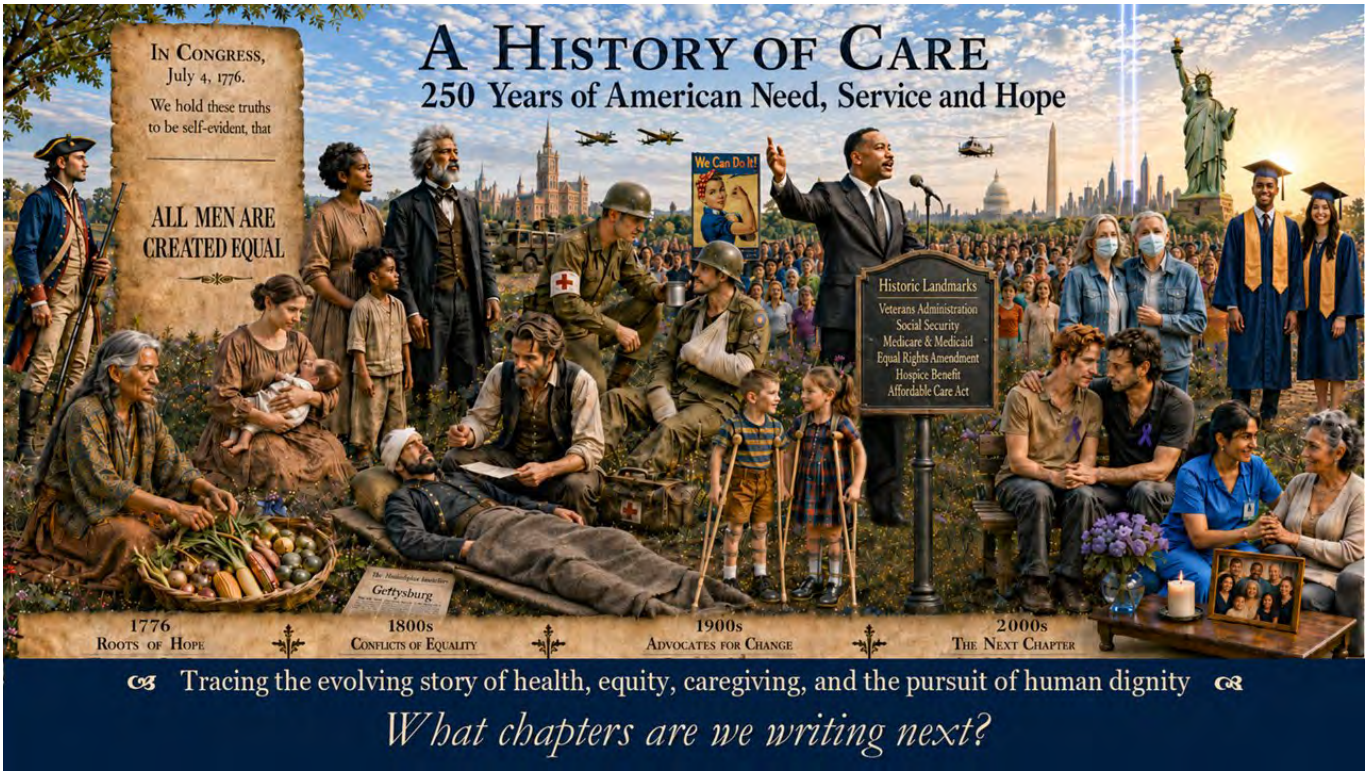


A HISTORY OF CARE

250 Years of American Need, Service and Hope

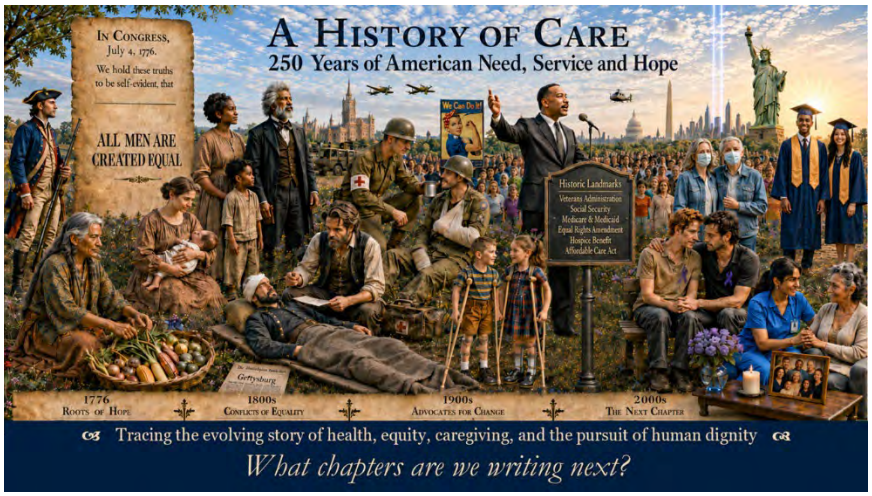
For July 4th, 2026 and Ahead

Care, grief, and courage in a hopeful country

This is the story of imperfect people who learn to see suffering more clearly—and choose to act so that others are not left out or left behind.

by Joy S. Berger, DMA, FT, BCC, MT-BC

About This Project: The Mural and History's Insights



This book began as a 25-part daily journey toward the 250th anniversary of the United States, created to trace a different kind of national story: the long, uneven history of how people in this country have responded to suffering. Decade by decade. Recurring themes and patterns. Crucibles of pain and change. Hope.

Its daily, decade-specific entries were published in *Hospice & Palliative Care Today* from June 10th – July 4th, 2026. This is not a comprehensive history, nor a neutral catalogue of dates and institutions. It is a curated timeline of witness—shaped by what has been recorded, what has been remembered, and what still remains too easily unseen.

Like any mural, it has edges. It cannot fully contain the quiet labor of unnamed caregivers, the wisdom of communities left out of official archives, or the full global context in which American medicine, public health, hospice and palliative care, and other forms of compassion have taken shape. Some absences are limits of space; others reflect the deeper truth that history itself records some suffering more readily than others. That, too, is part of the story.

Introduction

We celebrate the 250th anniversary of the United States by tracing a different kind of history: how people have responded to suffering.

Across epidemics and wars, plantations and prisons, almshouses and ICUs, homes and hospice beds, this is the story of those who tried to relieve pain, protect the vulnerable, and stay present when life grew fragile. They were physicians and nurses, social workers and chaplains, midwives and neighbors, abolitionists and reformers, community organizers and family caregivers—imperfect people who often failed to see or include everyone who was suffering, yet who at crucial moments chose to become companions through suffering rather than turn away.

This book focuses on today's hospice and palliative care, because that is my vocation, shared with valued colleagues throughout our nation. Within our broad history, hospice and palliative care have become specific, steadfast commitments: to walk with people when cure is not possible; to listen before intervening; to honor each person's goals, values, and relationships; and to treat pain, breathlessness, fear, and grief as worthy of serious, skillful attention. Hospice and palliative professionals work at the threshold where medicine, ethics, family, and community meet, in a time when care is expanding even as capacity fractures, moral distress rises, and fraud threatens integrity. We also work amid contested questions—about diversity, equity, and inclusion, about regulations and technologies, and about Medical Aid in Dying, where law, choice, suffering, and complex moral convictions collide. Our decisions and presence reveal how seriously we take the dignity of those who are dying—and the needs of those who love them.

This project looks backward and forward at once. It invites anyone who cares about suffering—whether at the bedside, in policy, in global health, in disaster response, or in the quiet labor of family life—to see themselves inside this 250-year mural of American need, service, and hope. It also asks readers to notice what lies beyond the mural's edges: stories underrepresented in archives, communities still left out of care, and controversies that reveal how unfinished our work remains. The sung prayer *"God mend thine every flaw"* does not belong to a hymn alone. It belongs to the journeys we navigate and choices we make about how suffering, dying, and grief are seen, honored, and met.

~ Joy S. Berger, DMA, FT, BCC, MT-BC
Composing Life Out of Loss, Founder/Author/Owner
Hospice & Palliative Care Today, Editor in Chief

Graphics and selected research supported by AI tools,
with all content authored and edited by Dr. Joy S. Berger

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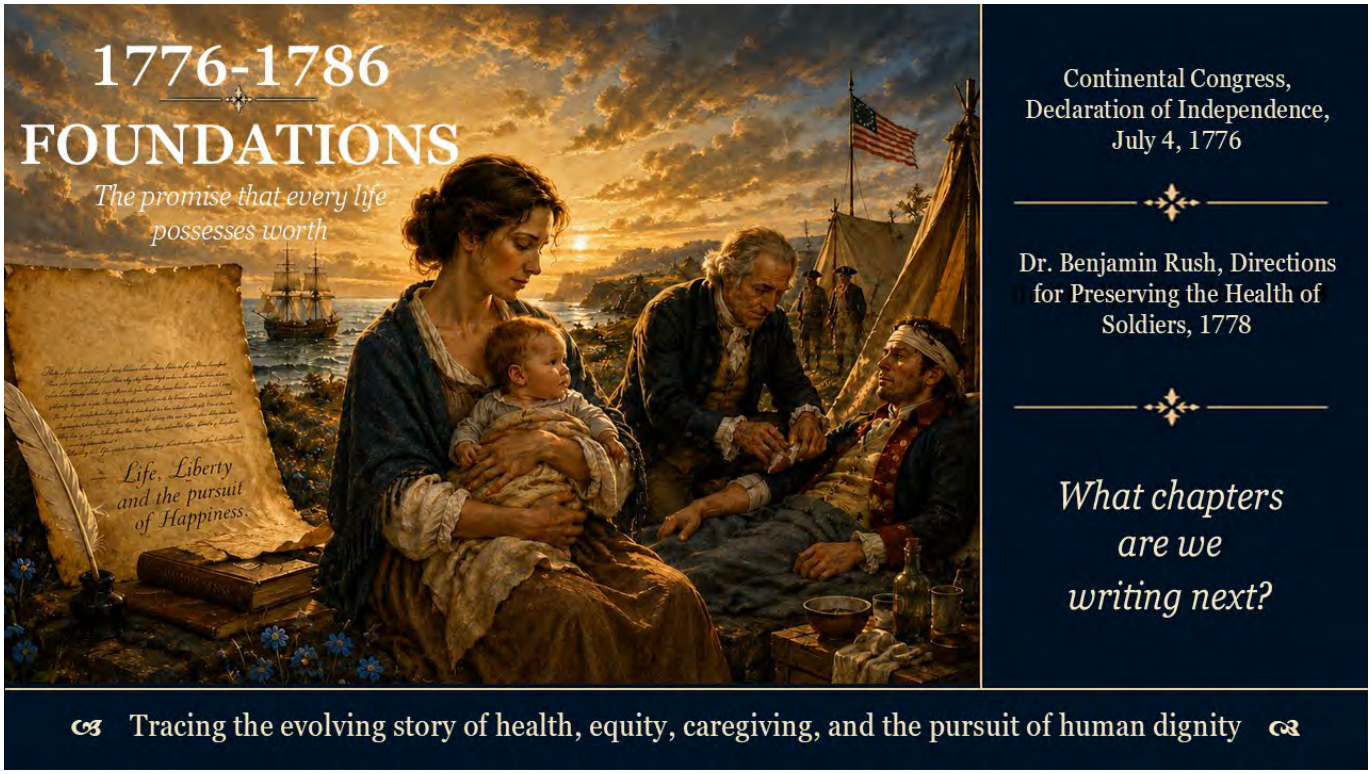


1776-1786

posted in *Hospice & Palliative Care Today*, June 10, 2026

1. Continental Congress, Declaration of Independence, July 4, 1776

> *"We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness."*

Thomas Jefferson, principal drafter for the Continental Congress

Historical context: Adopted by the Second Continental Congress, the Declaration's assertion of equality and human rights provided the moral language later used by abolitionists, reformers, disability-rights advocates, public-health leaders, and hospice and palliative care voices arguing for the dignity of every person. In a care-centered timeline, this is the foundational American claim that every life possesses worth.

