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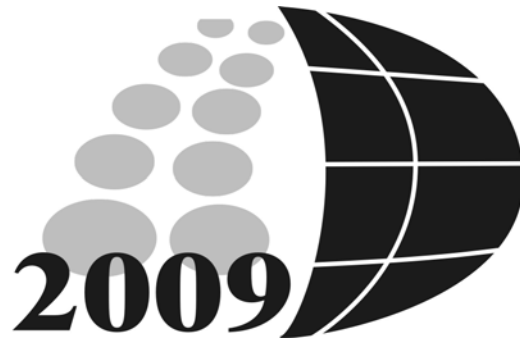


1st International Conference on
PUBLIC HEALTH AND PALLIATIVE CARE

16th & 17th January 2009
Institute of Palliative Medicine, Kozhikode, India

Conference Proceedings

Edited by
Dr Libby Sallnow, Dr Suresh Kumar and Professor Allan Kellehear



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Dr Libby Sallnow
Organising Secretary

Conference Committee
Professor Allan Kellehear | Dr Suresh Kumar
Mr Vinod K B | Ms Nisha K P | Mr Sudheer A V

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“But we’re already doing it!” Examining conceptual blurring between health promotion and palliative care.

Dr John Rosenberg

The University of Queensland / Blue Care Research and Practice Development Centre

ABSTRACT:

Attempts by scholars and palliative care organisations to integrate health promotion and palliative care demonstrate a growing awareness of the conceptual congruence between these two fields. Yet it is increasingly evident that this congruence has also brought with it a lack of clarity at individual and organisational levels of the key concepts underpinning HPPC.

A number of examples demonstrate that this conceptual blurring leads to a sense amongst practitioners that HPPC is already being done; when the presence of elements of health promotion in end of life care is viewed as the successful implementation of HPPC. For example, health promotion is commonly understood as health education (just another service, rather than engagement); death education can be reduced to providing information about palliative care resources; community development to community based service provision; and education to telling.

This reveals a challenge for the advocates of HPPC to address misconceptions of what health promotion is and what a public health approach to palliative care entails. How does the conceptual blurring between health promotion and palliative care impact upon this? In this paper, I draw on the scholarly work to date and examples from practice, to explore how the integration of HPPC relies upon a whole-of-organisation approach, if it is to counter the perception that HPPC is merely synonymous with many of the existing elements of palliative care practice.

Introduction

Over the past decade, an increasing number of palliative care service providers have attempted to integrate health promotion into their organisational practice. A key factor in the success of this endeavour has been the recognition by these providers of the conceptual ‘fit’ between two seemingly disparate approaches to health care. When informed of the elements of health promotion, palliative care professionals have expressed their recognition in the declaration, ‘But we’re already doing it!’ (Rosenberg, 2007).

Yet it appears that this association between the two suggests that health promotion in palliative care organisations is being understood in poorly defined ways. ‘Health promotion’ can be incorrectly assumed to be synonymous with ‘health education’; ‘death education’ can be understood to be synonymous with providing information about palliative care resources. Whilst these activities may be worthwhile of themselves, their presence in the activities of an organisation does not constitute the practice of health promoting palliative care [HPPC] (Kellehear, 1999).

The relatively recent return of palliative care services into mainstream health care systems has included systemic, public health approaches to the governance of the care and support of people at the end of life (Palliative Care Australia, 2005; Scott, 1992). These approaches represent a departure from the early origins of the modern hospice movement, where freestanding, independent hospices with home-based outreach were a common service configuration; typically these services were voluntarily sequestered from mainstream health care until more recently (Howarth, 2007). However, there are misconceptions about these public health approaches and a blurring of the key concepts in integrating a HPPC approach. Let's take a moment to examine these concepts.

Key concepts in health promotion and palliative care

Palliative care and health promotion have a great deal in common. Both emerged in the latter half of the 20th Century from dissatisfaction with the dominant biomedical approach to health care, which was criticised for its reductionist and mechanistic understanding of human disease and illness (Baum, 2008) and for the removal of the sick person from their social, cultural and spiritual contexts within which they experience illness (Bunton & MacDonald, 2002). Yet tacitly we can acknowledge that health – and death – are both experienced by people as deeply embedded in their lived experience.

