and cultural difference.
- Involves the grief and palliative care services in local government policy and planning.
- Offers its inhabitants access to a wide variety of supportive experiences, interactions, and communication.
- Promotes and celebrates reconciliation with indigenous peoples and the memory of other important community losses.
- Provides easy access to grief and palliative care services.
- Has a recognition and plan to accommodate those disadvantaged by the economy, including rural and remote populations, indigenous people, the disabled, the unemployed, and the homeless.
- Preserves and promotes a community’s spiritual traditions and storytellers.

The above definitions and theoretical characteristics of healthy and compassionate cities highlight a major departure from current ways of thinking about end-of-life care, in particular palliative care. The current interpretation of hospice and palliative care as clinical care at the end-of-life, although appropriate and worthy in its own terms, is not community care. Palliative care must develop a public health approach to end-of-life care if it is to embrace health promotion activities that draw it towards community partnerships beyond volunteer programs and towards broader collaborations such as compassionate cities.
CONCLUDING THOUGHTS

Should psychiatry, palliative care, or psychoanalysis become community development? The answer to this question is affirmative only if one believes that cardiovascular medicine should become a branch of nutrition, recreational, and sports science. Yet, clearly, cardiovascular medicine must interest itself in prevention and early intervention and, in that context, cardiology does have a public health research and practise interest in nutrition, exercise, stress, and substance use control. These knowledge areas exist alongside more organic understandings to create a holistic approach to human cardiovascular care across the lifespan and in multiple social and cultural contexts.

So, too, psychoanalysis twins its interests with the behavioral, psychodynamic, and organic with the more social understandings and practises of public health. In this way, in this seamless way, it is essential for community practises for the support of those living with death, dying, and loss to be complemented with the research and practise wisdom of clinical casework.

I have argued elsewhere (Kellehear, 2002) that it is time we raised questions about the existence and nature of “continuity of care” when it comes to addressing the complex death and loss needs of the national community. What are our practical offerings and suggestions for community support or partnerships in this important area of human suffering? There is a need for development and debate about how well-informed and how seamless our public policy – and practise models – for end-of-life care actually are. Are our community approaches to end-of-life care, such as they currently exist, fragmented around service territories such as palliative care, aged care, or bereavement care?

We need debate about the details and adequacy of our professional responses to community death and loss that are not simply limited to our caseloads. The compassionate cities policy and practise model offers one fertile set of ideas based on a successful world public health program. Such a model may provide a promising future direction not just for psychoanalysis but also for other psychological, behavioral, and social sciences as well. Let the debate begin.

REFERENCES


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