

Age-Friendly Communities: Are they also “Friendly” for Death, Dying, Grief, and Bereavement?

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Article

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Résumé

Le mouvement des collectivités-amies des aînés vise à créer les conditions d’une vie saine et satisfaisante pour les personnes vieillissantes. Il promeut l’activité et l’inclusion grâce à des politiques, des services et des structures qui permettent aux personnes âgées de continuer de pratiquer les activités qui leur tiennent à cœur. Nous suggérons que les collectivités pourraient accroître l’inclusion et réduire l’âgisme en améliorant leur attitude face à la mort. Une conception positive de la mort pourrait être la pierre angulaire d’une collectivité où les gens ne craignent pas de vieillir et où les personnes âgées ne sont pas exclues. Pour étayer cette hypothèse, nous étudions les bienfaits du modèle des communautés bienveillantes qui a émergé des soins palliatifs et de la pensée critique sur la santé publique. Les communautés bienveillantes se concentrent sur la planification de fin de vie, le soutien dans le deuil et une meilleure compréhension du vieillissement, de la mort, de la perte et des soins. Les collectivités-amies des aînés et les communautés bienveillantes sont complémentaires dans leurs objectifs, mais n’ont pas encore convergé dans la pratique. Nous suggérons qu’elles devraient le faire.

Abstract

The age-friendly movement aims to ensure that people can live healthy and meaningful lives as they age. It is committed to activity and inclusion, with policies, services, and structures that enable older adults to remain engaged in activities that they value. We suggest that there is further opportunity for communities to increase inclusion and reduce ageism by improving their “death-friendliness”. A death-friendly approach could lay the groundwork for a community in which people do not fear getting old or alienate those who have. To this end, we consider the merits of the compassionate communities framework which has emerged out of palliative care and critical public health. Compassionate communities focus on end-of-life planning, bereavement support, and improved understandings about aging, dying, death, loss, and care. The age-friendly and compassionate communities initiatives are complementary in their objectives but have not yet converged in practice. We suggest that they should.

Introduction

Age-friendly communities are ones in which policies, services, and structures are established to support older adults in “aging actively” (Public Health Agency of Canada, 2016). The World Health Organization (WHO) launched its Global Age-Friendly Cities Project in 2006 in an effort to shift from individual-focused service delivery towards a focus on the community context in which we age (Jeste et al., 2016) and broader determinants of health. This approach involves municipal planning and intersectoral collaboration related to eight priority domains: outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, and community support and health services (World Health Organization, 2007). The aim is to ensure that a community enables older people to be safe, healthy, and supported.

The concept of age-friendliness has garnered considerable international interest from researchers, policy makers, and community organizations (Novek & Menec, 2014). In the Canadian context, communities undertake a process of demonstrating to the provincial or territorial authorities that they have successfully achieved the five Pan-Canadian Age-Friendly Communities Milestones (Government of Canada, 2023). This grants them formal recognition as an age-friendly community. Additional recognition can be sought from the Public Health Agency of Canada or the WHO.

While conducting field research on age-friendly communities in 2019, we interviewed an older woman whom we will call Edna. We spoke with Edna at a seniors centre in Ottawa, Canada.

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She told us that after her husband died, she spent 13 years as a “shut-in” and barely left the house. She contemplated ending her life. Her daughter finally convinced her to take a tour of a local seniors centre and Edna went along “just to shut her up.” At the seniors centre, Edna met wonderful people, found meaningful activities, and became an active member of the centre. This could easily be understood as a story about the success of this centre and its programming; however, we also understood it as a story about unattended grief in older adulthood. The age-friendly movement is attentive to older adults becoming socially isolated. Seniors-focused organizations work to create more accessible transportation and more appropriate programming, which do help, but there is little discussion about the ways in which grief can contribute to isolation.

It seemed to us that there was opportunity for more discussion about dying, death, and bereavement in the age-friendly community context. We posed the question: what would it look like for a community to not only be age-friendly, but also “friendly” towards death, dying, and grief? In the WHO framework for age-friendly cities (World Health Organization, 2007), explicit discussions about death, dying, and grief are largely absent. For example, there is one reference to the potential erosion of social networks after the death of a spouse, but little else on this topic. Similarly, a scientometric review of the age-friendly communities and cities literature does not include the topics of serious illness, death, dying, and loss (Xiang, Shen, Tan, & Liu, 2021). As Vanderstichelen et al. (2022) suggest, “aging in place also requires thinking about dying in place. While there is some important literature on dying in place (Lau, 2021), the role of the community in achieving this outcome has not been fully explored” (p. 1394).

In North America, death is commonly framed as an individual problem, rather than a communal issue (Ariès, 1976; Clarke, 2006). It is often medicalized, resisted, and feared. As a result, we tend to attach negative associations to the concept of death and to the aging process itself (Davis, 2020). Kellehear (in Smith, 2019) claims that grief is also poorly understood and under-recognized, both as a personal experience and as a social issue. This is important to bear in mind given the cumulative losses experienced by older people who outlive many of their peers and loved ones.

In this article, we discuss an initiative born out of palliative care and critical public health: the compassionate community approach. This approach focuses on community development related to end-of-life planning, bereavement support, and improved understandings about aging, dying, death, loss, and care (Kellehear, 2013). We consider several of the merits of this approach, as it might relate to age-friendliness. The age-friendly and compassionate communities initiatives are complementary in several of their objectives but have not yet converged in practice. We suggest that they should.