Today's hospice and palliative care: Rights to dignity, access to care, core respect for each other (patients, families, staff, volunteers, leadership, community).

Source: National Archives, https://www.archives.gov/founding-docs/declaration-transcript

2. Dr. Benjamin Rush, Directions for Preserving the Health of Soldiers, 1778

"The art of preserving the health of a soldier consists in attending to the following particulars."

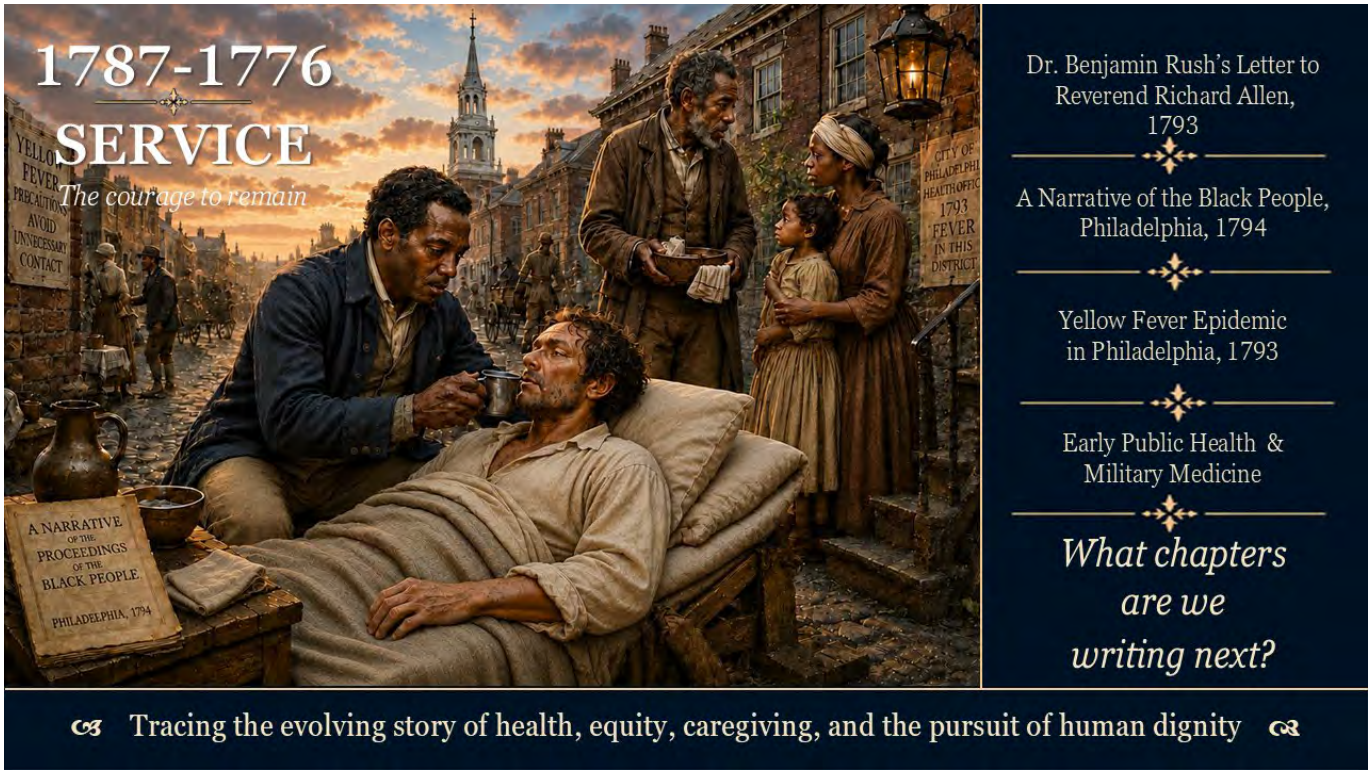
Dr. Benjamin Rush, physician, Continental Army medical leader, signer of the Declaration of Independence

Historical context: Rush's pamphlet was the first American public health manual focused on preventive medicine and military hygiene, articulating principles — clean water, proper food, adequate rest — that predated germ theory by a century. Rush is often called the "Father of American Psychiatry" and advocated for humane treatment of the mentally ill at a time when such individuals were routinely jailed.

Today's hospice and palliative care: Preventive medicine leads to longer life expectancy. Infection control. Caregiver wellness.

Source: The American Revolution Institute, “Benjamin Rush’s Directions for Preserving the Health of Soldiers”

What chapters are we writing next?



1787-1796

posted in *Hospice & Palliative Care Today*, June 11, 2026

1. Dr. Benjamin Rush, letter to Reverend Richard Allen, September 1793

> *"It has pleased God to visit this city with a malignant and contagious fever, which infects white people of all ranks, but passes by persons of your color."*

Dr. Benjamin Rush, the only signer of the Declaration of Independence with a medical degree, advocated for humanization of psychiatric treatment

Reverend Richard Allen, born into slavery 1760 and purchased his freedom. Prolific preacher. Co-founder of the African Methodist Episcopal Church (AME).

Historical context: During Philadelphia's catastrophic 1793 yellow fever epidemic — which killed approximately 5,000 of the city's 51,000 inhabitants — physician Rush asked Black Philadelphians to remain in the city and serve as nurses and undertakers, based on the erroneous medical belief that Black people were immune. Black Philadelphians who stayed and served did, in fact, die from the fever at significant rates.

Today's hospice and palliative care: Prevention of discrimination to patients and employees. Evidence-based research paired with clinical best practices and ethics.

Source: *American Journal of Public Health,* "A Contemporary Black Perspective on the 1793 Yellow Fever Epidemic"

2. Absalom Jones & Richard Allen, A Narrative of the Proceedings of the Black People, Philadelphia, 1794

> *"We have suffered equally with the whites, our distress hath been very great, but much unknown to the white people."*

Absalom Jones, born into slavery in 1746, learned to read, purchased freedom for his wife and himself. Co-founded the Free African Society with Richard Allen. Established the St. Thomas African Episcopal Church in Philadelphia, the first Black Episcopal congregation in America.

Reverend Richard Allen, born into slavery 1760 and purchased his freedom in the early 1780's. Prolific preacher. Co-founder of the African Methodist Episcopal Church (AME).

Historical context: During the catastrophic 1793 Philadelphia yellow fever epidemic, free Black Philadelphians — led by Jones and Allen — answered the city's call to nurse the sick and bury the dead, believing (mistakenly) that they had immunity. Their 1794 pamphlet, the first copyrighted work by African Americans, stands as the founding document of Black civic health witness in America.

Today's hospice and palliative care: Core, inclusive healthcare. Evidence-based research paired with clinical best practices and ethics. Emergency disaster management. Workplace safety. Infection control. Employee rights and responsibilities.

Sources: A Narrative of the Proceedings of the Black People During the Late Awful Calamity in Philadelphia (1794); A Contemporary Black Perspective on the 1793 Yellow Fever Epidemic in Philadelphia - PMC

3. United States Congress, An Act Relative to Quarantine, 1796

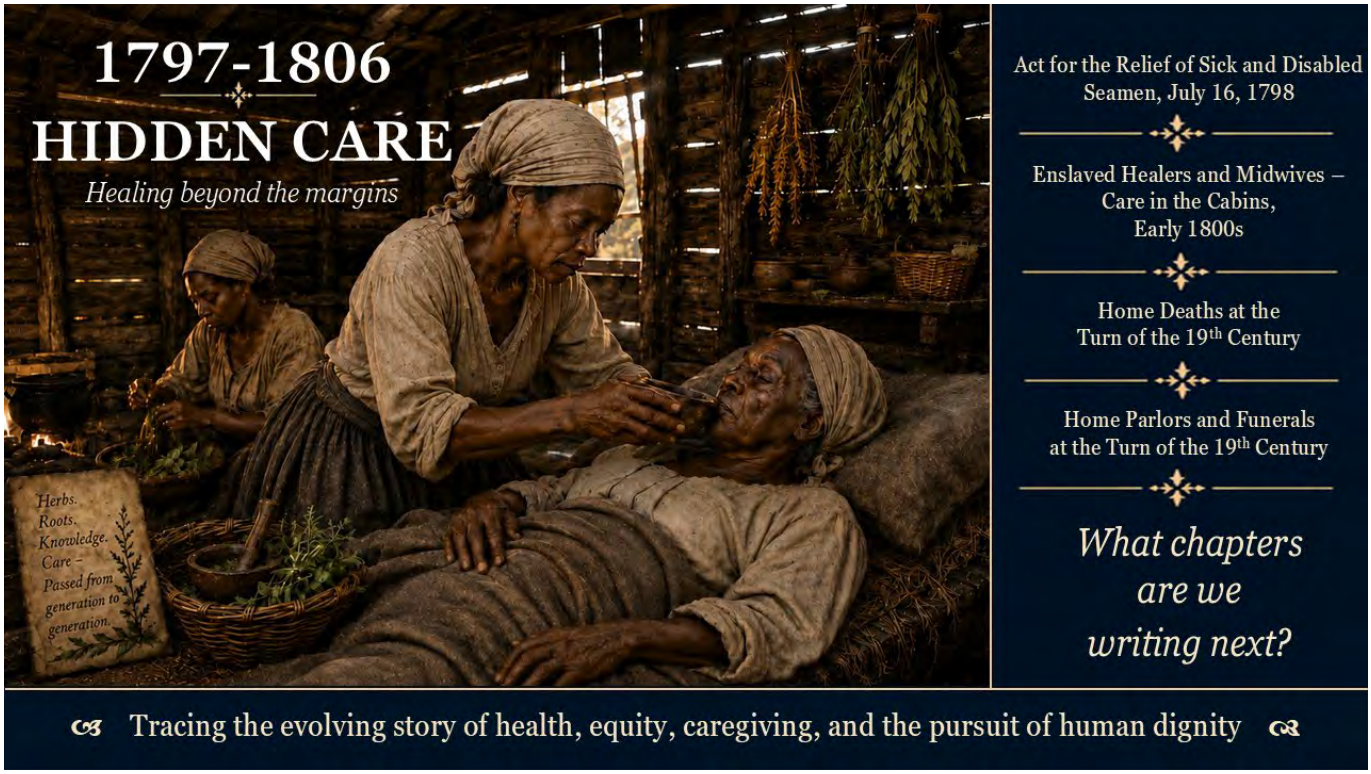
"An Act Relative to Quarantine," Adopted by the Third Congress and signed by George Washington

Historical context: One of the earliest federal public health statutes, the Quarantine Act established that the federal government had a role in protecting the public from epidemic disease — a foundational precedent for all subsequent public health law in the United States. The act was passed in response to the recurring yellow fever epidemics that devastated port cities in the 1790s. More comprehensive federal quarantine law in 1799, "Act Respecting Quarantines and Health Laws."

Today's hospice and palliative care: COVID 19. Centers for Disease Control and Prevention (CDC).

Source: Library of Congress Law Blog: An Act Relative to Quarantine (1796) – Statutes and Stories

What chapters are we writing next?