Palliative Care

Contemporary palliative care is derived from a “small rebellion” (Connor, 1998, p.xiii), which sought to restore “an holistic approach to patient care, the family as the focus of care, and importance of multidisciplinary collaboration on a day to day basis” (Hockley, 1997, p.84). Palliative care is underpinned by numerous key concepts, which include its aim to:

- Affirm life and regards dying as normal
- Integrate the psychological and spiritual aspects of care
- Offer comprehensive support to promote quality of life
- Offer support systems to help patients live as actively as possible until death

(World Health Organisation, 2008, ¶1)

These key concepts *for practice* clearly situate the dying person squarely in their lived reality. Dying is not simply a medical event, but a profoundly personal, interpersonal and communal one. The planning and provision of support by the health care professions, therefore, must be responsive to this view. It is clear to see, then, that the support of dying people and their families is the responsibility of both the health care professions and the communities in which the dying person lives:

The experiences of serious illness, dying, care giving, grieving and death cannot be completely understood within a medical framework alone. These events are personal, but also fundamentally communal. Medical care and health services constitute essential components of a community's response, but not its entirety.

(Byock, Norris, Curtis, & Patrick, 2003, p.760)

This understanding of palliative care as an holistic and contextualised endeavour underscores that death viewed as a part of life, understands the notion of the whole person experiencing terminal illness, and views the patient's family as 'client'.

By creating environments of care where these core values could be practiced, these concepts became accepted over time as the preferred method of caring for dying people. There were early indications that specialised hospice programs were more effective in relieving the suffering caused by pain and other symptoms (Mor, Greer, & Kastenbaum, 1998). The recognition of palliative medicine as a specialty in the UK in 1987 (Lewis, 2007) was an acknowledgment of the particular set of medical skills required to treat the dying person. The approach to care of the dying that was offered by specialist multidisciplinary palliative care teams was increasingly viewed as the optimal approach to end of life care, where places of specialised care were provided for a few, and clinical consultation for the many was provided to an even smaller number. The 'small rebellion' had evolved into a substantial parallel path to mainstream health care.

The difficulty that arose from this flanking was that this 'boutique' approach to care of the dying provided support to only a small minority of its potential patients; in one location in Australia, specialised palliative care was noted to be primarily provided to relatively younger people with cancer, and by no means all of them (Hunt & Maddocks, 1997). In practice, people dying with non-malignant disease or the very old were largely excluded from access to specialised palliative care services. In some parts of the USA, it has been suggested that the palliative care movement substantially – although not universally – failed in responding to the need for the care of people dying from AIDS as it emerged as a new life-limiting disease (Beresford, 1993). There were concerns that this specialisation may also place the original core values of palliative care at risk, with its practitioners becoming little more than 'symptomatologists' (Kearney, 1992) as they responded to requests for intervention in difficult cases. The need for a broader scope of practice was increasingly evident.

Fortunately, a growing awareness of the potential for a complementary coexistence between mainstream health care and palliative care arose:

While the early hospices had often sought to stand outside the constraints of health care planners and their associated bureaucracies, the maturation of the movement was to bring about a growing interdependence with the wider structures of health care delivery

(Clark, Hockley, & Ahmedzai, 1997, p.60)

This reintegration into mainstream health care acknowledged that the care of the dying person was an important part of *all* health professionals' practice and that palliative care should be regarded as an integral part of health care for many patients (UK Department of Health, 1995). As such, it was not simply the responsibility of individual practitioners or sole hospices, but of the health care systems of countries or their jurisdictions. The World Health Organisation's *Cancer Relief and Palliative Care Report* (1990) emphasised the need for a systematic, planned approach to the provision of care for people dying from cancer and this represents an early and significant attempt to influence the utilisation of public health approaches in palliative care delivery.

This mainstreaming has brought both benefits and risks to the key concepts of palliative care. By conforming to the regulatory norms of health care systems, palliative care is at risk of fulfilling Kearney's (1992) fear that the spiritual and social realms will be lost; care of the dying could be reduced to little more than a set of medico-nursing interventions provided at the expense of psychological and social interventions (Kellehear, 1999).