Although some individuals have cultural communities or faith groups with practices and rituals to support them through dying and grieving, there is little done by the secular state to support this important part of life. Given that the work of age-friendly communities takes place at the municipal level of governance (the level of government generally considered closest to the people), we think that there is opportunity and responsibility for those undertaking this work to better engage with our mortality.

In what follows, we outline several common assumptions about dying and death in the Canadian context and discuss the medicalization of death, the connection between fear of death and negative views about aging, and the potential benefits of bringing together the work of age-friendly and compassionate communities. We conclude by recommending that those involved in developing

and implementing age-friendly strategies reflect on how people prepare for death in their cities and when this process begins. Where do people go to die? Where and how do people grieve? To what extent, and in which ways, does a community prepare for death and bereavement? We suggest that age-friendly initiatives would be richer if they contended with our mortality, anticipated diverse end-of-life needs, and sought to understand how communities can indeed become more “death-friendly”.

Canadian Context for Death and Dying

Canadian Assumptions about Death and Dying

In the Canadian context, there are a number of common assumptions about death, many of them related to end-of-life care. It is important to question these assumptions because they shape our experiences and inform our policy responses. Some of these assumptions contribute to the underfunding of end-of-life care (Coyle & McKeever, 2001) and are often shattered when one has to make use of the care system. At this point, the gaps between assumptions and reality become very tangible.

One common assumption is that publicly funded home care services will be available to us when we are dying (Arnup, 2013). “Home care” refers to personal care, health care, and/or palliative services provided for an individual living in their own home or in another private residential setting. However, home care is not an essential health care service guaranteed under the Canada Health Act. It is provided regionally with funding from provincial and territorial governments. The exact nature of the service and the number of available hours varies across provinces and territories (Coyle & McKeever, 2001). With varying levels of access to these services, many people rely upon informal care work from family members and friends for end-of-life care. In fact, some regions anticipate that home care will work in tandem with informal support networks. In the province of Alberta, for example, “[h]ome care services are intended to supplement, not replace, the help and support received from family, friends, and other community supports” (Alberta Health Services, 2019). Embedded in this assumption about home care are expectations that 1) we each have a home and 2) that home will be where we die. Until the 1950s, most Canadians did die in their homes. However, in recent years, the site of death has largely shifted to hospitals, hospices, long-term care homes, or other health care institutions. Between 2013 and 2017, 59 to 62 per cent of deaths in Canada took place in a hospital (Statistics Canada, 2017), in contrast with 29.8 per cent in the United States (Cross & Warraich, 2019) and 46 per cent in England (Public Health England, 2021). This shift has had profound societal implications. For example, fewer people are present for a death and, as a result, the dying process has become less familiar and more frightening to us. “Fear of the actual death is one of the main reasons people re-hospitalize the patient at the point of death or refuse to care for the dying at home” (Sankar, 1991, p. 134). Therefore, despite a system that increasingly relies upon it, many families feel unprepared to support a relative through the dying process at home.

This leads to the next assumption, the assumption that family members will take care of us when we die (Arnup, 2013). Within this assumption are a number of expectations. One such expectation is that older people will have family members living nearby, with whom they have a close relationship. Another is an expectation that these family members, traditionally women, will willingly provide unpaid care in the family home (which is assumed to have

sufficient space and appropriate amenities) at little cost to themselves (Shooshtari, Duncan, Roger, Fast, & Han, 2017; Williams, Giddings, Bellamy, & Gott, 2017). There is little public discussion about the division of this labour amongst family members, the expenses related to providing care at home, or the family histories and dynamics that can complicate care planning. Another assumption is that family members are best suited to provide this care and that their efforts will be sustainable until the point of death. To date, there has been limited systemic attention paid to the challenges that informal end-of-life care poses for families with lower incomes, heavy paid workloads, and/or multiple dependents. There is considerable evidence that many family caregivers are stretched beyond their capacity, experiencing physical, psychosocial, and financial challenges (Stajduhar, 2013) and yet, dominant representations of death in Canada portray death as a relatively solitary journey of the dying person, without significant impact on others.

This leads to the next assumption, or better yet concern, that the dying person will become a burden, particularly if they are to die at home. Research suggests, however, that caring for a dying loved one can be a deeply meaningful, if not sacred experience (Hudson, 2004; Phillips & Reed, 2009). As one family member put it, "Care-giving for Mum has been one of the most rewarding things I have ever done – I am left with the most wonderful memories of my mother whom I got to know in a way that was so much deeper than I could ever have imagined," (quoted in Aoun, Kristjanson, Hudson, Currow, & Rosenberg, 2005, p. 322). However, this positive experience may be intertwined with deep distress if the needs of carers and especially of the dying are not able to be met with existing supports (O'Sullivan, Alvariza, Öhlén, & Larsdotter, 2021).

Another assumption is that we will have some degree of control over our death. In an analysis of the portrayal of death in Canadian mass print English language magazines, Clarke (2006) notes that this media's discourses about death reflect a focus on the individual and their capacity to exercise control over the timing and manner of death. There has been considerable focus on individual rights to die, to extend life, and to make choices about medical intervention and there has been less attention to communal aspects of dying and death:

[Death] is not portrayed in the context of prevention, suffering, palliation, or community supports. The links between economic, ethnic, and other forms of inequality and death rates are ignored... Death in communities and families is virtually absent (Clarke, 2006, p. 162).

In other words, there appear to be assumptions in Canada that death is an individualized experience and that the supports available to those who are dying are homogenous, consistent, and equally accessible. It is important to note that these assumptions do not reflect the diversity of perspectives of death and dying present in Canada, particularly Indigenous and Eastern perspectives. Rather, these assumptions reflect the dominant views that we see in the health care system and in popular discourse.