1797-1806

posted in *Hospice & Palliative Care Today*, June 12, 2026

1. United States Congress / President John Adams, Act for the Relief of Sick and Disabled Seamen, July 16, 1798

> *"[Congress established a fund] to provide treatment for sick and injured merchant seamen."* United States Congress; signed by President John Adams

Historical context: The Act for the Relief of Sick and Disabled Seamen created the Marine Hospital Service, the direct predecessor of the U.S. Public Health Service, and is widely regarded as the first federal healthcare program in America. It levied a mandatory payroll deduction of twenty cents per month from merchant seamen's wages to fund hospital care, establishing the principle of contributory public health financing 167 years before Medicare.

Today's hospice and palliative care: Today's U.S. Public Health Service. Veterans Administration hospitals.

Sources: U.S. National Library of Medicine, History of PHS; Marine Hospice Service formally renamed US Public Health Service (1912); NIH Images – Health Care for Seamen

2. Enslaved Healers and Midwives — Care in the Cabins, Early 1800's

> *Often practicing in the privacy of their cabins, enslaved people drew on their knowledge of local flora and healing practices to make medicines and provide care, … much of it with roots in West African traditions. … Enslaved women played a particularly powerful role in enslaved communities as healers and midwives. … Black people … tended to the mental and emotional health of their families as well, a need that white doctors and overseers did not bother with.*

Historical Context: Enslaved women and men used African and local botanical knowledge to tend the sick, deliver babies, and comfort the dying in slave quarters across the South. Their unacknowledged expertise underwrote a parallel system of end-of-life care built on mutual aid and resilience, in sharp contrast to a legal system that treated them as property and offered no formal protection in illness or death. And, upon learning of their expertise, some white owners prohibited their access to the plants used to bring comfort and healing.

Today's hospice and palliative care: Long history of inequitable systems for healthcare medicines, timely and affordable care, and (until recent decades) medical employment.

Sources: Medical Care and the Health of Enslaved People; Herbal Use by Enslaved Africans

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3. Home Deaths at the Turn of the 19th Century (Late 1700's-Mid 1800's)

> *Women who cared for the dying were called 'watchers' or 'watchwomen.' People died at home. Family members, typically the women, cared for their loved one's body (i.e., bathed and dressed for burial).*

Historical Context: For white North Americans, death was expected to happen in one's own bed, surrounded by kin, with clergy and neighbors moving in and out of the sickroom. Women in families and communities were the ones who sat up through the night, watched for changes in breathing, offered sips of water, and prayed at the bedside. There were little formal medical interventions at the end of life and no funeral industry. Instead, communities relied on customs, faith, and women's caregiving skills to accompany the dying and tend the dead.

Today's hospice and palliative care: The American hospice movement returned care to the "home" death. This "home preference" frames much hospice marketing, today. The gender gap among caregivers has been closing. Still, recent research shows expectations for daughters to provide more care than sons.

Sources: When Death Was Women's Work; Death and Dying in North America, Late 18th–19th Century; Study Who Cares for Mom and Dad? The Sibling Divide in Caregiving

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4. Home Parlors and Funerals at the Turn of the 19th Century (Late 1700's-Mid 1800's)

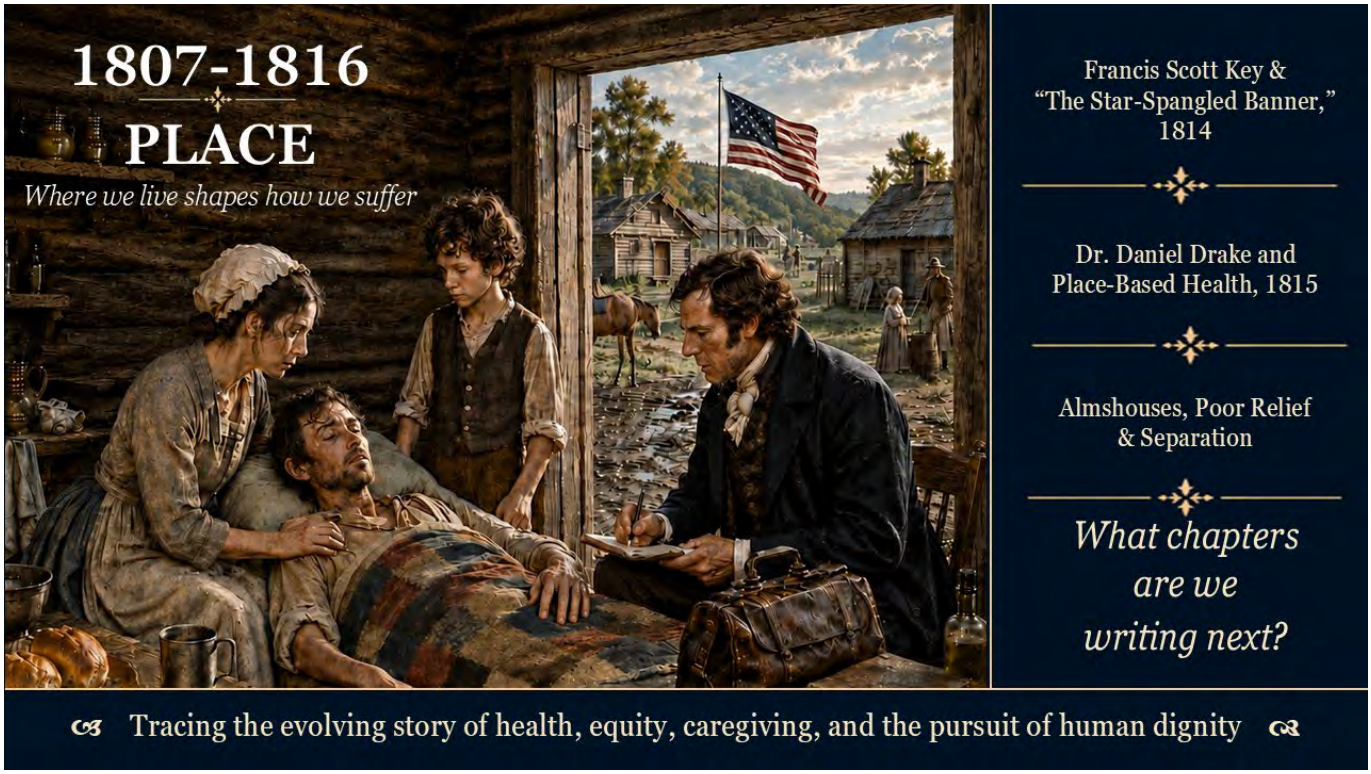
> *Once a person died, they were bathed by either family or servants and laid out in their best clothes so their loved ones could say one last goodbye. … The body would then be laid out and displayed at home, in the parlor if the house had one, or even on the dining table.*

Historical Context: Family and neighbors washed and dressed the body, kept watch, and laid out the body for a period of 1-3 days. This time of final "watching" and of family "Wakes" helped ensure that the person had indeed died. Strong smelling flowers such as lilies were often used to hide smells of decomposition. The deceased person was carried to and buried at a nearby family or church plot. Death was close, visible, and woven into daily life.

Today's hospice and palliative care: The "Wake" moved to funeral homes and more recently has been shifting to "Celebration of Life" venues. Today's common cremation practices significantly changed practices of viewing the body, timing, location, and more. Today's "green burials" are growing as environmentally friendly options.

Sources: Remembering a Life—'From Parlors to Slumber Rooms'; Grave decisions: Understanding attitudes and perceptions towards green burial — A review of literature

What chapters are we writing next?



1807-1816

posted in *Hospice & Palliative Care Today*, June 13, 2026

1. Francis Scott Key, 'The Star-Spangled Banner,' September 14, 1814

"O'er the land of the free and the home of the brave."

Historical context: Key's line emerges from a moment of wartime crisis, linking national survival with military sacrifice and an ideal of freedom—voiced in a nation still shaped by slavery. In *O Say Can You Hear: A Cultural Biography of "The Star Spangled Banner,"* Mark Clague traces how the anthem's meaning has evolved across two centuries. As The National Endowment for the Humanities notes, Clague argues that the anthem reflects the nation's ongoing effort to become "a more perfect union." Read. Learn. Sing it with fresh understanding.

Today's hospice and palliative care: In today's hospice and palliative care, "freedom" gets very personal—deciding goals of care, where someone wants to die, and putting advance directives in place within the bounds of the law. It also brings tougher questions: what "freedom" means when a mother's life is at risk in a perinatal crisis, or when considering medical aid in dying (MAiD). And "brave" is shifting too. Instead of "fighting a battle," we're talking more about living as fully as possible—and, when the time comes, peacefully letting go.

Sources: Smithsonian National Museum of American History, lyrics PDF; The Star Spangled Music Foundation; National Endowment for the Humanities

2. Dr. Daniel Drake, Natural and Statistical View, or Picture of Cincinnati, 1815

> *"The diseases of this country are modified by the climate, the soil, the state of society, and a variety of local causes... [The] poor settler's family, exposed to all the vicissitudes of the climate, without comfortable lodging, and with a scanty, often unwholesome diet, is peculiarly liable to every species of disease."*

Dr. Daniel Drake (1785-1852), physician and founder of medical education in the American Midwest; founder of the Cincinnati School of Medicine

Historical context: Daniel Drake, a leading frontier physician and medical educator in Cincinnati and Louisville, was one of the first American physician voices to frame illness and mortality as shaped by climate, housing, poverty, and "the state of society"—not just individual bodies. Writing amid high mortality among women, infants, and children, and life expectancy often between 20 and 40 years, he insisted on bedside and hospital-based training grounded in lived conditions, helping shift medical understanding toward what we now call the social determinants of health.

Today's hospice and palliative care: We continue Drake's insight that place matters. Bedside teaching and interdisciplinary training remain central. Local and national data—from CMS, NHPCO/The Alliance, and Hospice Analytics—help map serious illness "hot spots" and guide equity efforts. Social workers and care teams translate social risks into care plans, extending this place-based lens to hospice access, experience, and outcomes.