Health Promotion

Like palliative care, health promotion emerged in response to a perceived overemphasis on disease and its diagnosis, treatment and cure. Again, it seemed that the dominant biomedical approach to health care failed to adequately embrace whole population issues and the complex interrelationships between the physical, psychological and social components of health and wellbeing (Bunton & MacDonald, 2002). Unlike palliative care, the proponents of health promotion formed a more structured, global movement whose key concepts were integrated more quickly into health care systems.

The Ottawa Charter for Health Promotion originally defined health promotion as "the process of enabling people to increase control over, and to improve, their health" (World Health Organisation, 1986, p.1). It described the highly contextualised nature of health and wellbeing, where the determinants of health are based upon a broad range of physical, social and environmental factors. Significantly, the *Ottawa Charter* explicitly asserted that responsibility for the promotion of health rests not simply with the health sector but with governments, social and economic sectors, industry and media, and communities themselves. The *Ottawa Charter* famously provided a framework to achieve these goals in its five key action areas:

- Building public policies that support health
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting health services (World Health Organisation, 1986)

The implementation of multiple, concurrent strategies in each of these key action areas is based upon the premise that people, and the communities in which they live, are central players in obtaining satisfactory states of health and not merely the passive recipients of health services; enabling people to achieve their full potential for health requires their engagement in the strategies being implemented (Baum, 2008). In so doing, people will bring with them the social, cultural, spiritual and social elements of their experiences of health and illness. Subsequent WHO Health Promotion statements have reiterated and built upon the *Ottawa Charter's* original key concepts; the *Jakarta Declaration on Leading Health Promotion into the 21st Century* (World Health Organisation, 1997) re-emphasised the need for strategies beyond the health sector to optimise health and the *Bangkok Charter for Health Promotion in a Globalised World* (World Health Organisation, 2006) advocated placing the development of health at the centre of the global agenda, as a core responsibility of all governments and a key focus of communities.

It is clear that attempts to shape the attainment of health of individuals, families and communities were based on a broad range of health promotion strategies from local to global.

Health Promoting Palliative Care

The seemingly paradoxical nature of suffering and the promotion of health may have been considered conceptually incompatible. Yet this only presents a paradigmatic difficulty when "...the perception of health [is] the absence of disease, and demands are made for medical services when treating ill health to have as their goal the absence of disease" (Pegg & Tan, 2002, p.25). The aim of health promotion to enable people to increase control over and to improve their health is not incompatible with the goals of palliative care to relieve pain and distress, and promote autonomy and self control, even in the absence of a likely cure (Pegg & Tan, 2002).

Despite misgivings about conceptual compatibility, health promotion and palliative care have now been considered together for more than a decade. Evidence of this in the 1990s can be found (Faulkner, 1993; Rosenberg, 1992; Russell & Sander, 1998; Scott, 1992; Zeefe, 1996), however it was the seminal work of Australian sociologist Allan Kellehear (1999) that first provided a substantial and systematic examination of their compatibility. His contention was that "...if health is everyone's responsibility then it is also the responsibility of those living with a life-threatening or terminal illness as well as those who care for them" (Kellehear, 1999, p.31). This assertion reaffirms the statement within the *Ottawa Charter* in its key action area of *developing personal skills* that states the need for lifelong learning for people preparing themselves for *all of life's stages*.¹ Whilst dying as a life stage is not explicitly mentioned in the *Ottawa Charter* (or for many years thereafter in the health promotion literature), it is interesting to note this phrase in such a key document!

Whilst the centrality of holism as a response to the multidimensional nature of care at the end of life was present in the rhetoric of palliative care, Kellehear (1999) referred to a number of examples that illustrate the overemphasis on physical – and, to a lesser extent, psychological – symptomatology at the expense of the social and spiritual domains, referring to the concerns expressed by Kearney (1992). A HPPC approach, Kellehear claimed, addresses five underdeveloped aspects of conventional palliative care:

- Social and public health components
- The social aspects of care
- Early stage care
- Active treatment of disease
- Life-threatening illness (not just terminal care) (Kellehear, 1999)

Contemporary palliative care, Kellehear claimed, for the most part shows a "palpable" (p.7) absence of social science and public health components leading to the neglect of the social domain within palliative care's own holistic framework. It falls short of providing truly 'social' care through its hybridisation of the psychological (ie: individual) and social (ie: collective) domains as 'psychosocial'. It fails to meet its own goal of providing support from the time of diagnosis and is primarily focussing its limited resources upon terminal care.

