philosophy and ethics have much to learn from each other as have those from different ethnic backgrounds and religions.

This conference provided us with the opportunity and privilege of crossing these boundaries and was highly valued by its participants. Congratulations are due to the staff of Cruse Bereavement Care and, particularly to the conference organiser, Sarah Hill, who not only made the whole event possible but serenaded us all as we danced the night away on a delightful trip down the River Thames.

It is with great pleasure that we welcome the decision to hold the 8th **International Conference** on Grief and Bereavement in Contemporary Society in **Melbourne, Australia in 2008** under the auspices of the Centre for Grief Education and the Australian National Association for Loss and Grief. Watch this space! ●

TRIBUTE

Cicely Saunders OM DBE FRCP FRCN 1918-2005

photo © St Christopher's Hospice

Although Cicely Saunders is best known as a pioneer of the hospice movement and concerned with improving the care of dying cancer patients, she also played a major part in supporting their families. Rather than yet another obituary, this tribute focuses on the influence she had on hospice bereavement services.

Cicely first wrote to me in 1965 in response to my paper, 'The pastoral care of the bereaved' [1]. She described a new type of hospice she was founding in London (later to be called St Christopher's after the patron saint of travellers). Meeting her in person with John Bowlby later that year, I was impressed by her single-minded devotion to her patients and her recognition of the need for family care.

Soon afterwards Cicely came to stay with my family in Boston, USA. She spoke of her regret that, as a doctor, she could do little for families after bereavement and asked me to help her to create a service for bereaved people at St Christopher's Hospice. At the time I was directing the Harvard Bereavement Project, a short longitudinal study of young widows and widowers looking at risk factors at the time of bereavement which would predict who would do well and who badly. Cicely's request coincided with my wish to find a 'test bed' for the results of my researches. She had a quality of directness and a lack of dissimulation; by the time she left our home I was hooked.

Within psychiatry, an idea was gathering momentum of replacing the staff-dominated mental hospitals with therapeutic communities of staff and patients working together to find a better quality of life for the patient. It seemed to me that what Cicely Saunders was describing was a kind of therapeutic community for families invaded by cancer. I wrote down my thoughts in the form of a letter to which she replied enthusiastically, expressing her interest in the 'non-hierarchical staff structure' I had described and also `the work [with] families both while the patient is ill and afterwards' [2].

St Christopher's Hospice opened its doors in 1967 and it has been my privilege to act as psychiatrist to the hospice ever since. While there was never any doubt who had the final say, Cicely was very open to new ideas and listened with respect to all of her staff. As a result we all felt valued and gradually learned to respect and, in the end, to love her. She wrote, 'The long pain of the family's bereavement is a part of terminal pain. They will begin to grieve their imminent parting during the patient's illness but the real letting go and approach to the new situation will rarely happen before the patient dies'[3].

Although the idea of a family service had been approved by Cicely, and encouraged from the start, the details were worked out over several years. From the outset all members of staff were encouraged to get to know the families, but it took several years before the family tree got onto the front of the case notes and all nurses, doctors and social workers could draw one. Staff members were encouraged to provide ongoing support to any bereaved family member who asked for it and to make home visits when necessary, but few relations asked for help and busy staff seldom made home visits after bereavement.

It took the suicide of the widow of one of our patients to persuade us that self-referral was not the best method of choosing patients for follow-up. At this juncture, I was able to initiate the research project that subsequently demonstrated the value of proactive intervention for high-risk bereaved people using carefully selected and trained volunteer counsellors.

Looking back it seems amazing how quickly the model of palliative care that was initiated at St Christopher's has spread across the world. The focus on cancer has been widened to include HIV and other life-threatening illnesses; indeed, an entire science of palliative medicine has come into being with university chairs and huge tomes, such as the *Oxford Textbook of Palliative Medicine*[4], encapsulating a growing literature on every aspect of symptom control and other treatments.

TRIBUTE

Within that huge *corpus*, bereavement has remained something of a Cinderella.

In some hospices the model of bereavement service developed at St Christopher's has been copied, often in a slavish way, and without the fresh research that encourages healthy growth; in others the need for bereavement support has been exaggerated. Thus, in the USA it became a condition of hospice funding that every bereaved person should receive the help of a bereavement service. It is paradoxical that, in many parts of the world, it is now necessary for someone to die in a hospice for the family to obtain bereavement care.

Outside of the hospice movement the research and service developed at St Christopher's has stimulated a wide range of services including services for bereaved children and in disaster areas. For example, St Christopher's now runs its own child bereavement service (The Candle Project) that is not restricted to the children of patients dying in the hospice. Likewise, several hospices in the Indian Ocean region provided bereavement support to survivors of the tsunami on 26 December last year.

The institutionalisation, or fossilisation, that often accompanies charismatic movements may now be changing. Several well-conducted evaluations of hospice services have shown that most bereaved people do not need and will not benefit from counselling. On the other hand a number of methods of helping with particular problems have proved their worth. These include David Kissane's family focused grief therapy, which was developed in hospices and cancer units in Australia[5].

Cicely's model of care grew out of her love for a patient and it is not surprising that, within the hospice movement, it is the patient who remains the focus of care. But the time may be approaching when it is the family, which includes the patient, which will be recognised as the appropriate unit of care, for in the end the patient's troubles will soon be over, while those of their families may just be beginning.

Cicely Saunders died peacefully, aged 87, of cancer, in the hospice that she had created. When last I talked with her she told me that her bags were packed and, although she was not suffering and was full of praise for the staff, she was tired of life and ready to move on. In a book of selected readings she edited, *Beyond All Pain*[6], is a quotation from Hebridean altars that can be taken as a farewell message to us all:

> Beloved, go and live thy life in the
> spirit of my dying,
> In righteousness and love;
> Then truly shalt thou share my victory
> and taste my peace. ●

Colin Murray Parkes
Consultant Psychiatrist

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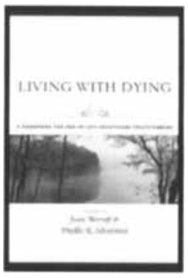
BOOK REVIEW

Living with Dying

A Handbook for End-of-life Healthcare Practitioners

Joan Berzoff, Phyllis R. Silverman (eds)



New York/Chichester
W Sussex, UK
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This large tome of 44 chapters is mainly written by and for social workers. The editors are leading figures in American end-of-life social work. Four sections present personal experiences and reflections, theory in death and dying, clinical issues in work in particular groups and settings, and policy and management issues.

The main focus is on social work during the process of dying. The editors see bereavement work as integral to that but most chapters do not attempt this integration explicitly. For example, otherwise good overviews of social work in hospice, and on clinical social work, practice in end-of-life care barely mention bereavement. Silverman's thoughtful chapters on the history of social work in end-of-life care, on bereavement as a transition and on helping bereaved people are some compensation.

The perspective is often psychodynamic. Berzoff's excellent chapter on psychodynamic perspectives in grief and bereavement is not matched by similar treatment of other approaches, although constructivist viewpoints using narrative are represented. Cultural factors in assessment and treatment are emphasised, an approach that distinguishes American social work from the British focus on anti-discrimination. Case management and advocacy in social work, recognised by the editors, are not reflected in the largely counselling focus of many chapters.

Much of this book, therefore, does not speak to theoretically eclectic social workers in the British welfare system as well as Currer's briefer text[1]. However, applying the insights on end-of-life care in Berzoff and Silverman's broad-ranging collection to bereavement care offers interesting ideas, covering individual, family and group work. ●

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