Sources: About Daniel Drake; Indiana University Lilly Library commentary on Drake's medical geography work; Natural and Statistical View, or Picture of Cincinnati (1815)

3. Almshouses as Places to Die — Poor Relief and Separation

> *From the late seventeenth century to the early twentieth century, almshouses offered food, shelter, clothing, and medical care to the poorest and most vulnerable, yet often in exchange for hard labor and forfeiture of freedom.*

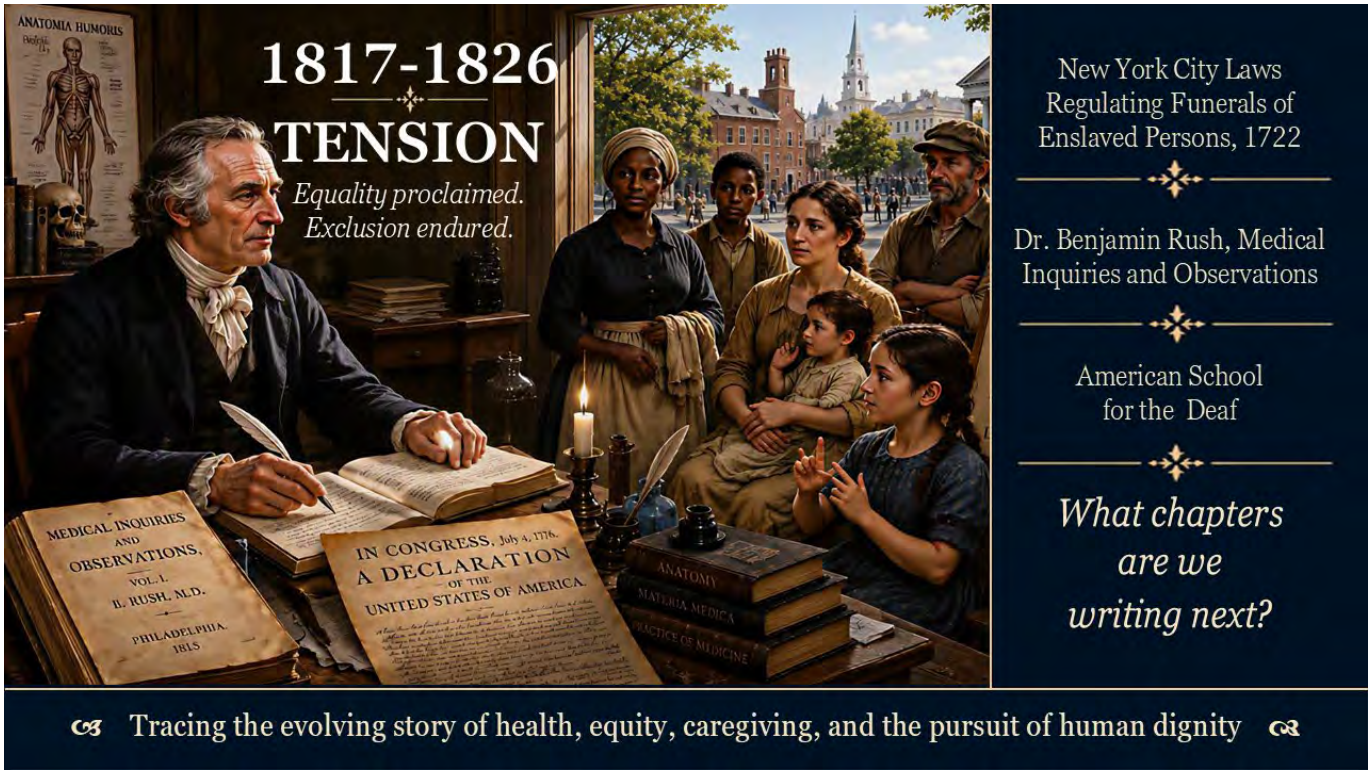
Historical context: By the early 1800s, almshouses had become the default destination for people who were poor, chronically ill, mentally ill, or without family support. Many died there, far from home. Care and containment were intertwined, as communities struggled to meet complex needs with limited medical knowledge and caregiving resources.

Today's hospice and palliative care: Then—almshouses blurred care and containment. Now—care focuses on person-centered comfort, dignity, and goals of care across homes, senior living, assisted living, and skilled nursing facilities. Medicaid, Medicare, and nonprofit and philanthropic support expand access—including for those unable to pay.

Still, “who dies where” is shaped by insurance coverage, medication costs, access, rural gaps, workforce shortages, and cultural and language barriers. Emerging models, including prison hospice, continue to extend compassionate end-of-life care.

Sources: Philadelphia Encyclopedia — Almshouses/Poorhouses; Poor Relief and the Almshouse

What chapters are we writing next?



1817-1826

posted in *Hospice & Palliative Care Today*, June 14, 2026

1. New York City Common Council laws regulating funerals of enslaved persons – 1722, with increasingly restrictive laws and informal practices nationwide

> *For the preventing of great numbers of slaves assembling and meeting together at their Funerals, … it was ordered that, if more than twelve slaves assembled at a slave funeral, those present were to be whipped at the discretion of the Mayor, Recorder or one of the Alderman except the 12 slaves admitted by the owner of the dead slave, the gravedigger and the corpse bearers.*

Historical context: Such American legislation began as early as 1680 among colonists, seeking to eliminate any rituals, music, beliefs related to enslaved persons' homeland; seeking to control. Among a few of the many restrictions (with variations): specific hours for burials that often conflicted with enforced work hours; numbers of persons (as in the example above); the funeral had to be led by a white priest or preacher; no singing, drumming, dancing (culturally important rituals); no use of palls (the cloth covering the casket or body, hence "pallbearer"); and more. Over time, African American funerals became known as "home-goings," as in being released from suffering and the soul either returning to Africa or going to heaven. Black spirituals that grew out of suffering and prayer became signals for the Underground Railroad: "Wade in the Water," "Steal Away," "Swing Low Sweet Chariot."

Hospice and palliative care today: Attend a vibrant, full-of-love Black funeral in America today, and you will likely experience a deep sense of community, emotion, storytelling, formal greetings from other Black communities of faith, and music! A lot of music. The burial may be accompanied by a solemn jazz band processional, followed by a "second line" New Orleans-style community celebration when leaving.

Sources: Homegoing; Harriet Tubman Historical Society; New Orleans Second Line History; Music of the Soul – Composing Life Out of Loss

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2. Dr. Benjamin Rush, *Medical Inquiries and Observations, Volume I* (4th edition, published posthumously in 1815 and actively circulated in medical schools during this period)

> *"The customs of civilized life have given rise to a great number of diseases, which are unknown in savage and barbarous nations."*

Historical context: Benjamin Rush—signer of the Declaration of Independence—remained an influential medical voice decades later, as his widely circulated work shaped early American medical education. Yet his legacy is deeply conflicted. During Philadelphia's 1793 yellow fever epidemic, he urged Black residents to remain and serve as nurses and undertakers, based on the false belief that they were immune—reinforcing patterns of racial exploitation and harm. At the same time, his writings advanced an early recognition that the conditions of "civilized" life—its habits, environments, and inequities—could themselves produce disease.

Today's hospice and palliative care: Rush's era exposed a tension we still carry—equality is proclaimed, yet care is marked by bias and exclusion. Hospice care is growing more honest about that legacy by tracking disparities, building trust, and confronting its own blind spots. Many professionals name the "moral distress" they experience when ethics collide with unequal systems. Many organizations are doing crucial work to close that gap.

Sources: Medical Inquiries and Observations, Volume I (4th ed., 1815) - National Library of Medicine digital collection; A Contemporary Black Perspective on the 1793 Yellow Fever Epidemic in Philadelphia

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3. American School for the Deaf, Hartford, Connecticut, April 15, 1817

> *The founding of the American School for the Deaf in Hartford, Connecticut, in 1817 was a crucial milestone in the way society related to people with disabilities.*

Historical Context: On April 15, 1817, the Connecticut Asylum for the Education and Instruction of Deaf and Dumb Persons, later renamed the American School for the Deaf, opened in Hartford with seven students. As the first permanent school for deaf children in the United States, it helped establish American Sign Language, Deaf education, and a durable Deaf community and culture.

Today's hospice and palliative care: This entry offers a hopeful reminder that care is not only clinical treatment; it is also communication, belonging, dignity, and social inclusion. For hospice and palliative care,

the ongoing lesson is that people who communicate, perceive, age, grieve, or suffer differently deserve systems designed to meet them where they are, not systems that define them by exclusion.

Source: American School for the Deaf: History & Cogswell Heritage House

What chapters are we writing next?

1827-1836

posted in *Hospice & Palliative Care Today*, June 15, 2026

1. Dr. Thomas Percival, *Medical Ethics* published 1803 in England and circulating in American medical education during this timeframe

> *"The feelings and emotions of the patients under critical circumstances require to be known and to be attended to, no less than the symptoms of their diseases."*

Historical context: Though British in origin, Percival's *Medical Ethics* became a foundational source for American medical ethics. The American Medical Association's 1847 Code of Ethics drew heavily on Percival's *Medical Ethics*. Its insistence that patients' feelings matter alongside symptoms anticipates the humane, whole-person approach that modern hospice and palliative care would later describe more fully.

Today's hospice and palliative care: Percival's principle is an early ethical ancestor of palliative care's attention to the whole person, including fear, grief, distress, family concerns, and meaning. In today's hospice and palliative care, excellent care requires more than treating symptoms. It requires listening for the emotional, relational, and existential suffering that patients and families carry under "critical circumstances."

Source: American Medical Association Code of Ethics History (Ochsner Journal, 2003)

2. U.S. Congress, Indian Removal Act, 1830; Cherokee Nation Memorial, 1829, on the Eve of the Trail of Tears

> *Cherokee Nation plea to Congress upon threats of removal: To the land of which we are now in possession we are attached, it is our father's gift, it contains their ashes, it is the land of our nativity, and the land of our intellectual birth. 1829*
>
> *Congressional Indian Removal Act: An Act to provide for an exchange of lands with the Indians residing in any of the states or territories, and for their removal west of the river Mississippi. 1830*
>
> *The soldiers came and took us from home. ... The drove us out of doors and did not permit us to take anything with us, not even a second change of clothes. ... They marched us, ... even our little children ..." Oo-la-cha, widow of Sweet Water, as told in 1842, The Trail Where They Cried*

Historical context: In December 1829, Cherokee leaders and citizens petitioned Congress against removing them from their homeland. They described their homeland not simply as property, but as the land of their birth and death, from generation to generation to generation. Still, Congress passed the Indian Removal Act the following year, signed by President Andrew Jackson, beginning a broader removal era that affected many Native nations, including the Choctaw, Muscogee/Creek, Chickasaw, Seminole, and Cherokee. The Cherokee forced removal of 1838-1839 became the event most specifically remembered as the Trail of Tears, but the suffering reached across multiple peoples and homelands for generations. Oo-loo-cha's 1842 testimony gives human voice to that history: families were not merely "removed"; they were stripped of their dignity, homes, possessions, children's safety, ancestors' graves, and places where life and death had meaning.

Today's hospice and palliative care: This history reminds us that grief can be communal, ancestral, cultural, and tied to place. In hospice and palliative care today, cultural humility requires us to truly hear generational stories of injustice, spirituality, rituals, roles, language needs, land connections, and sources of mistrust that may shape illness, dying, remembrance, and care. That humility matters for Native patients and families whose histories long predate the United States, and for patients, families, and staff from many nations and languages who may carry displacement, trauma, or sacred traditions we do not yet understand, but are called to meet with wise care.

Sources: Cherokee Nation Memorial to Congress, 1829; U.S. Congress, Indian Removal Act, 1830; Oo-loo-cha, as told in 1842; The Trail of Tears and the Forced Relocation of the Cherokee Nation, National Park Service; President Andrew Jackson's Message to Congress "On Indian Removal," National Archives; End-of-Life Care Disparities Experienced by American Indian and Alaska Native Peoples, Journal of Palliative Medicine, 2025; Healing with Humility: Palliative Care for Refugee Communities, American Journal of Nursing, 2026

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3. Narrative of Frederick Douglass, an American Slave, 1845; describing c. 1833-1835

> *"I was broken in body, soul, and spirit. My natural elasticity was crushed, my intellect languished, the*

disposition to read departed, the cheerful spark that lingered about my eye died; the dark night of slavery closed in upon me; and behold a man transformed into a brute!"

Historical context: Douglass wrote this passage describing the physical and psychological destruction wrought on his body and mind by the slave-breaker Edward Covey, who beat Douglass repeatedly when Douglas was about 15-17 years old. This passage is one of the clearest first-person accounts in American literature of how slavery deliberately attacked human health, dignity, intellect, and spirit as instruments of control.

Today's hospice and palliative care: Douglass's words reveal suffering as assaults on a person's whole humanity: body, soul, spirit, intellect, and hope. For hospice and palliative care today, this calls us to more than comfort; it calls us to trauma-informed care that restores dignity, listens without defensiveness, and recognizes how histories of dehumanization still shape trust, access, fear, and the care people need at life's most vulnerable thresholds.

