

New challenges for a newly emerging field

Palliative care is a fledgling field of care.

Modern palliative care had its beginnings in the 1960s and 70s in Britain and the USA. Its substantial uptake in those countries in both practice and policy terms can be dated merely to the 1980s. Its spread and uptake in Asia, Europe, Africa, and South America is more recent still. The definition of palliative care remains pluralist and contentious. In some quarters, palliative care is synonymous with palliative medicine. Other definitions include other health care professions but only as a collection of clinical specialisms focused on ‘symptom science’ and often solely in the last few days of life. The broader more inclusive view sees palliative care as embracing more than clinical sites or health care as other policies strive to connect spiritual and social aspects to the professional efforts of chaplains, social workers, or music therapists to name only a few. But even now, this most eclectic and inclusive view of palliative care is one bound by what professional individuals and teams can do—in whatever health and social care service is being offered by their government or private providers. In this way, hospice and palliative care—however these are defined—struggle to shake off a 1950s understanding of health care as a solely profession-based, direct service provision-bound type of care. Unlike broader health care policies and activities that now assume that ‘health’ is everyone’s responsibility, palliative care has struggled to make these civic and public health connections for the end of life.

In this special issue of the *Annals of Palliative Medicine* we provide a glimpse of the growing international practice and policy development in palliative care that views the care at the end of life as everyone’s responsibility. Palliative care is not solely a face-to-face clinical encounter, in the last weeks of life. Palliative care is not solely about dying but also long-term caregiving that can last for years, and a grief and loss that may span the rest of a bereaved life. The co-morbidities of living with dying, caregiving and bereavement—depression, anxiety, loneliness, or stigma, job loss, and social isolation or withdrawal—are amenable to prevention, harm reduction, and early intervention by civic effort. Clinical interventions can and should address severe examples of these problems but most other examples can be addressed at the workplace, schools, churches or temples, or the clubs and bars where ordinary people gather all over the world. The attempt to create alliances with communities goes beyond the good and necessary work of hospice volunteers. This is because people who live with life-limiting illness, grief and loss, or caregiving are found everywhere and therefore support for these common life experiences must be found everywhere. Most countries now accept the value and importance of smoking cessation, physical fitness, or dietary information as crucial prevention and harm reduction strategies as well as promoting health and wellbeing. Equally, the practices of widening social support, increasing death literacy, or encouraging workplace preparedness for personal crisis can provide palliative care—by any definition—with stronger, more successful strategies for ‘quality of care’ and ‘continuity of care’.

The public health movement in palliative care is less than 20 years old and its practices, rationales, and impact remain poorly understood. Yet, in these last two decades the literature has grown exponentially, its practice developments have grown spectacularly across the UK and Commonwealth countries, Continental Europe, North and South America, Asia and Africa. The Public Health Palliative Care International Conference Series is approaching its 12 years. An International Association has been established with a rapidly growing, global membership (www.phpci.info). This special Public Health issue of the *Annals of Palliative Medicine (APM)* is the second special issue on this topic in recent years (the first was published by *Progress in Palliative Care* in 2016).

The aim of this special issue is to showcase some of the important international practice developments (Original Articles and Reviews); provide some insight into a recent public health palliative care conference (Meeting Report); shows examples of systematic implementation of the compassionate city charter; reports on sustained programs of research over a number of years into the public health approach and provides a new theoretical model for the new essentials of palliative care. This public-health issue is designed to raise awareness among clinical colleagues of the complementary value of the public health approach to clinical work. But the following articles also underline the fact that good palliative care, like any aspiration for a good death, must be based not solely on strong clinical provision but even stronger civic partnerships and alliances with that style of health care. We must ensure equity of care for all who undergo the experiences of caregiving, dying and loss.

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