The Medicalization of Death

Our health care system often accepts a medicalized version of health and of death. Indeed, death is a classic example of medicalization (Illich, 1976), which is a process by which social and personal issues are understood as medical problems requiring clinical management (Zola, 2005). Medicalization should not be understood as an *imposition* of medical power (Conrad, 1992), because as many palliative care physicians will report, family

members are often the ones who have a very difficult time accepting death and push for continued treatment (Lind, Bengtsson, Alvariza, & Klarare, 2022). Medicalization is perhaps better understood as a form of "collusion" between us and our fears of death and medicine's utopian aspirations. As Heath (2013, p. 2) puts it: "The whole discipline of medicine has colluded in the wider societal project of seeking technical solutions to the existential problems posed by the finitude of life and the inevitability of ageing, loss, and death."

The medical system typically treats death as something to be resisted, postponed, or avoided (Clark, 2002), often via the use of medical technology. Death is then depicted and experienced as a medical failure. This leads to a contemporary dance of death where physicians are often cast as our dance partners and death and dying become highly professionalized: the purview of experts (Banerjee, 2008). It is also worth noting this is a very particular kind of death; an enemy. A dangerous death to be feared. Given this, it should not be surprising that it can be difficult to have "friendly" conversations about death in the health sector and related fields.

Arguably, dying in Canada has come to be further medicalized through the legalization of medical assistance in dying (MAiD) in 2016 with the passing of Bill C-14 (Government of Canada, 2022). Bill C-14 allowed for individuals who meet certain criteria (i.e., have a grievous and irremediable medical condition that includes having a serious and incurable illness, disease, or disability for which a natural death has become reasonably foreseeable) to solicit assistance in ending their lives via a prescribed lethal substance. Assessments and provisions are handled by physicians and/or nurse practitioners. The passing of the law responded to a long debate and series of court challenges. Since its passing, there have been at least four additional court challenges, two for expanded access and two for greater protections (Government of Canada, 2020). In 2021, the law was amended via Bill C-7 to allow people who are experiencing grievous and irremediable suffering but whose deaths are not reasonably foreseeable to have access to MAiD. The practice creates a unique context for dying, both for individuals making the decision to actively solicit medical assistance, and for the bereaved, whose grief may be different depending on how the decision was made and their involvement in it (Cullen, 2016; Walker & Wong, 2018). MAiD medicalizes death insofar as it involves turning to the health care system to hasten and manage a naturally occurring process, making death the work of clinical care professionals. The increasing popularity of MAiD (3.3% of all deaths in Canada in 2021 [Government of Canada, 2022]) aligns with Clark's (Clarke, 2006) discursive findings regarding a growing understanding of death as something that can be controlled, clinically managed, and directed via individual autonomy.

However, MAiD may also be understood as an attempt to bring dying back into life, resisting the health care system's battle against the inevitability of death, accepting mortality, and providing a safe and supportive context for dying. The issue is complex. What is clear is that the creation of space to have these conversations about death skillfully, as well as the cultivation of these skills, are heightened in the post-MAiD era (Serota & Ho, 2021).

How Might Death-Friendliness Improve Age-Friendliness?

Age-friendly communities have a stake in addressing the fear of death. In Western culture, aging and death are frequently associated with one another, and not positively. Growing old can signal one's mortality and trigger avoidance. Not surprisingly,

“anti-aging”, rejuvenation, and turning back the epigenetic clock have become goals for both health and beauty. The fear of death can also contribute to prejudice against older adults. An example of this comes from a study that looked at graduate trainees in psychology. The authors found that students with death anxiety were less willing to work with older adults in their practice because they associated them with death and dying (Mejia, Hyman, Behbahani, & Farrell-Turner, 2018). Similarly, a study found that death and aging anxieties were both positively related to ageism (Bodner, Shrira, Bergman, Cohen-Fridel, & Grossman, 2015). The relationship between these anxieties and the prejudicial views remained significant even after the authors controlled for a variety of characteristics and health measures. In other words, “older adults represent their own future death, and, therefore, [younger adults] buffer against this threat by assigning older adults outgroup status” (Barnett & Adams, 2018).

Addressing the fear of death may therefore support the cultivation of age-friendly communities by reducing the fear of aging and ageism. Whereas it may be comparatively easy to imagine an age-friendly society, what would it mean for a community to be *friendly* towards death? Let us begin by taking the metaphor of “friendliness” seriously. Friendship suggests familiarity. It suggests efforts to know and understand death. It suggests an acceptance of mortality. Not all friendships are easy; and we are not suggesting that this relationship need be. However, it is a relationship in which death has a place. A death-friendly community might therefore not push death to the margins of society or seek to avoid it in life. It might instead actively cultivate connection with death. This could include implementing structures, services, and practices that anticipate and make space for dying, death, and grief as normal parts of living. It could include learning from Indigenous traditions that have long understood the boundaries between life and death to be porous. And it could include learning from wisdom traditions that have understood mortality to be central to the human condition and to living well. Canada is a diverse country and there are many sources of inspiration for positively engaging with death as an integral part of life.

Within the field of gerontology itself, narrative and contemplative approaches to aging provide resources for a friendlier relationship with death and can contribute to the goals of both age-friendly and compassionate communities. Narrative gerontology, for example, has emerged as a rich subfield developing theoretical and practical strategies to work with loss, grief, and death. Narrative gerontology recognises the importance of an interior life and, in particular, the role that story plays in the construction of personal identity (de Medeiros, 2013). With the recognition that there is space between what happens to us and the meaning that these events are given, forms of narrative care have developed to support individuals in facing their finitude and mortality (Irwin-Kenyon, 2016; Randall, 2019; Synnes, 2015).