Source: Narrative of the Life of Frederick Douglass, an American Slave (1845), Chapter X

What chapters are we writing next?

1837-1846

posted in *Hospice & Palliative Care Today*, June 16, 2026

1. Joseph Warrington's Nurse Society of Philadelphia, 1839, "This Room Holds Life and Death"

> *"To engage in the important business of nursing mother and child in the lying-in chamber..." [the bedroom where a woman labored and recovered after childbirth]*

Historical context: In 1839, Quaker physician Joseph Warrington helped organize the Nurse Society of Philadelphia, training working-class women to care for mothers and infants in their own homes during childbirth and the precarious days after delivery. These nurses entered cramped back bedrooms where poverty, infection, and hemorrhage meant that birth and death were close neighbors, and their work included recognizing danger, comforting families, and keeping vigil when a mother or newborn was dying. Warrington's Nurse's Guide named women's bedside tasks—watching, washing, soothing, staying—as skilled labor that mattered at the boundary between life and death and in the first hours of grief, when the room held both a body and a stunned family.

Today's hospice and palliative care: Today, pregnancy and birth still carry real risks, especially in rural and under-resourced communities where maternity units have closed and emergency transfers are long. Mothers still die from complications of pregnancy and childbirth, and whole families live with grief from miscarriages, stillbirths, and the loss of infants after high-risk births. Perinatal and pediatric palliative care teams now walk with parents when a fetus, newborn, or child has a life-limiting condition, and grief counselors tend these especially painful losses. At the bedside—whether in a home or a small rural

hospital—hospice team members continue Warrington's work when they stay present in the delivery space that has become a deathbed, help parents hold and bless a baby who has died, and make sure no one faces that grief alone.

Sources: Joseph Warrington, The Nurse's Guide (1839); American Nursing: An Introduction to the Past

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2. Oliver Wendell Holmes Sr., "The Contagiousness of Puerperal Fever," 1843

> *"The woman about to become a mother, or with her new-born infant upon her bosom, should be the object of trembling care and sympathy wherever she bears her tender burden or stretches her aching limbs... God forbid that any member of the profession to which she trusts her life, doubly precious at that eventful period, should hazard it negligently, unadvisedly, or selfishly!"*

Historical context: In 1843, Boston physician Oliver Wendell Holmes Sr. argued that puerperal (childbed) fever often was carried from one woman to another on the unwashed hands and instruments of doctors—turning birthbeds into deathbeds through preventable infection. His essay, later reissued with an even sharper preface in 1855, accused the profession of killing new mothers at horrifying rates and demanded that physicians stop moving directly from autopsies and infected patients to the delivery room without cleansing themselves or their tools. Preceding Semmelweis's work in Vienna, Holmes's fury at this obstetric violence was a landmark in medical ethics and an early step toward germ theory, insisting that respect for mothers required strict attention to how clinicians' own bodies and instruments transmitted disease.

Today's hospice and palliative care: Holmes's warning puts today's common infection-control practices into an ethical framework, grounded in the hard outcomes of maternal and infant deaths. Safety culture, hand hygiene, PPE, and other infection-control measures now shape basic care so that people near the end of life are less likely to be harmed by the very hands meant to help them. We saw similar excruciating deaths during COVID-19 when infections ravaged health throughout hospitals, nursing homes, and households.

Source: Oliver Wendell Holmes (1809–1894) and his essay on puerperal fever

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3. Dorothea Dix, Petition for the Mentally Ill to the Legislature of Massachusetts, January 1843

> *"I proceed, Gentlemen, to call your attention to the present state of Insane Persons confined within this Commonwealth, in cages, closets, cellars, stalls, pens... I come to present the strong claims of suffering humanity..."*

Historical context: In 1843, reformer Dorothea Dix carried a searing report to the Massachusetts legislature after visiting jails, almshouses, and poorhouses where people with mental illness were chained, beaten, left naked in cold cells, and abandoned without treatment. Her petition described lives pushed toward early death and what we might now call social death—people cut off from family and community, suffering and dying unseen. By insisting that those hidden in "cages" and "pens" deserved warmth, safety, and care at the

end of life, Dix turned private horror into public responsibility and helped spark a movement for state hospitals that, at its best, was meant to replace degradation with basic comfort.

Today's hospice and palliative care: Dix's witness challenges us to ask who is still suffering and dying "out of sight" today. Hospice and palliative teams now work in settings for the unhoused, mentally ill, incarcerated, and under-resourced communities to bring pain and symptom relief, companionship, and spiritual care. When we problem-solve services for the unhoused, for psychiatric patients' access to palliative consults, for hospice beds behind bars, or other similar suffering, we carry forward Dix's conviction that the measure of a society is found in whether anyone is willing to see, name, and stand beside those whom others would prefer to lock away and forget.

Source: Dorothea Dix, "Memorial to the Legislature of Massachusetts" (1843), The American Yawp Reader

What chapters are we writing next?

1847-1856

posted in *Hospice & Palliative Care Today*, June 17, 2026

1. Lemuel Shattuck, Report of the Sanitary Commission of Massachusetts, 1850

> *"The conditions which now surround a large portion of the population, especially in cities and large towns, and sometimes also in smaller towns and rural districts, are clearly unfavorable to health; and the reform which is now needed demands the attention of the government, the physician, and the philanthropist."*

Historical context: Lemuel Shattuck (1793–1859) was a statistician and public health reformer. His 1850 report marked the first systematic American use of birth and death records to describe population health and the first attempt to articulate a comprehensive public health code. Written when life expectancy in Boston was approximately 25 years, it explicitly linked poverty, overcrowding, and inadequate sanitation to preventable death.

Today's hospice and palliative care: Shattuck showed, with data, that poor living conditions lead to preventable illness and early death—and that addressing them is a public responsibility. Building on earlier physicians like Daniel Drake and working alongside reformers like Dorothea Dix, he demonstrated that where and how people live shapes who suffers and dies—and that this demands a public response. This carries forward into hospice and palliative care's focus on inequity, social determinants, and the responsibility to care at and beyond the bedside.

Sources: Report of a General Plan for the Promotion of General and Public Health (1850); Internet Archive

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2. Elizabeth Cady Stanton and delegates of the Seneca Falls Convention, Declaration of Sentiments, July 1848

> *"We hold these truths to be self-evident; that all men and women are created equal."*

Historical context: The Declaration of Sentiments deliberately echoed the Declaration of Independence to expose women's exclusion from the political and civic promises of 1776. By naming equality for "men and women," the Seneca Falls Convention located women's rights within the nation's ongoing argument over liberty, consent, bodily autonomy, and citizenship.

Today's hospice and palliative care: This claim that women's lives and choices carry equal moral and civic weight undergirds contemporary commitments to respect autonomy in serious illness. In hospice and palliative care, it strengthens the insistence that women's voices, bodies, caregiving burdens, and end-of-life decisions deserve the same authority, protection, and dignity as men's within families, systems, and law.

Source: "Declaration of Sentiments," National Park Service, Women's Rights National Historical Park

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3. Sojourner Truth, Ohio Women's Rights Convention, Akron, 1851 (as recorded by Frances Dana Gage, 1863)

> *"I have borne thirteen children, and seen most all sold off to slavery, and when I cried out with my mother's grief, none but Jesus heard me! And ain't I a woman?"*

Historical context: Sojourner Truth, born into slavery in New York, delivered this speech against arguments that women were too delicate to claim rights, answering instead with her enslaved life of hard labor, repeated childbearing, and the sale of her children. The speech stands as a foundational document of Black maternal suffering, naming the forced sale of children as a grief uniquely borne by enslaved women in a nation that claimed to honor motherhood.

Today's hospice and palliative care: Sojourner Truth's testimony names a mother's grief that was both deeply personal and created by slavery's laws and violence. Her question, "Ain't I a woman?" shows how race and gender shape whose pain is believed and whose motherhood is honored—and whose is not. For hospice and palliative care, her voice calls us to recognize disenfranchised suffering and loss, and to make sure that people's traumatic stories and grief are fully heard, valued, and woven into how we understand and respond to their present struggles.

Source: Speech at the Ohio Women's Rights Convention, Akron, Ohio [National Park Service]

4. Frederick Douglass, "What to the Slave is the Fourth of July?" Rochester, New York, July 5, 1852

> *"The sunlight that brought life and healing to you, has brought stripes and death to me. This Fourth of July is yours, not mine. You may rejoice. I must mourn."*

Historical context: Douglass delivered this speech thirteen years after escaping slavery, addressing a largely white audience gathered in Rochester to commemorate Independence Day. By pairing "life and healing" with "stripes and death," he used the language of the body to name the contradiction of a nation that celebrated liberty while permitting the ongoing violence, illness, and early deaths of enslaved people.

Today's hospice and palliative care: Douglass's contrast between "life and healing" for some and "stripes and death" for others' names people whose enslavement and suffering were ignored even as the nation celebrated freedom. Read alongside Cicely Saunders's insistence, *"You matter because you are you,"* and her claim that *"approaches to death and dying reveal much of the attitude of society as a whole."* Paired together, their words call hospice and palliative care to ask where we are truly embodying equal regard—and where our approaches to death and dying still inflict avoidable suffering and reveal attitudes that some lives and losses matter less.

Sources: "What to the Slave is the Fourth of July?" Rochester, New York; [National Constitution Center]; Saunders' quotes in *Foreword in The Oxford Textbook of Palliative Medicine. Oxford University Press, Oxford (1993)*

What chapters are we writing next?

1857-1866

posted in *Hospice & Palliative Care Today*, June 18, 2026

1. Dr. Oliver Wendell Holmes, Sr., Annual Meeting of the Massachusetts Medical Society, 1860

> *"I firmly believe that if the whole materia medica, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind — and all the worse for the fishes."*

Historical context: On the eve of the Civil War, Oliver Wendell Holmes, Sr.—Boston physician and Dean of Harvard's Medical School—warned his colleagues that many popular drugs and treatments did more harm than good. He called for restraint and evidence rather than blind faith in the *"materia medica"* (pharmacology).

Today's hospice and palliative care: His 19th-century skepticism foreshadowed today's concerns about polypharmacy and futile interventions near the end of life.

Sources: Baylor University Medical Center Proceedings: Medical and Surgical Care During the American Civil War

2. Walt Whitman, "The Wound-Dresser," written from his wartime nursing experience 1862-1865

> *"I am faithful, I do not give out, The fractur'd thigh, the knee, the wound in the abdomen, These and more I dress with impassive hand, (yet deep in my breast a fire, a burning flame.) I sit by the restless all the dark night, some are so young, Some suffer so much, I recall the experience sweet and sad."*

Historical context: After his brother was wounded at Fredericksburg, Walt Whitman spent three years as a volunteer nurse in Washington, D.C. military hospitals during the war, writing letters for dying soldiers and dressing wounds. “The Wound-Dresser” is his poetic record of those experiences and a central literary document of American nursing care from the Civil War era, told from the caregiver’s perspective.

Today's hospice and palliative care: Whitman’s “wound-dresser” shows what care looks like when cures are few: steady hands, night-long presence, and attention to bodies that are “so young” and “suffer so much.” His poem gives hospice and palliative care an early language for the quiet work of sitting at the bedside, witnessing pain, and finding something “sweet and sad” in staying faithful to the wounded and dying rather than turning away.