It is health promotion in the context of public health which Kellehear claimed addresses the risks – or actual inadequacies – in contemporary palliative care. He proposed five core concerns of HPPC:

- Provide education and information for health, death and dying
- Provide social support at both personal and community levels
- Encourage interpersonal reorientation
- Encourage reorientation of palliative care services
- Combat death-denying health policies and attitudes (Kellehear, 1999)

Are there examples from real life illustrate both philosophical and practical attempts to take a health promoting approach to palliative care? How do they demonstrate an ongoing attempt to clarify the conceptualisation of HPPC?

Conceptualising health promoting palliative care

Whilst the *practice* of public health and health promotion in palliative care it has not always been systemically evident (Stjernsward, 2007), the application of health promotion and public health approaches to palliative care have been *written about* by a number of scholars and practitioners. Attempts to integrate health promotion and palliative care demonstrate a growing awareness of the conceptual congruence between these two fields. Yet it is increasingly evident that this congruence has also brought at individual and organisational levels a lack of clarity, or conceptual blurring, of the key concepts underpinning HPPC.

Health Education and Information

Education has been viewed as the primary tool in informing and equipping members of the public for their inevitable involvement in death and dying (Gallagher, 2001). This is seen as a strategy in reorientating health services by Zeefe (1996) who discussed the place of death education for staff, patients and families, and society more widely, as a pre-emptive strategy in equipping people with the life skills necessary for a healthy engagement with death and dying. This perspective reflects elements of health promotion in the *Ottawa Charter* in its use of empowerment and education to strengthen communities and develop personal skills of community members.

A Canadian author described an innovative public awareness and education tool that demonstrated the limited extent to which community engagement has been attempted. Gallagher's (2001) survey of trade-show visitors assessed respondents' knowledge of issues about dying and anticipated needs if they were to face a terminal illness. He identified varying levels of knowledge between health professionals and the general public about death, dying, care services, and euthanasia. A focus upon highly socially contextualised care included not simply the provision of clinical care, but information and education to "overcome fear, relieve helplessness and promote health" (Scott, 1992, p.47).

Social Support

The centrality of holism in the practice of a health promoting approach to palliative care was discussed by Buckley (2002), who viewed the process of adaptation experienced by dying people.

Empowerment was a crucial attribute of the health promoting approach she proposed. In their study, Pegg and Tan (2002) similarly identified a link between suffering and quality of life, caused by lack of knowledge and limited empowerment. Weaver (2004) focused mostly on the needs of families during life-threatening illness and at the end of life, with its primary focus limited to promoting the health of the family unit. The dying patient was not seen as a recipient of health promotion strategies in this example.

The importance of support networks in the promotion of healthy bereavement was briefly described by Faulkner (1993) who integrated it into a risk-assessment tool titled *Pre-Bereavement Predictors of Poor Outcome*. In particular, she considered the impact of absent or unsupportive family members, and detachment from traditional cultural and/or religious contexts on bereavement outcomes. Such use of preventative interventions in bereavement is commonplace today and is strongly congruent with the tenets of health promotion, given its potential to reorientate health services providing end of life care.

Skill Development

Russell and Sander (1998) proposed a set of personal skills for professionals providing palliative care that demonstrated core elements of health promotion. *Enabling* requires both symptomatic expertise and social sensitivity to promote autonomy and control. *Advocacy* acknowledges the role of the health care professional to facilitate control back to the dying person. *Mediacy* influences the practices of the multidisciplinary team, and the wider context of health care. They also described the potential influence of nurses in reorientating health services in the care of dying people, in tandem with informing public policy. HPPC, they suggested, requires the development of a set of skills for professionals that could change the nature of health care practice.