Similarly, in advocating for contemplative aging, Edmund Sherman (2010), recognises the value of cultivating a rich inner life and the benefits of reflecting on “the meaning and experience of one’s own being” (p. 6). From a contemplative perspective, these reflections are often prompted by the losses that come with aging. Thus, rather than understanding loss, frailty, or even death as threats to self, contemplative approaches recognise that not only are they normal parts of life but also that engaging with them may reveal truths about existence. Importantly, a contemplative approach cultivates values different from the will to control that contributes to medicalization, valuing instead openness, receptivity, acceptance, and “being with” (Kenyon, 2011).

From this space of contemplation, we may be more willing to learn from wisdom traditions that have been long ignored, neglected, colonized, or actively suppressed. Yoga and Buddhist-inspired mindfulness, for example, are fundamentally concerned with the challenge of living well under conditions of impermanence (Banerjee, 2023). Although they are gaining in popularity in Canada, within the health sciences, their contemplative dimension tends to be neglected in favour of a more medicalized approach that reduces them to tools in a project of fighting aging and death. Similarly, Indigenous knowledges have much to teach us, given they tend not only hold more accepting views of mortality but also to encourage more sustainable ways of living, which as Rowe and Matthews (2021) point out, are not unrelated. A contemplative gerontology may be more open to learning from these traditions and contributing to the development of what Randall and Kenyon (2004) refer to as “wisdom environments.” These are environments that provide knowledges, skills, and resources (e.g., stories, metaphors, or role models) for people to age well and approach the end of life with less trepidation.

There are therefore important synergies between age-friendly and compassionate communities approaches. In addition to responding to ageism through educational efforts and intergenerational activities/opportunities as the WHO framework for Age-Friendly Communities (World Health Organization, 2007) suggests, there is further opportunity for communities to reduce ageism by improving their death-friendliness. A wiser, more death-friendly approach could potentially lay the groundwork for a community in which people do not fear getting old or alienate those who have. Gerontological scholarship, particularly of the narrative and contemplative subfields could support this endeavour, while the compassionate communities offer a potential framework to pursue death-friendliness.

The Compassionate Communities Approach: A Promising Practice?

The compassionate communities approach has its origins in the WHO concept of “healthy cities” or “healthy communities” (Kellehear, 2005, 2013), and the notion that health is everyone’s responsibility, not only that of health professionals. The approach emerges from two critiques (Kellehear, 2005). The first is a critique of the professionalization of end-of-life care and a call to “recreate community involvement” in the care of the dying (p. ix). The second is a critique of public health and its failure to adequately respond to death and loss. The compassionate communities approach uses public health methods (e.g., public education, health promotion, participatory action) and collaborates with those in palliative care to engage in community development around dying and death. A compassionate community is one that recognizes “all-natural cycles of sickness and health, birth and death, and love and loss occur every day within the orbits of its institutions and regular activities” (National Council for Palliative Care, 2015).

A key development tool is the Compassionate Communities Charter that identifies 13 sites for action (Abel & Kellehear, 2021a). The original charter made recommendations for addressing grief and death across several locations, focusing on institutions and public bodies (e.g., schools, workplaces, churches, museums). With the aim to respond to the diversity of experiences, the 2021 revision brings “the charter into streets and neighbourhoods, making it as inclusive as possible in covering the full range of human activities” (Abel & Kellehear, 2021b). The 13 domains identified by the

charter are reproduced in Table 1. Given that the Charter was conceived prior to the COVID-19 pandemic, we would add a 14th domain which would address the growth of online funeral sites and bereavement support networks (Muturi, Freeman, & Banner-Lukaris, 2020). The virtual world will likely continue to be a valued “location” for celebrating and grieving post-pandemic. It is also worth noting that the Compassionate Community Charter calls not only for efforts to raise awareness and improve planning,

Table 1. Compassionate Communities Charter, 13 action points

Through auspices of the mayor’s office a compassionate city will – by public marketing and advertising, by use of the cities’ network and influences, by dint of collaboration and cooperation, in partnership with social media and its own offices – develop and support the following 12 social changes to the cities’ key institutions and activities.
1. Our schools will have annually reviewed policies or guidance documents for dying, death, loss, and care.
2. Our workplaces will have annually reviewed policies or guidance documents for dying, death, loss, and care.
3. Our trade unions will have annually reviewed policies or guidance documents for dying, death, loss, and care.
4. Our churches and temples will have at least one dedicated group for end-of-life care support.
5. Our city’s hospices and nursing homes will have a community development program involving local area citizens in end-of-life care activities and programs.
6. Our city’s major museums and art galleries will hold annual exhibitions on the experiences of aging, dying, death, loss, or care.
7. Our city will host an annual peacetime memorial parade representing the major sectors of human loss outside of military campaigns – cancer, motor neuron disease, AIDS, child loss, suicide survivors, animal companion loss, widowhood, industrial and vehicle accidents, the loss of emergency workers and all end of life care personnel, and more.
8. Our city will promote compassionate communities programmes to engage neighbourhoods and local streets in direct care activities for their local residents living with health crises, aging, caregiving, and grief.
9. Our city will create an incentives scheme to celebrate and highlight the most creative compassionate organization, event, and individual/s. The scheme will take the form of an annual award administered by a committee drawn from the end-of-life care sector. A “Mayors Prize” will recognize individual/s for that year who most exemplify the city’s values of compassionate care.
10. Our city will publicly showcase, in print and in social media, our local government policies, services, funding opportunities, partnerships, and public events that address “our compassionate concerns” with living with aging, life-threatening and life-limiting illness, loss and bereavement, and long-term caring. All end-of-life care-related services within the city limits will be encouraged to distribute this material or these Web links, including veterinarians and funeral organizations.
11. Our city will work with local social or print media to encourage an annual city-wide short story or art competition that helps raise awareness of aging, dying, death, loss, or caring.
12. All our compassionate policies and services, and the policies and practices of our official compassionate partners and alliances, will demonstrate an understanding of how diversity shapes the experience of aging, dying, death, loss, and care – through ethnic, religious, gendered, and sexual identity and through the social experiences of poverty, inequality, and disenfranchisement.
13. We will seek to encourage and to invite evidence that institutions for the homeless and the imprisoned have support plans in place for end-of-life care and loss and bereavement.