Sources: "The Wound-Dresser," Drum-Taps (1865); Biography – Walt Whitman(1819-1892); Medical and surgical care during the American Civil War, 1861–1865

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3. President Abraham Lincoln, Gettysburg Address, November 19, 1863

> *"Four score and seven years ago our fathers brought forth on this continent, a new nation, conceived in Liberty, and dedicated to the proposition that all men are created equal... that this nation, under God, shall have a new birth of freedom — and that government of the people, by the people, for the people, shall not perish from the earth."*

Historical context: Delivered at the dedication of the Soldiers’ National Cemetery at Gettysburg, where thousands of dead were reburied after the battle of July 1–3, 1863, this address reshaped how Americans understood mass death and national sacrifice.

Today's hospice and palliative care: At Gettysburg, Lincoln asked a grieving nation to face mass death and respond with a “new birth of freedom,” not only with monuments and memory. His words resonate with hospice and palliative care’s long work of bereavement: walking with people whose losses may never fully heal, yet whose inconsolable sorrows can be honored, carried, and sometimes turned toward new purpose beyond the grave.

Sources: Abraham Lincoln Online, The Gettysburg Address (Bliss copy); Cornell University’s Transcript

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4. President Abraham Lincoln, Second Inaugural Address, March 4, 1865

> *"With malice toward none, with charity for all, with firmness in the right as God gives us to see the right, let us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan."*

Historical context: Two years after Gettysburg (July 1863), with the war nearly over and the toll of suffering clearer, Lincoln's second inaugural named a national duty "to care for him who shall have borne the battle, and for his widow and his orphan," a line later adopted as the official motto of the Department of Veterans Affairs.

Today's hospice and palliative care: This call to "bind up the nation's wounds" echoes in modern hospice and palliative care for veterans, their families, and survivors of war. It reminds clinicians and systems that serious illness, disability, and bereavement among those who served are not just private tragedies, but shared obligations of the community and the state.

Source: National Park Service, "With Malice Toward None":

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5. United States Congress, Act Establishing the National Asylum for Disabled Volunteer Soldiers, signed by President Abraham Lincoln, March 1865

> *Congress created the National Asylum for Disabled Volunteer Soldiers.*

Historical context: One of Lincoln's last acts of legislation before his April 1865 death, the National Asylum for Disabled Volunteer Soldiers — later renamed the National Home for Disabled Volunteer Soldiers — was the first large-scale federal institution dedicated specifically to the long-term care of disabled veterans, inaugurating the principle of government responsibility for those injured in national service. By 1873, Congress had also established pension programs and a home-nursing aid program for disabled veterans unable to care for themselves.

Today's hospice and palliative care: This act stands at the root of today's veteran-focused care, such as NHPCO/The Alliance's widespread "We Honor Veterans" programs, which recognize the ongoing impact of military service at the end of life. Today, hospice and palliative care teams put into action that caring for veterans means honoring their service and addressing war's lasting physical, emotional, and moral wounds for both veterans and their families.

Sources: Journal of the Civil War Era, "Caring for Veterans: The Civil War and the Present"; We Honor Veterans

What chapters are we writing next?

1867-1876

posted in *Hospice & Palliative Care Today*, June 19, 2026

1. U.S. Congress, Freedmen's Bureau and the Medical Care of the Formerly Enslaved, 1865–1872

> *"An Act to establish a Bureau for the Relief of Freedmen and Refugees" provided "food, shelter, clothing, medical services, and land to displaced Southerners, including newly freed African Americans."*

Historical context: Created in 1865 within the War Department, the Freedmen's Bureau supervised "all matters relating to the refugees and freedmen," including hospitals, camps, and the distribution of rations and clothing. Through its medical division and facilities such as Freedmen's Hospital in Washington, D.C., it became an early, if limited, experiment in federally supported health care for people emerging from slavery and war.

Today's hospice and palliative care: The Bureau's medical work shows both the promise and limits of federal care for a population whose illness and grief were shaped by generations of racial violence. For hospice and palliative care, it stands as an ancestor of efforts to address racial health inequities, reminding us that serious-illness care for Black communities must confront this history and actively build trustworthy, accessible end-of-life support.

Sources: National Archives – The Freedmen's Bureau; How History Has Shaped Racial and Ethnic Health Disparities

2. Embalming and the Rise of the Funeral Profession after the Civil War, c. 1860s-1870s

After the Civil War, embalming, first used widely to preserve soldiers' bodies for shipment home, helped shift care of the dead from families to a growing profession of undertakers and funeral directors.

Historical Context: During the Civil War, arterial embalming became common as families sought to have soldiers' bodies shipped long distances home for burial, and embalmers set up camps near battlefields. In the years that followed, embalming and new mortuary technologies fostered the rise of funeral homes and undertakers as a distinct profession, gradually moving washing, laying out, and preparing the dead from parlors and kitchens into commercial funeral parlors and altering how families participated in the care of bodies after death.

Today's hospice and palliative care: Today, choices abound—before, at, and after the death. At a hospice death, clinicians must sensitively attend to many practical details and intensely emotional dynamics with the family: who is present (or needs to come), who touches the body (or not), and how long families remain physically present with the body. Needs vary by cultural and religious practices and by disposition choices—burial, cremation, organ donation, medical/research donations, green burials. These at-the-death moments often lodge in family memory for the rest of their lives.

Sources: Medical and surgical care during the American Civil War, 1861–1865; Frazer Consultants — A History of Funerals in the United States

3. U.S. Marine Hospital Service, Reorganization and Supervising Surgeon (later Surgeon General), 1870–1873

In 1870, the Marine Hospital Service was reorganized as a national hospital system with centralized administration under a medical officer, the Supervising Surgeon, later given the title of Surgeon General.

Historical context: Founded in 1798 to care for sick and disabled merchant seamen, the Marine Hospital Service was reorganized in 1870, and in 1871 Dr. John Maynard Woodworth became its first Supervising Surgeon, now recognized as the first U.S. Surgeon General. This shift from scattered local hospitals to a coordinated federal service laid groundwork for a national public health role that would later include infectious disease control, immigrant health, and broader population health responsibilities.

Today's hospice and palliative care: The emergence of a national "doctor" signaled that the health of vulnerable groups—sailors, immigrants, and the poor—was a matter of public responsibility, not private charity alone. For hospice and palliative care, it underscores that bedside compassion must be supported by policy and coordinated systems if relief and dignity are to reach people far beyond any one institution or family.

Source: History of the Office of the Surgeon General

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4. Poverty and Disease in the Postwar South, 1865–1876

> *The pinch of want is making itself felt more severely every day and we haven't the thought that we are suffering for our country that buoyed us up during the war.~ a white Southern woman from a former slaveholding family, writing in the aftermath of Confederate defeat*

Historical context: In the ruined South, former slaveholding families and poor white households faced burned farms, lost livelihoods, and the deaths or disabilities of husbands and sons. A Georgia woman's complaint that "the pinch of want is making itself felt more severely every day" captures how, once the Confederacy was lost, many widows and families faced hunger, debt, outbreaks of smallpox and cholera, and grief without the belief that their suffering served a higher purpose.

Today's hospice and palliative care: In a divided country, naming the suffering of "the other side" without erasing injustice can itself be a kind of hospice skill: sitting with complicated legacies while tending to the immediate needs of suffering.

Sources: Documenting the American South; Reconstructing the Confederate Widow: An Analysis of the Wives of Fallen Confederate Soldiers and their Response to Reconstruction and the Post War Era

What chapters are we writing next?

1877-1886

posted in *Hospice & Palliative Care Today*, June 20, 2026

1. Clara Barton and the Founding of the American Red Cross, 1881

> *"You must never think of anything except the need, and how to meet it."*

Historical context: After the Civil War, Clara Barton learned about the International Red Cross in Europe and became convinced the United States needed similar organized relief. In 1881 she founded the American Red Cross and, through the 1880s, led volunteer responses to fires, floods, and epidemics, shifting aid from improvised charity to a neutral, coordinated movement centered on people in acute distress.

Today's hospice and palliative care: Barton's focus on "the need, and how to meet it" echoes the daily discernment of hospice and palliative teams at the bedside. Her legacy invites us to see symptom control, family support, and advocacy for neglected patients as forms of organized compassion—practical, disciplined, and directed toward those whose suffering is greatest, regardless of status or setting.

Sources: Clara Barton Birthplace Museum; American Red Cross – 145 Years of Humanity

2. Westward Expansion and Displacement, 1870s–1880s — New Starts, Old Wounds

> *It is estimated that in the 1870s, approximately 40,000 to 60,000 African Americans left the South and migrated westward*.

Historical context: In the late 1870s and early 1880s, tens of thousands of Black Southerners—Exodusters—fled lynching, debt peonage, and Jim Crow violence, heading to Kansas and other Western states in a "Great Exodus." Many arrived destitute, prompting the Kansas Freedmen's Relief Association and local Black churches to provide food, clothing, and help in finding homes and work. At the same time, westward expansion deepened the long dispossession of Native nations as treaties were broken, wars waged, and communities pushed onto reservations, with hunger, disease, and population loss following the seizure of Indigenous lands.

Today's hospice and palliative care: This era shows how one group's "fresh start" can rest on another's prolonged suffering, and how migrants may reach new places already worn down by trauma, illness, and loss. For hospice and palliative care, it is a reminder that many patients—especially those displaced by racism, poverty, or violence—carry histories of movement and broken promises, and that compassionate care includes attention to safety, shelter, and belonging alongside the management of serious illness.

Sources: Exoduster – Homestead National Historical Park; Westward Expansion and Displacement

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3. The Gilded Age & High Society (late 1870s–1890s)

> *"The construction of these new hospitals and hospital wings and extravagant new medical office buildings serve to 'represent power, conquest, legacy building, and achievement, and yet are not always in line with what is best for the populace.'" – Tom Dahlborg, 2011, reflecting on medicine's "gilded age"*

> *"We are in a 'Gilded Age of medicine' in which patients are often treated less as humans in need of care than consumers who generate profit." – Dhruv Khullar, MD, 2024*

Historical context: Mark Twain and Charles Dudley Warner coined the term "Gilded Age" in their 1873 novel of the same name to describe a society whose glittering surface concealed deep corruption and widening gaps between rich and poor. During the Gilded Age, wealthy elites endowed grand hospitals and medical institutions that signaled power, prestige, and civic legacy, while poor, immigrant, and racially marginalized communities were relegated to charity wards, almshouses, or went without adequate care. This paradox—impressive "gilded" buildings for the few and thin, unequal care for the many—helped normalize a stratified system in which class, race, and wealth strongly shaped who benefited from emerging scientific medicine.

Today's hospice and palliative care: Just as Gilded-Age hospitals became symbols of wealth and status that did not necessarily serve "what is best for the populace," some for-profit hospices today mirror that pattern—entities whose financial and M&A narratives can overshadow their commitments to bedside time, continuity, and quality at the end of life. At the same time, nonprofit and many for-profit hospices alike are working intentionally against this drift, grounding their decisions in patient, family, and community needs rather than in valuations alone.

Sources: Dahlborg T. “The gilded age of healthcare”; Khuller, D. “The gilded age of medicine is here”; History of Public Health: National developments in the 18th and 19th centuries; Gilded Age - Britannica

What chapters are we writing next?

1887-1896

posted in *Hospice & Palliative Care Today*, June 21, 2026

1. Lillian Wald, Henry Street Settlement, 1893

> *Lillian Wald, widely credited with coining the term public health nurse in 1893, linked bedside care in poor neighborhoods with organized public health, social reform, and nursing leadership.*

Historical Context: In 1893, after encountering severe poverty and illness on New York's Lower East Side, Lillian Wald began the home nursing work that grew into Henry Street Settlement and the Visiting Nurse Service. Widely credited with coining the term "public health nurse," Wald helped define a new model of care in which nurses worked not only at the bedside but also within the life of a neighborhood, attending to housing, sanitation, labor conditions, and family well-being. She pioneered school nursing and broader public health nursing as organized, community-based work rather than charity alone.