Encourage interpersonal reorientation

In an attempt to reorientate occupational therapists' service provision to dying patients, vanderPloeg (2001) challenged her peers to extend their professional boundaries to optimise quality of life for their palliative care clients through the application of health promotion principles. She urged occupational therapists to optimise quality of life for palliative care clients through the use of a health promotion approach, and to provoke thought about individual practice rather than the wider issues of health care systems.

In a qualitative study of patient's perceptions of the therapeutic relationship with their nurses, another author proposed a "definition of health promotion relevant to palliative nursing in the primary setting" (Richardson, 2002, p.432). Richardson described twelve patients' perceptions of the therapeutic relationship with their nurses, which enhanced their feelings of health and wellbeing. The therapeutic interventions contained in these relationships were modelled on health promotion principles, distinguishing between the therapeutic relationship and the attention to the disease and its related symptoms.

Encourage reorientation of palliative care services

In an early attempt to articulate my nascent beliefs about how care of the dying could be done differently, I considered the inclusion of home-based palliative care services as integral to the Primary

Health Care framework as described in the *Declaration of Alma-Ata* (World Health Organisation, 1978); I suggested that a 'healthy death for all' was a worthy goal for the provision of palliative care outside of institutional care (Rosenberg, 1992). Whilst I make no claim to have had early inklings of a HPPC approach, my presentation at a national primary health care conference in 1992 has appreciably influenced my doctoral research which I will refer to shortly.

Combat death-denying health policies and attitudes

In Canada, Scott (1992) used an epidemiological examination of life-threatening illnesses to show that a significant proportion of the population were not likely to survive their ailments, demonstrating an ongoing need for comprehensive and responsive palliative care. He was critical of an over-emphasis upon the prevention of cancer at the expense of education for the palliative care phase, in light of the prevalence of incurable cancer, and the suffering it caused. Scott proposed health promotion and public education as key strategies to address the escalating burden of suffering. He also claimed that this approach holds benefits for the cost effectiveness of palliative care, and suggested that the application of public health principles to end of life care could lead to an acceptance by government of the role of palliative care services in promoting public health.

More recently, Rao and colleagues (Rao et al., 2005; Rao, Anderson, & Smith, 2002) have provided the most substantive descriptions of public health and health promoting approaches to end of life care. They assert the need for the concrete inclusion of a public health foundation in palliative care service planning. They have argued that connecting health to the community, providing information and establishing partnerships will raise death awareness, empowering the community to contribute to debate of issues of quality of life at the end of life is a sound basis for end of life care. Indeed, in their study of public health priorities for end of life initiatives, Rao and colleagues (2005) identified nine clusters of public health activity that were directly relevant to the provision of palliative care. Of these, five were identified as most feasible:

- Public education
- Patient, family and caregiver education
- Research, epidemiology and evaluation
- Professional education
- Policy and planning

Importantly, each these clusters were accompanied by a set of recommendations for action. For example, in the public education cluster, Rao et. al (2005) advised the use of strategies to raise public awareness of palliative care, increase the use of advanced health directives, integrate end of life issues into chronic disease educational materials, and operate some form of information clearing house for end of life issues.

An Australian Story

I conducted my doctoral research at an Australian palliative care service providing support to people choosing to die in their homes. As an organisation, the service had undertaken to integrate a HPPC approach as described in Kellehear's work. I studied the process of implementation of health promotion elements into the service's organisational structures and practices.

I asked staff and volunteers from the service about core concepts of health promotion, such as enabling, advocacy and mediacy (Russell & Sander, 1998) and these were instantly recognisable to staff as core concerns for palliative care. There was an acceptance that health promotion and palliative care were, at least in principle, congruent:

I think from the definitions I've read of health promoting palliative care, and the principles of it, and then hospice, they seem to fit together very closely... [director]

However for the most part, my examination of the transition being made to HPPC was framed by the five key action areas of the *Ottawa Charter*. Staff recognised some of these components in their palliative care organisation more readily than others. In particular, the two components that were most readily viewed as conceptually congruent were (a) *creating supportive environments* for consumers and for staff/volunteers, and (b) *developing personal skills*. Whilst other components of health promotion were less familiar to some respondents, they were, for the most part, viewed as appropriate inclusions in the work of palliative care. For example, strategies for *strengthening community action* such as an annual street market were seen as a fitting set of activities, but resource intensive.