Source: Abel, J., & Kellehear, A. (2021). Compassionate Cities Charter 2021 update. <https://www.phpci.org/news/2021/1/17/compassionate-cities-charter-2021-update>.

but also for accountability related to death and grief. It highlights the need to review and evaluate a city’s targets (for example, review of local policy and planning, annual emergency services round table, public forums, art exhibits, and more). Whether instigated from the top down or the bottom up, the aim is to encourage a “participatory” process to foster a community that “encourages, facilitates, supports and celebrates care for one another during life’s most testing moments and experiences” (Abel & Kellehear, 2021a, p. 1).

There are several promising benefits to the compassionate communities approach. First, the approach is community driven, rather than medicalized. It offers a counter narrative to the notion that mortality is the purview of health professionals and that dying ought to be sequestered in hospitals or palliative care units. It understands death as a public, communal issue. In doing so, it acknowledges the effects that an individual’s death has on others, both through the dying process itself and after death. It creates space for addressing loss and bereavement and cultivates social support for the dying and their families. One recent compassionate communities program, for example, used a volunteer “connector” model to address isolation among the dying and link families to both volunteer and professional care networks (Aoun et al., 2022). Such an approach has much in common with age-friendly attempts to address isolation among older adults, in which similar connector programs are being developed (Ouellet, de Molitor, Kealey, & Banerjee, 2022). Second, the approach normalizes death (e.g., by connecting school children with hospices, integrating end-of-life discussions into workplaces, providing bereavement supports, and creating opportunities for creative expression regarding grief and mortality). This can make the dying process less mysterious and less fear inducing. It also facilitates productive conversations about loss, suffering, and dying. Third, this approach is intended to be flexible and inclusive. It acknowledges that there are diverse settings and cultural contexts for responding to death. It is not prescriptive about death or grief rituals and holds space for a variety of practices and experiences to emerge. Importantly, the thinking behind the compassionate communities approach is not new; in many ways, it recognises the importance of mortality and the place of death in life, understandings that are well developed in ancient wisdom from traditional Indigenous and Eastern ways of knowing and being (Bastien, 2004; Highway, 2022; Kabat-Zinn, 2020; Kimmerer, 2013; Loy, 2018; Shyam, 2011) that have been overlooked and actively ignored in colonial Canada. Compassionate communities can help to potentially bridge the dominant, medicalized narratives about death with these long-standing traditions and nurture much-needed conversations and the formation of a diverse wisdom environment.

The compassionate communities approach has seen rapid uptake globally with initiatives being developed in Argentina, Australia, Belgium, Brazil, Canada, and the United Kingdom and others (Smith, 2019). Research strategies are also developing in ways that are sensitive to the dynamics of these interventions. For example, as Quintiens, Smets, Chambaere, Deliens, and Cohen (2022) observe, it becomes important to look beyond predefined outcomes, because the co-created and organic dynamics of compassionate communities means that outcomes might be unpredictable and that what matters to community stakeholders may not dovetail with researchers’ concerns. Similarly, the Compassionate Communities Center of Expertise in Belgium has made important strides in outlining an interdisciplinary framework for research and evaluation to

adequately capture the complexity of implementation and outcomes (Vanderstichelen et al., 2022). These complexities will be familiar to researchers studying age-friendly interventions, where interdisciplinary and ecological perspectives are also being developed for many of the same reasons (Menec, Means, Keating, Parkhurst, & Eales, 2011).

Within Canada, there has already been some effort dedicated towards implementing compassionate communities strategies. These efforts are developing into a national movement with considerable support (Tompkins, 2018). There is growing engagement with workplaces and employers, as well as death education for health professionals. These efforts have been accompanied by awareness campaigns, death cafés, and interest from faith communities. Tompkins (2018) acknowledges that the age-friendly communities movement complements this work and could help the sustainability of the compassionate communities movement. However, there is little evidence to date of the two approaches working in tandem.

There is rich opportunity for age-friendly initiatives to converge with the work of compassionate communities in their efforts to make a community a good place to live, age, and ultimately, die. Much like the age-friendly framework, the Compassionate Communities Charter is seen as a best, or promising, practices framework, adaptable to any city and attentive to inclusivity (Tompkins, 2018). Both approaches have potential for international use and can adapt to local concerns and diverse community needs. The Compassionate Communities Charter emphasizes the opportunity for a number of initiatives at the municipal level, which is the primary site for age-friendly city designations and strategies. This shared municipal focus could be useful for integration and congruence of programming, as well as for monitoring and accountability.