Today's hospice and palliative care: Nursing wherever people call" home" has become one of the clearest expressions of person-centered care—meeting people in houses and apartments, in senior living and long-term care, and in shelters and other fragile places of refuge. Home health and hospice nurses—with interdisciplinary colleagues—now meet needs where people live life, while supporting family caregivers. Our work ahead is to extend that promise—closing equity gaps in under-resourced and rural communities; ensuring excellent care that more fully lives out our founding claim that all are created equal and endowed with certain unalienable rights.

Sources: Lillian Wald (1867-1940); The Atlantic / NYPL Wald Papers

2. New York State Legislature, State Care Act, 1890

In 1890, New York State prohibited the confinement of indigent people with mental illness in jails and poorhouses and required that they be cared for in state institutions at state expense.

Historical context: The State Care Act shifted indigent New Yorkers with mental illness out of county poorhouses and jails and into a state hospital system. While this was an improvement, it also reveals time-sensitive gaps in dignity. The Act's 1896 "completion" document described persons as "lunatics," "indigent insane, and "wretched loves," language that exposes how stigma was embedded in the system. While these new settings promised more consistent and medically supervised care, stigmas lived on in the asylum model itself, where separation, prejudice, chronic illness, and long confinement shaped how they lived—and died.

Today's hospice and palliative care: People living with serious mental illness still too often miss the access and dignity that end-of-life care should offer everyone. Hospice and palliative care can answer that gap best when mental health, medical, and caregiving teams work together so that no one remains unseen at the end of life. Side note: in Spanish, the word "hospice" translates to "asilo or asylum," which can carry negative connotations. Many international hospices use the word "palliative care."

Sources: NY State Archives, Hospital Commission; NY State Care System for the Insane Completed: 1896

3. Emerging U.S. Vital Statistics and Death Registration, 1890s

By the 1890s, the United States was building a more systematic way of recording deaths, as states adopted laws requiring registration of deaths with details such as cause, age, and place of residence.

Historical context: In the 1890s, death registration in the United States was still strong in some cities and states, weak or absent in others. Still, the idea was taking hold that every cause of death should be counted. Early mortality tables showed, for example, that tuberculosis and infant deaths were concentrated in crowded, poor urban districts. The records were incomplete and often biased, especially in rural areas and among marginalized communities, yet they marked a turning point: mortality became not only a family event, but also a public fact that could reveal patterns of suffering and push for reform.

Today's hospice and palliative care: Today's hospice and palliative care live in the world those early tables made possible, drawing on data from CMS, NHPCO/The Alliance's annual Facts and Figures, Hospice Analytics, state scorecards, and evidence-based studies to see who is—and is not—reached by serious-illness care. Location-of-death reports, race and ethnicity utilization tables, and tools such as CMS's Mapping Medicare Disparities now highlight patterns of inequity that used to remain invisible. And, while today's exploding uses of Artificial Intelligence promise new ways to forecast risk, guide palliative referrals, and support decision making—but such AI demands careful ethical scrutiny so that algorithms deepen, rather than distort, the commitment to dignity, access, and human judgment for care the end of life.

Sources: US Census Office, Vital and Social Statistics of Death, 1890, Mortality Differentials within Large

Cities in 1890; CMS.gov – Hospice; NHPCO/The Alliance Facts and Figures; Hospice Analytics; CMS Mapping Medicare Discrepancies

What chapters are we writing next?

1897-1906

posted in *Hospice & Palliative Care Today*, June 22, 2026

1. Hospital Electrification — Light in the Night, early 1900s

By 1900, Edison's 1879 incandescent bulb was replacing kerosene lamps and gas fixtures.

Historical context: Electric lighting was part of the broader industrial age: new power plants, wiring, and bulbs made it possible to illuminate wards, operating rooms, and corridors through the night. This shift improved visibility, safety, and infection control, and allowed clinicians to respond more quickly to emergencies. Still, access remained unequal, with rural and segregated communities often left behind.

Today's hospice and palliative care: Yesterday's new light bulbs are now today's middle-of-the-night smartphones and emergency telehealth visits, with artificial intelligence casting powerful searchlights on how we anticipate and relieve suffering. Yet gaps in broadband, bias in algorithms, and uneven access to clinicians mean these tools can deepen inequity as easily as close it—unless we use them intentionally to bring timely, person-centered care to communities that have waited longest.

Sources: The History of Surgical Lights; Lighting America – The Early Adoption of Electric Light

2. American Medical Association (AMA) — Council on Medical Education, 1904

> *In 1904 the AMA formed its Council on Medical Education to investigate and set standards for medical schools in the United States.*

Historical context: At the turn of the twentieth century, U.S. medical education was uneven and often commercial, with proprietary schools, low admission standards, and little accountability for outcomes. The AMA's new Council on Medical Education began rating and reforming medical schools, pushing toward scientific rigor, standardized curricula, and eventually the Flexner Report's sweeping changes—a shift from medicine as a trade to medicine as a profession with shared standards.

Today's hospice and palliative care: Today, the AMA's medical education policies and its work on Undergraduate Medical Education competencies and standards press for consistent, outcomes-focused training for every physician, echoing the Council's original call for rigor and public accountability. Building on that foundation, the American Academy of Hospice and Palliative Medicine(AAHPM) and the Accreditation Council for Graduate Medical Education (ACGME)–accredited hospice and palliative medicine fellowships advance subspecialty training, board certification, and quality initiatives so more clinicians are prepared to deliver high-quality serious-illness care wherever patients are. View AAHPHM's "Pledge to Diversity, Equity & Inclusion."

Sources: The Flexner Report: A Revolution in American Medical Education; AMA's Recommendations for Future Directions for Medical Education H-2295.995, 2024; AAHPM's Hospice and Palliative Medicine Fellowships; AAHPHM's Pledge to Diversity, Equity & Inclusion

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3. W.E.B. DuBois, The Health and Physique of the Negro American, 1906

> *"The Negro death rate and sickness are largely matters of condition and not due to racial traits and tendencies." ~ W.E.B. DuBois*

Historical Context: In the grip of Jim Crow, Du Bois rejected the false biology of racial inferiority and showed that Black health disparities arose from living conditions, labor exploitation, housing, and discrimination. He replaced stigma with evidence and insisted that unjust conditions—and the suffering they cause—can be changed.

Today's hospice and palliative care: Today, CMS Hospice Conditions of Participation anchor care in "exercise of rights and respect for property and person" (Patient Rights § 418.52(b), making dignity a core requirement, not an aspiration. CAHPS Hospice then asks the primary caregiver, "How often did the hospice team treat your family member with dignity and respect?" and "While your family member was in hospice care, how much support for your religious, spiritual, or cultural beliefs did you get from the hospice team?" Together, these commitments show real progress toward the humane, condition-aware care DuBois envisioned, even as equity and trust remain active work, not a finished chapter.

Sources: The health and physique of the Negro American, W.E.B. DuBois, 1906; CMS Hospice Conditions of Participation; CMS CAHPS Hospice Survey

What chapters are we writing next?

1907-1916

posted in *Hospice & Palliative Care Today*, June 23, 2026

1. The Flexner Report, Medical Education in the United States and Canada – A Report to The Carnegie Foundation for the Advancement of Teaching, 1910

> *"A well-taught negro sanitarian will be immensely useful; an essentially untrained negro wearing an M.D. degree is dangerous." ~ Dr. Abraham Flexner, The Flexner Report's author, 1910*

Historical context: Abraham Flexner's 1910 report modernized American medical education—and gutted it for Black and women physicians. Within 15 years, 5 of 7 Black medical schools had closed; women's enrollment fell by half. Flexner's use of lowercase "negro"—at a time when Black writers and advocates were actively demanding capitalization as a matter of dignity—was not accidental. His explicit intent was to train Black physicians as servants of white public health, not as clinicians. Researchers estimate that had those schools survived, 30,000–35,000 more Black physicians would have entered the workforce by 2019.

Today's hospice and palliative care: Flexner's legacy still shapes today's workforce. For many Black patients and families, mistrust is not a personality trait; it is the lived memory of generations blocked from the "pursuit of happiness" through medical education and service. The deeper work is rebuilding trust through action: supporting culturally and gender-concordant teams where possible, partnering with communities, and using research, quality data, and carefully designed AI tools to surface and address longstanding gaps in pain control, access, and hospice referrals—so the care we provide more faithfully reflects the communities we serve.

Sources: The Flexner Report, Medical Education in the United States and Canada – A Report to The Carnegie Foundation for the Advancement of Teaching; How one 1910 report curtailed Black medical education for over a century; AAMC renames prestigious Abraham Flexner award in light of racist and sexist writings

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2. The Triangle Shirtwaist Fire, New York City, Garment District, 1911

> *"The life of men and women is so cheap and property is so sacred. There are so many of us for one job it matters little if 146 of us are burned to death." ~ Rose Schneiderman, labor organizer, New York City, April 2, 1911*

Historical context: On March 25, 1911, fire consumed the Triangle Shirtwaist Factory's upper floors. Doors were locked, ladders fell short, and 146 workers—most of them young immigrant women—died. The owners were acquitted. But from the ash came 30+ New York workplace safety laws, the U.S. Department of Labor (1913), workers' compensation reform, Frances Perkins's Fair Labor Standards Act (1938), and—six decades later—OSHA (1970). This 1911 fire rewrote the legal obligation of employers to the people in their care.

Today's hospice and palliative care: Every hospice agency now operates under OSHA standards, fire safety codes, and a federally required Emergency Preparedness Program—a direct legacy of this tragedy. The cycle of mitigation, preparedness, response, and recovery now covers hospice office sites, GIP units, and patients wherever they call "home," along with the teams and volunteers who care for them on the road. When California wildfires displaced patients or Hurricane Helene cut off rural hospice teams, these plans meant the difference between abandonment and continuity of care. Disasters still expose gaps in communication and patient care. The 1911 Triangle fire reminds us that the cost of poor safety is measured in lives.

Sources: How a Factory Fire in 1911 Changed Workplace Safety Forever; Schneiderman's April 1911 Speech

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3. RMS Titanic (1912) and the Safety of Life at Sea (SOLAS – 1914)

> *"The first Convention for the Safety of Life at Sea was prompted by the sinking of RMS Titanic." ~ The National Archives (UK)*

Historical context: On April 15, 1912, the "unsinkable" Titanic sank in the North Atlantic after striking an iceberg. More than 1,500 people died — about two-thirds of all on board. Survival was sharply stratified: passengers in first-class cabins near the deck lived at far higher rates than immigrant families confined to third-class steerage. Outrage over inadequate lifeboats, poor drills, and missed wireless warnings led directly to the first International Convention for the Safety of Life at Sea (SOLAS) in 1914, which set binding global standards for lifeboats, lifejackets, drills, and continuous radio watch.

Today's hospice and palliative care: Titanic and SOLAS reshaped what we expect from safety planning: enough "lifeboats," clear procedures, and someone always listening for distress (24/7 on-call). In serious-illness care, which translates into patient-specific emergency plans and equitable access to safety:

backup power for home oxygen, routes for safe transfer and evacuation, and disaster planning that includes people who are homebound and far from the nearest hospice team. Hospice and palliative care inherit Titanic's question in a new form: are we planning so that every patient, in every setting, has a real chance to be reached, communicated with, and kept safe where they are—or safely moved when they cannot stay?

Source: The National Archives - The Convention for the Safety of Life at Sea (SOLAS)

What chapters are we writing next?