With the health promotion component *building public policy*, there were some concerns expressed about the capacity of small, under funded palliative care organisations like this service to participate, despite the relevance of this component. However, a greater impediment to the implementation this component of health promotion was an apparent lack of understanding of the scope of public policy itself. Whilst there were a few examples of participation in committees responsible in some part for policy development that impacts upon the provision of palliative care, an understanding of the scope of public policy was not strongly evident. This includes the notion of advocacy by palliative care service providers to governments for consumers' needs as an organisational responsibility rather than simply a characteristic of individual practitioners.

For the most part, however, they were able to grasp the conceptual congruence of all the elements after further consideration. This is well demonstrated in this quotation from an interview with a staff member:

It's going to be taken up more readily and incorporated more readily because there's an alignment there...it's not out of place with what is already in the philosophical thinking or with the work practice... [staff member]

So there was a sense amongst the staff that, using the *Ottawa Charter* key action areas, the service already demonstrated to varying degrees the components of health promotion, in its practice. This dynamic state is illustrating in Figure 1, which I've reproduced here from my thesis.

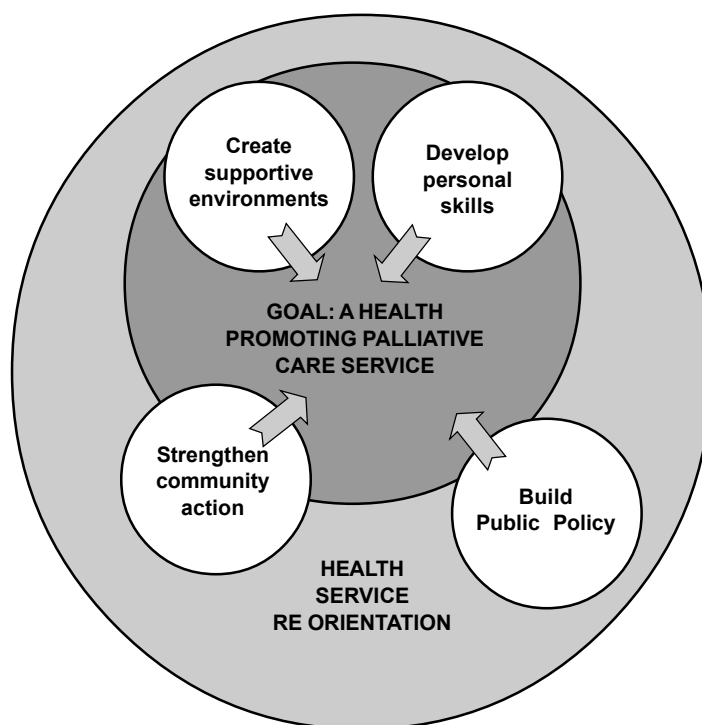


Figure 1: Integration of Health Promotion components

However, this understanding led the staff to ask questions about the HPPC approach. Firstly, there were questions whether ‘health promoting palliative care’ was just the latest jargon used to describe established and familiar elements of palliative care practice, particularly the components of *creating supportive environments* and *developing personal skills*. Their familiarity with these elements perhaps led to their perception that HPPC is a new term for established practices. This focus group participant asserted that

...health promotion is what we do. Someone has now come up and given it a name. I think all we can keep doing is keep on at it.

Whilst this claim showed conceptual congruence was strong, it also demonstrates that participants in my research overlooked consideration of the other key action areas of HPPC as equally important in end of life care and integral to a HPPC model. As it was perceived as a new way of describing much of what was already done, the integration of health promotion principles and practice was viewed somewhat uncritically by some as already underway in the service.