The combination of age-friendly and compassionate communities approaches would foster much-needed conversations about aging and death. As noted earlier, normalizing death can have potential benefits for combating ageism. Less fearful attitudes about our mortality could mean a reduction in ageist attitudes and beliefs. It could also foster the acquisition of skills and the creation of support structures to better engage with morality, whether it be in the form of aging or dying. In this regard, age-friendliness and death-friendliness are rather connected. A more death-friendly community can address the WHO domain regarding respect and inclusion by creating a setting in which one is less afraid to grow old and die. Therefore, we may develop promising strategies by putting death in conversation with aging or bringing out of aging a stronger connection to mortality.

Conclusion

In this article, we have raised the question of what a death-friendly community might be. We suggest that a death-friendly community would be one that understands death as a natural and important part of life. It recognizes that we are taught to relate to death and would explore diverse sources of learning to counter the current medicalization of death that turns our mortality into a health problem. A death-friendly community would seek more positive ways of engaging with our mortality, understanding that there is wisdom to be gained by inviting death in, metaphorically speaking. Such an approach might foster a sense of solidarity and cultivate an understanding that we all age and die, and that support for dying and grief is everyone's responsibility.

We are not suggesting a naïve friendliness, but rather a more life-affirming relationship with our mortality as a means of living well in the present. At the same time, we suggest that such efforts might create fertile grounds to both move into aging with less aversion and better support those who are actively dying or grieving. To that end, we suggest that the compassionate communities approach may be worth integrating with age-friendly communities initiatives. Both foster inclusivity and meaning, are global in scope while encouraging local community participation, and are responsive to individual diversity in the context of social and environmental supports. These overlaps offer opportunities for synergies; therefore, we suggest that there is a productive dialogue to be had between the age-friendly and compassionate communities movements. Such a dialogue may contribute to the development of communities where people are less afraid to grow old and die.

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References

- Abel, J., & Kellehear, A. (2021a). Compassionate cities charter 2021 update. Retrieved 29 September 2023 from <https://www.phpci.org/news/2021/1/17/compassionate-cities-charter-2021-update>.
- Abel, J., & Kellehear, A. (2021b). Compassionate cities charter 2021 update: Explainer. Retrieved 29 September 2023 from <https://static1.squarespace.com/static/57f61928d2b857de53f3b0a6/t/600418bb8a2b87460a06dadbf1610881212461/Charter+V2.pdf>.
- Alberta Health Services. (2019). About continuing care. Retrieved 29 September 2023 from <https://www.alberta.ca/about-continuing-care.aspx#toc-1>.
- Aoun, S. M., Kristjanson, L. J., Hudson, P. L., Currow, D. C., & Rosenberg, J. P. (2005). The experience of supporting a dying relative: Reflections of caregivers. *Progress in Palliative Care*, 13(6), 319–325. <https://doi.org/10.1179/096992605X75930>
- Aoun, S. M., Richmond, R., Gunton, K., Noonan, K., Abel, J., & Rumbold, B. (2022). The Compassionate communities connectors model for end-of-life care: Implementation and evaluation. *Palliative Care and Social Practice*, 16, 1–18. <https://doi.org/10.1177/26323524221139655>
- Ariès, P. (1976). *Western attitudes towards death: From the Middle Ages to the present* (P. M. Ranum, Trans.). London: M. Boyers.
- Arnup, K. (2013). Death, dying, and Canadian families. Retrieved 29 September 2023 from https://vanierinstitute.ca/wp-content/uploads/2015/12/CFT_2013-11-00_EN.pdf.
- Banerjee, A. (2008). Disciplining death: Hypertension management and the production of mortal subjectivities. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 12(1), 25–42. <https://doi.org/10.1177/1363459307083696>
- Banerjee, A. (2023). Learning to live well within limits: Exploring the existential lessons of climate change and an aging population. In N. W. Balestrini, J. Hoydis, A.-C. Kainradl, & U. Kribernegg (Eds.), *Aging studies and ecocriticism: Growing old amid climate change* (pp. 183–198). Washington, DC: Lexington Press.
- Barnett, M. D., & Adams, C. M. (2018). Ageism and aging anxiety among young adults: Relationships with contact, knowledge, fear of death, and optimism. *Educational Gerontology*, 44(11), 693–700. <https://doi.org/10.1080/03601277.2018.1537163>