Secondly, questions were asked whether HPPC captured the ‘core business’ of the palliative care service – again, for just a few respondents understood HPPC as a whole approach:

...while our core business remains home-based palliative care and education and support for families, it's also looking at affecting community attitudes to life and living, death and dying, funeral, the whole topic of death and preparing for death.[director]

Others, however, viewed elements of HPPC as ‘optional extras’ for the conventional approach to palliative care service provision. The ‘clinical’ components were seen to be of a higher priority by

these staff members than those focused upon community action. Significantly, those non-clinical services that can be 'delivered' as a 'service' – such as education – appeared more acceptable than those requiring robust engagement with the wider community.

These misgivings exceed Kellehear's (1999) prediction that HPPC might be viewed as simply "an additional thing to do" (p.23). This 'conceptual blurring' represents a risk to the effective implementation and practice of HPPC.

Achieving conceptual clarity

These examples demonstrate a paradoxical situation in the integration of HPPC in organisations. On the one hand, when the elements of health promotion are defined and explored by palliative care organisations, conceptual recognition seems to enable acceptance of HPPC as a valid approach to end of life care. On the other hand, however, the recognition of these elements has also led to both a sense of HPPC being an 'add-on' to clinical work, and a ready assumption of success in the integration of HPPC. This apparent ambivalence about elements of a HPPC model is worth considering in light of Kellehear's assertion that:

Supplying health education or social support does not make a palliative care service health promoting any more than the provision of pain relief and a chaplain constitutes a conventional palliative care service. The practice of health promoting palliative care is a practice that embraces all the concerns together, in

concert. (Kellehear, 1999, p.23)

This quote, the descriptions from the literature and my own study illustrate that conceptual blurring represents a great risk to the integration of HPPC. How then can conceptual blurring be avoided or remedied?

Let's return to the original components of the *Ottawa Charter* and pay specific attention to their translation into palliative care (Table 1). Taking *Building public policies that support health* as an example, we know a number of authors have conceptually linked the practice of palliative care to public policy, arguing that death and dying are concerns for whole communities and society, and is consequently a concern of governments in their policy-making role. In turn, therefore, organisations that utilise a social model of health, such as that presented in HPPC, are validly able to include the development of public policy within their remit. This lends some support to the view that the end of life is indeed a public health concern, given the "universal incidence" (Rao, Anderson, & Smith, 2002, p.215) of death. In *Compassionate Cities* it is proposed a comprehensive policy framework for public health approaches to the end of life, including but not restricted to HPPC (Kellehear, 2005). For example, Kellehear suggests the expression of compassion around issues of end of life translates into local health policies that recognise compassion as an ethical imperative, demonstrated in community education strategies including public forums, discussion groups, and crisis intervention. The responsibility of developing, implementing and evaluating these activities rests in partnerships between communities and organisations concerned with end of life issues. Notably, whilst this includes palliative care services, these public health strategies could be provided by grief and bereavement support services, aged care facilities, funeral directors, and other organisations concerned with end of life issues.

Key Action Areas to Support Health	Health Promotion Description	In Palliative Care Organisations
Building public policies that support health	Health is on the agenda of all policy makers, who must consider the health consequences of policy decisions. Obstacles to the adoption of healthy public policies need to be identified and removed.	Concerned with the participation of organisations in the development and/or uptake of public policy relating to palliative care and the support of dying people.
Creating supportive environments	Health cannot be separated from other societal goals. A sociological basis for health embraces the links between people and their environment.	Concerned with the ways in which organisations contribute to the creation of supportive environments to enhance well-being for consumers and employees of the palliative care service.
Strengthening community action	Communities set their own health priorities, make decisions, and plan and implement strategies to promote their empowerment. Community development enhances participation in, and direction of health matters.	Related to the nature of the engagement of organisations with the wider community, beyond the recipients of palliative care services, to promote community action towards improved support of people at the end of life.
Developing personal skills	The enhancement of life skills through personal and social development promotes people exercising control over their health throughout life.	Concerned with organisations' participation in the development of personal skills to assist individuals to deal with issues around death and dying. Includes both health care professionals and primary caregivers.
Reorienting health services	Responsibility for health promotion within the health care system rests with all participants. Health services must move beyond clinical and curative services to support individuals and communities for a healthier life. Health research, professional education and training are necessary strategies for refocusing health services toward the needs of the whole person.	Related to the activities of organisations in reorienting their members to a health promoting approach, and has a particular focus on the holistic needs of its client population, and changes in organisational attitudes.

A genuine embracing of the social domain of dying through HPPC could lead to a paradigmatic shift in our many health systems and communities wherein dying people and their families are participants in the identification of need, and in the direction of care and support. These are clearly concepts close to both health promotion *and* conceptualisations of patient-centered care and holism so evident in the key concepts of palliative care. HPPC facilitates the preservation of social networks (including family) being seen as a priority for recipients of palliative care services and a validation of the desirability of social models of care (D'Onofrio & Ryndes, 2003).

Create a Critical Mass for HPPC

Fundamental to the integration of health promotion with palliative care is the acceptability of the key concepts to the stakeholders in its implementation. Yet, in my study, the only respondents who demonstrated an understanding of the model as a whole were (a) the senior staff member charged with responsibility for the implementation of health promotion principles and practice in the service, and (b) a general staff member who had undertaken post-graduate studies in HPPC. That is to say, while other respondents demonstrated accurate understandings of specific components of health promotion, they did not demonstrate understanding of the HPPC model as both multifaceted and a whole approach. The suggestion of creating a critical mass of organisational personnel skilled and knowledgeable in health promotion (Whitelaw, Martin, Kerr, & Wimbush, 2006) may have addressed this.

Whole-of-Organisation Transition

To counter the risk of the compartmentalising of the elements of health promotion evident in my study and others' work, I believe a whole-of-organisation approach is optimal. There was some debate amongst respondents of my study as to whether a paradigmatic shift of this scale should – or even could – be implemented in a single, organisation-wide adjustment or rather, incrementally. In the service I studied the implementation of health promotion principles and practice was apparently piecemeal and, apart from a single planning document, seemed to lack a systematic, planned and organisation-wide perspective. This perhaps reflects limited understanding of the whole-of-organisation approach and the broader health promotion agenda. The fact that the site of my study struggled to formulate a comprehensive plan is itself indicative of the complex nature of the task and the multifaceted response it requires for success:

...we need a whole plan under the five strategies rather than doing one thing at a time. If you're changing public policy, you should be able to build sustainable communities at the same time...you have to create awareness, so people are aware what palliative care is...to effect public policy change, you have to get the voters to change public policy, so creating awareness is part of building sustainable communities.)

Frameworks to facilitate such a plan have been suggested. For example, the HPPC practice guidelines developed by Kellehear and colleagues (Kellehear, Bateman, & Rumbold, 2003) provides a framework to guide palliative care organisations to undertake concrete health promoting activities such as support groups, death education and policy development at governmental levels. One criterion of this framework is comprised of elements of a discrete community development program.

Salau (2006) proposed her “*Big 7 Checklist*” based on the work of Kellehear and his colleagues, which enables palliative care organisations to assess the alignment of end of life programs with public health and health promoting criteria. This checklist includes prevention of social difficulties around death and loss through early intervention, participation of community members, the sustainability of programs, and evaluation of their outcomes. An operational model for community based quality improvement in palliative care has been proposed by Byock et al. (2003) which demonstrated a method by which an organisation can establish the basis for its planned change, target priorities, develop and apply interventions and evaluate their effectiveness. It utilises the quality improvement cycle. With organisation-wide goals, it accommodates incremental implementation of strategies on an ongoing basis. In its emphasis upon a community approach to end of life care, it offers one approach to implementing HPPC.

Approaches other than whole-of-organisation have been suggested. Support for an incremental approach is found in work by Stajduhar et al. (2006) who chose a graduated approach in order to limit the risk of staff becoming overwhelmed by change of this magnitude. Others describe a lengthy, cyclical and complex process (Elwyn & Rhydderch, 2002). Further evaluation of the effectiveness of these approaches is required.

Conclusion

This discussion has attempted to explore the phenomenon of conceptual blurring within HPPC, where the key concepts of both health promotion and palliative care are poorly understood and can lead to insufficient implementation of HPPC. An incomplete understanding of the scope of HPPC is likely to result in the failure to successfully integrate HPPC. The need for systematic approaches across the whole of organisations and health systems to implementing organisational change is clear.

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