- Bastien, B. (2004). *Blackfoot ways of knowing: The worldview of the Siksikaitsitapi* (p. 255). Calgary, Alberta: University of Calgary Press.
- Bodner, E., Shira, A., Bergman, Y. S., Cohen-Fridel, S., & Grossman, E. S. (2015). The interaction between aging and death anxieties predicts ageism. *Personality and Individual Differences*, *86*, 15–19. <https://doi.org/10.1016/j.paid.2015.05.022>
- Clark D. (2002). Between hope and acceptance: The medicalisation of dying. *BMJ*, *324*(7342), 905–907. doi: [10.1136/bmj.324.7342.905](https://doi.org/10.1136/bmj.324.7342.905)
- Clarke, J. N. (2006). Death under control: The portrayal of death in mass print English language magazines in Canada. *Omega-Journal of Death and Dying*, *52*(2), 153–167. <https://doi.org/10.2190/COE2-YTE3-PR9T-7JAV>
- Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology*, *18*, 209–232. <https://doi.org/10.1146/annurev.so.18.080192.001233>
- Coyte, P., & McKeever, P. (2001). Home care in Canada: Passing the buck. *Canadian Journal of Nursing Research Archive*, *33*(2), 11–25. <http://cjinr.archive.mcgill.ca/article/view/1631/1631>
- Cross, S. H., & Warraich, H. J. (2019). Changes in the place of death in the United States. *New England Journal of Medicine*, *381*(24), 2369–2370. DOI: [10.1056/NEJMc1911892](https://doi.org/10.1056/NEJMc1911892)
- Cullen, C. (2016, September 21). Assisted death the ‘right thing to do’, but takes emotional toll on sister left behind. *CBC News*. Retrieved 29 September 2023 from <https://www.cbc.ca/news/politics/emotional-toll-of-assisted-death-1.3770639>.
- Davis, J. E. (2020). Introduction: Towards an ethics of aging. In J. E. Davis & P. Scherz (Eds.), *The evening of life: The challenges of aging and dying well* (pp. 1–19). Notre Dame, IN: Notre Dame.
- de Medeiros, K. (2013). *Narrative gerontology in research and practice*. New York: Springer.
- Government of Canada. (2020). *What we heard: A public consultation on medical assistance in dying (MAID)*. Retrieved 29 September 2023 from <https://www.justice.gc.ca/eng/cj-jp/ad-am/www-cqnae/access/index.html>.
- Government of Canada. (2022). Third annual report on Medical Assistance in Dying in Canada 2021. Retrieved 29 September 2023 from <https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2021.html>.
- Government of Canada. (2023). Age-friendly communities. Retrieved 29 September 2023 from <https://www.canada.ca/en/public-health/services/health-promotion/aging-seniors/friendly-communities.html#sec1>.
- Heath, I. (2013). Overdiagnosis: When good intentions meet vested interests - An essay by Iona Heath. *BMJ*, *347*, f6361. doi: <https://doi.org/10.1136/bmj.f6361>
- Highway, T. (2022). *Laughing with the Trickster: On sex, death, and accordions*. Toronto: House of Anansi Press Inc.
- Hudson, P. (2004). Positive aspects and challenges associated with caring for a dying relative at home. *International Journal of Palliative Nursing*, *10*(2), 58–65. <https://doi.org/10.12968/ijpn.2004.10.2.12454>
- Illich, I. (1976). *Limits to medicine: Medical nemesis: The expropriation of health*. Toronto: McClelland and Stewart.
- Irwin-Kenyon, G. (2016). *Pathways to stillness: Reflect, release, renew*. Victoria, BC: Friesen Press.
- Jeste, D. V., Blazer II, D. G., Buckwalter, K. C., Cassidy, K. L. K., Fishman, L., Gwyther, L. P., et al. (2016). Age-friendly communities initiative: public health approach to promoting successful aging. *American Journal of Geriatric Psychiatry*, *24*(12), 1158–1170. <https://doi.org/10.1016/j.jagp.2016.07.021>
- Kabat-Zinn, J. (2020). Dying before you die. *Mindfulness*, *11*, 829–831. <https://doi.org/10.1007/s12671-020-01310-z>
- Kellehear, A. (2005). *Compassionate cities: Public health and end-of-life care*. London and New York: Routledge.
- Kellehear, A. (2013). Compassionate communities: End-of-life care as everyone's responsibility. *QJM*, *106*, 1071–1075. <https://doi.org/10.1093/qjmed/hct200>
- Kenyon, G. (2011). On suffering, loss, and the journey to life: Tai chi as narrative care. In G. Kenyon, E. Bohlmeijer, & W. L. Randall (Eds.), *Storying later life: Issues investigations, and interventions in narrative gerontology* (pp. 237–251). Oxford: Oxford University Press.
- Kimmerer, R. (2013). *Braiding sweetgrass: Indigenous wisdom, scientific knowledge and the teachings of plants*. Minneapolis: Milkweed Editions.
- Lind, S., Bengtsson, A., Alvariza, A., & Klarare, A. (2022). Registered nurses' experiences of caring for patients in hospitals transitioning from curative to palliative care: A qualitative study. *Nursing and Health Sciences*, *24*, 820–827. <https://doi.org/10.1111/nhs.12982>
- Loy, D. (2018). *Lack and transcendence: The problem of death and life in psychotherapy, existentialism and Buddhism*. Somerville, MA: Wisdom Publications.
- Mejia, M., Hyman, S. M., Behbahani, S., & Farrell-Turner, K. (2018). Death anxiety and ageist attitudes are related to trainees' interest in working with older adults. *Gerontology & Geriatrics Education*, *39*(3), 341–356. <https://doi.org/10.1080/02701960.2016.1247063>
- Menec, V. H., Means, R., Keating, N., Parkhurst, G., & Eales, J. (2011). Conceptualizing age-friendly communities. *Canadian Journal on Aging / La Revue canadienne du vieillissement*, *30*(3), 479–493. <https://doi.org/10.1017/S0714980811000237>
- Muturi, I., Freeman, S., & Banner-Lukaris, D. (2020). Virtual funerals during COVID-19 and beyond. *Innovation in Aging*, *4*, 966. <https://doi.org/10.1093/geroni/igaa057.3530>
- National Council for Palliative Care (2015). *Public health approaches to end of life care: A toolkit*. Public Health England.
- Novak, S., & Menec, V. (2014). Older adults' perceptions of age-friendly communities in Canada: A photovoice study. *Ageing & Society*, *34*(6), 1052–1072. <https://doi.org/10.1017/S0144686X1200150X>
- O'Sullivan, A., Alvariza, A., Öhlén, J., & Larsdotter, C. (2021). Support received by family members before, at and after an ill person's death. *BMC Palliative Care*, *20*(92), 1–12. <https://doi.org/10.1186/s12904-021-00800-8>
- Ouellet, L., de Molitor, R., Kealey, L., & Banerjee, A. (2022). *Connector programs as a promising means of addressing social isolation and loneliness among older adults: A review of the evidence*. Fredericton, NB: St. Thomas University. <https://www.stu.ca/media/stu/site-assets/images/faculty-pages/Community-Connector-KS-Report.pdf>.
- Phillips, L. R., & Reed, P. G. (2009). End-of-life caregiver's perspectives on their role: Generative caregiving. *Gerontologist*, *50*(2), 204–214. <https://doi.org/10.1093/geront/gnp116>
- Public Health Agency of Canada. (2016). Age-friendly communities. Retrieved 29 September 2023 from <https://www.canada.ca/en/public-health/services/health-promotion/aging-seniors/friendly-communities.html>.
- Public Health England. (2021). Palliative and end of life care profiles. Retrieved 29 September 2023 from <https://fingertips.phe.org.uk/profile/end-of-life/data#page/4/gid/1938132883/pat/6/par/E92000001/ati/15/are/E92000001>.
- Quintiens, B., Smets, T., Chambaere, K., Van Den Block, L., Deliens, L., & Cohen, J. (2022). Researching two compassionate cities: study protocol for a mixed-methods process and outcome evaluation. *Palliative Care and Social Practice*, *16*, 26323524221137601. <https://doi.org/10.1177/26323524221137601>
- Randall, W. L. (2019). *In our stories lies our strength: Aging, spirituality and narrative*. Kindle Direct Publishing.
- Randall, W. L., & Kenyon, G. M. (2004). Time, story and wisdom: Emerging themes in narrative gerontology. *Canadian Journal on Aging*, *23*(4), 333–346. <https://doi.org/10.1353/cja.2005.0027>
- Rowe, J., & Mathews, D. (2021). Death denial, human supremacy, and ecological crisis: Indigenous and Euro-American perspectives. *Arrow: A Journal of Wakeful Society, Culture & Politics*, *8*(1), 13–32. DOI: [10.1080/07393148.2020.1847539](https://doi.org/10.1080/07393148.2020.1847539)
- Sankar, A. (1991). *Dying at home: A family guide for caregiving*. Baltimore and London: A Johns Hopkins Press Health Book.
- Serota, K., & Ho, A. (2021). Improving end-of-life conversations in the post-MAiD era. *Journal of Public Health*, *2*(2), 1–2. <https://doi.org/10.33137/utjph.v2i2.36749>
- Sherman, E. (2010). *Contemplative aging: A way of being in later life*. New York: Gordian Knot Books.
- Shooshtari, S., Duncan, K. A., Roger, K., Fast, J., & Han, J. (2017). Care-related out-of-pocket spending and caregiving consequences: Results from a Canadian population-based study. *Journal of Family and Economic Issues*, *38*(3), 405–420. <https://doi.org/10.1007/s10834-016-9516-1>
- Shyam, S. (2011). *A human being should know the self never dies*. Kullu, India. IMI Publications.

- Smith, R. (2019). The public health of death, dying, and grief has been neglected, but now is the time. Retrieved 29 September 2023 from <https://blogs.bmj.com/bmj/2019/02/07/richard-smith-the-public-health-of-death-dying-and-grief-has-been-neglected-but-now-is-the-time/>.
- Stajduhar, K. (2013). Burdens of family caregiving at the end of life. *Clinical and Investigative Medicine*, 36(3), E121–E126. <https://doi.org/10.25011/cim.v36i3.19722>
- Statistics Canada. (2017). Deaths, by place of death (hospital or non-hospital). Retrieved 29 September 2023 from <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310071501>.
- Synnes, O. (2015). Narratives of nostalgia in the face of death: The importance of lighter stories of the past in palliative care. *Journal of Aging Studies*, 34, 169–176. <https://doi.org/10.1016/j.jaging.2015.02.007>
- Tompkins, B. (2018). Compassionate communities in Canada: it is everyone's responsibility. *Annals of Palliative Medicine*, 7(2), 118–129. doi: 10.21037/apm.2018.03.16
- Vanderstichelen, S., Dury, S., De Gieter, S., Van Droogenbroeck, F., De Moortel, D., Van Hove, L., et al. (2022). Researching compassionate communities from an interdisciplinary perspective: The case of the compassionate communities center of expertise. *Gerontologist*, 62(10), 1392–1401. <https://doi.org/10.1093/geront/gnac034>
- Walker, A., & Wong, G. (2018). Working with clients who choose medical assistance in dying (MAID): A new landscape for counsellors. *Canadian Journal of Counselling and Psychotherapy*, 52, 366–385.
- World Health Organization. (2007). *Global age-friendly cities: A guide*. Geneva: World Health Organization.
- Williams, L. A., Giddings, L. S., Bellamy, G., & Gott, M. (2017). 'Because it's the wife who has to look after the man': A descriptive qualitative study of older women and the intersection of gender and the provision of family caregiving at the end of life. *Palliative Medicine*, 31(3), 223–230. <https://doi.org/10.1177/026921631665327>
- Xiang, L., Shen, G. Q. P., Tan, Y., & Liu, X. (2021). Emerging evolution trends of studies on age-friendly cities and communities: A scientometric review. *Ageing and Society*, 41(12), 2814–2844. <https://doi.org/10.1017/S0144686X20000562>
- Zola, I. K. (2005). Medicine as an institution of social control. In G. Scrambler (Ed.), *Medical sociology: Major themes in health and social welfare* (Vol. 1, pp. 193–198). London and New York: Routledge.