1917-1926

posted in *Hospice & Palliative Care Today*, June 24, 2026

1. World War I – Battlefield medicine reshapes American care

> *"War is the most powerful instrument of medical progress."* ~ *Dr. William Osler, John Hopkins University's first professor of medicine; his son died in action during World I, with a grief-stricken William dying in 1919*

Historical context: World War I forced American clinicians to manage unprecedented volumes of traumatic injury and infection in young soldiers, driving advances in surgery, antisepsis, X-ray use, and the organization of hospitals and rehabilitation services. Triage systems became more explicit—deciding who received immediate surgery, who could wait, and who would receive only comfort—while the long-term needs of wounded and disabled veterans spurred expanded hospital capacity, prosthetics, and structured rehabilitation in the United States.

Today's hospice and palliative care: Modern hospice and palliative care build directly on these currents: better pain control, systematic triage, stronger nursing, and recognition that serious, life-limiting illness demands organized, ongoing support rather than episodic rescue. We inherit the wartime lesson that those expected to die still require expert symptom management and presence. Today, we extend these insights into comprehensive palliative services for veterans and civilians alike, addressing physical pain, psychological distress, and moral injury across the lifespan.

Sources: William Osler, 1849-1919; How World War I Influenced the Evolution of Modern Medicine; Advancements in Medical Care during World War I

2. 1918 Spanish flu pandemic in America – Mass suffering and the call to comfort

> *"The influenza epidemic that swept the world in 1918 killed an estimated 50 million people. ... Within months, it had killed more people than any other illness in recorded history." ~ U.S. National Archives*

Historical context: The 1918–1920 "Spanish influenza" pandemic devastated families and communities, attacking roughly one-fifth of the world's population and killing about 50 million people worldwide, including an estimated 675,000 in the United States. Young adults who were previously healthy could go from first symptoms to suffocating death in a few days. In some cities, hundreds died in a single day. Life expectancy in the U.S. dropped by 12 years, and grief piled up faster than funerals could be held.

Today's hospice and palliative care: The twin pandemics of 1918's Spanish influenza and 2020's COVID-19 revealed how quickly deadly disease can spread, how easily people can die in isolation, and how severely economics and everyday life can be disrupted. Ongoing, COVID-era solutions have become new norms—telehealth, stricter infection control, masking when needed, vaccination campaigns, and even video-streamed funerals—each reshaping how we accompany seriously ill and dying people across distance and danger.

Sources: National Archives – The Deadly Virus, The Influenza Epidemic of 1918; COVID-19: a comparison to the 1918 influenza and how we can defeat it

3. Automobiles, telephones, and the shrinking distance to the bedside

> *By the 1920s, the automobile and telephone were changing how Americans lived, worked, and stayed connected.*

Historical context: In the years after World War I, mass-produced cars, better roads, and expanding rail networks allowed doctors and patients—especially those who were urban and better-off—to travel more quickly between home, clinic, and hospital. Telephones spread rapidly through cities and towns, letting families summon physicians and seek advice without sending a messenger, and reinforcing the expectation that medical help could be both mobile and rapidly reachable.

Today's hospice and palliative care: Emergency response, hospital transfers, and coordinated hospice care now depend on complex infrastructures of mobility and communication, extended through driving to patients, using mobile devices, EMR professional communications, and telehealth. Cars, roads, and phone networks—and their modern descendants—enable hospice and palliative teams to respond quickly to crises, link hospitals with home-based services, and hold time-sensitive family and team conversations across distance, even as they highlight gaps for those still living far from well-resourced centers.

Sources: Smithsonian National Museum of American History – Better Roads; Smithsonian - Communication; Telephones Through Time: Smithsonian's Historic Collection

What chapters are we writing next?

1927-1936

posted in *Hospice & Palliative Care Today*, June 25, 2026

1. The Great Depression and Lack of Medical Care

> *"Pain, sickness, and bereavement have shadowed mankind throughout the ages; today there is a vast amount of unnecessary sickness and many thousands of unnecessary deaths." ... "The rising costs of medical care focus public attention on economic issues. Equally important but less publicized are issues of the quality and quantity of such services. ... For many people, health services are not available or not accessible, or not affordable, or all of these." Medical Care for the American People, University of Chicago Press, 1932, pages xv and iii*

Historical context: [More from this 1932 report] **"...** Each year, over a hundred thousand babies die during the first year of life, many of them needlessly. Of the many thousand victims of tuberculosis, over 88,000 died in 1930 alone. Pellagra and hookworm disease reduce the economic efficiency of a large proportion of the people of the South. Syphilis and gonorrhea destroy fertility, deform babies and wreck homes. Over one-third of a million people are mentally diseased. The death rates for cancer, diseases of the heart, and diabetes are rising. Many of the people, young and old, are handicapped by one or more defects—particularly decayed teeth, enlarged or diseased tonsils, defective vision, partial deafness, and weak feet. *Medical Care for the American People, 1932, page xv*

Today's hospice and palliative care: Medicare, Medicaid, and insurance reforms now fund hospice and palliative care so that many more seriously ill people can receive pain relief and interdisciplinary care regardless of income or diagnosis. Still, when payment systems prioritize profit over access and quality—disrupting services, straining staff, or inviting fraud, we must keep asking: who is being abandoned in their

suffering? What will it take to realign our ethics, operations, and advocacy so that the people we serve remain at the center of financial decisions?

Sources: A forgotten landmark medical study from 1932 by the Committee on the Cost of Medical Care; Medical Care for the American People – The Final Report of The Committee on the Costs of Medical Care, 1932

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2. National Negro Health Week and the Shadow of Tuskegee

> *"In 1932, the U.S. Public Health Service, working with the Tuskegee Institute, began a study to record the natural history of syphilis." Tuskegee Study of Untreated Syphilis in the Negro Male*

Historical context: By the 1930s, National Negro Health Week at Tuskegee mobilized Black churches, schools, and leaders to confront deadly health disparities under Jim Crow. In that same place and decade, the U.S. Public Health Service began the Tuskegee study, enrolling Black men without true informed consent and later withholding penicillin, causing preventable deaths and deepening mistrust. This study continued until 1972, after media exposure and public outcry led to an advisory panel that called the study "ethically unjustified."

Today's hospice and palliative care: The "National Negro Health Week" evolved into "National Public Health Week," reiterating that "all are created equal." Today, hospice and palliative care are shaped by government and corporate decisions about who gets covered, where care is offered, and what is paid for. When those decisions widen access, they honor people who were once exploited or excluded. When they restrict access or chase profit, we must ask whose trust is being broken now—and who is again being left to suffer without the care they need?

Sources: Moving From the National Negro Health Week to the National Public Health Week in the United States; The Untreated Syphilis Study at Tuskegee Timeline The Legacy of the Tuskegee study; National Public Health Week

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3. The New Deal and a Social Safety Net

> *"This law represents a cornerstone in a structure which is being built but is by no means completed... a law that will take care of human needs and at the same time provide for the United States an economic structure of vastly greater soundness." Franklin D. Roosevelt, statement on the Social Security Act, 1935*

Historical context: In 1935, the Social Security Act established federal old-age benefits and, through state partnerships, began supporting some widows, children, and disabled workers. It did not create universal health insurance and often excluded Black, rural, and low-wage workers. Still, it signaled that aging, disability, and poverty in later life were now shared public responsibilities rather than left solely to family or charity.

Today's hospice and palliative care: Today, Medicare, Medicaid, and related insurance programs—descendants of that "cornerstone" vision—allow many seriously ill people to receive hospice and palliative care they could never privately afford. When laws and payment models widen coverage and sustain safety-net providers, they honor that commitment to human needs. When they narrow benefits or reward profit over access, we must keep asking: whose final years are being made more precarious? What will it take to keep our safety net truly holding across race, class, and geography?

Sources: The Social Security Act of 1935; Anniversary of the Social Security Act of 1935;

What chapters are we writing next?

1937-1946

posted in *Hospice & Palliative Care Today*, June 26, 2026

1. 1937–1941: The Gathering Storm

> *"To establish and maintain the highest possible standards of health among the people of the United States." ~ National Health Act of 1939*
>
> *"We cannot be a strong nation unless we are a healthy nation. And so, we must recruit not only men and materials, but also knowledge and science in service of national strength." ~ President Franklin D. Roosevelt, on the opening of the new National Institutes of Health campus, 1940*

Historical context: As the Depression dragged on, federal leaders began to say out loud that health was a national responsibility, not just a private burden or local charity. Even as war loomed overseas, they drafted surprisingly bold plans to expand public health, finance medical care, and protect those most likely to be left out.

- 1937: Technical Committee on Medical Care created to study national health needs and options for national health insurance.
- 1938: National Health Conference convenes in Washington, gathering public health officials, providers, labor, and others to debate federal responsibility for medical care and public health.
- Late 1930s: Reformers call for prepaid group practice and broader coverage as medical costs rise and access remains uneven.

- 1939: Senator Wagner's National Health Act proposes federal funds for public health, maternal–child health, medical care for low-income people, and hospital expansion—one of the boldest pre-war attempts at a national health program.

Today's hospice and palliative care: Today's hospice and palliative care inherit both sides of this moment: the memory of families priced out of care, and the vision that health systems should protect the most vulnerable.

Sources: National Health Act of 1939; A (Brief) History of Health Policy in the United States; Places of Public Health: Medical Research during World War II

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2. 1941-1945: America at War – Saving Lives, Counting Losses

"December 7th, 1941—a date which will live in infamy." ~ President Franklin D. Roosevelt, 1941

Historical context: After Pearl Harbor, the U.S. rapidly converted civilian life and medicine to a war footing, scaling up induction centers, military hospitals, and research labs. Medicine focused on keeping troops "fit to fight," developing new ways to prevent disease, move the wounded quickly, and salvage lives that would have been lost in earlier wars.

- **1941–1945:** millions of recruits processed through induction centers with medical exams, vaccinations, and classification for service.
- **Battlefield medicine advances:** organized forward aid stations, surgical hospitals, and evacuation chains (including growing use of air evacuation).
- **Blood and fluids:** shift from limited plasma early in the war to more effective products like serum albumin by 1945.
- **Infection control:** first large-scale combat use of penicillin and streptomycin, dramatically reducing deaths from infected wounds.
- **Trauma surgery:** more aggressive debridement (removal of dead tissue) lowers amputation rates compared with earlier wars.
- **Morphine for the dying:** medics carried morphine and basic supplies to relieve severe pain and offer as much dignity as possible in the thick of battle.
- **Black Americans:** more than 1.5 million Black Americans served in the military, still segregated; the "Double V" campaign—victory over fascism abroad and racism at home—advocated the belief that their military service and sacrifice should lead to full civil rights and equal access to jobs, education, and health care.
- **Women:** nearly 350,000 U.S. women served in the military, about 3 million worked in war plants and other defense-related jobs, and more than 19 million were in the wartime workforce overall.

- **Mental health:** "combat fatigue" units provide rest and removal from the front; many soldiers return to duty, but long-term psychological trauma remains underrecognized.

- **Home-front hospitals:** civil-defense drills, staff redeployment to the military, and wartime research projects reshape hospital routines and accelerate innovative technologies.

Today's hospice and palliative care: Today's hospice and palliative care are indebted to the millions whose wartime traumas pushed medicine from darkest pain and despair toward seismic shifts in compassionate care.

Sources: Take A Closer Look: America Goes to War; Medical Improvements Saved Many Lives During World War II; World War II: The African American Experience; Women in the Military During World War II

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3. 1945: Liberation and the Holocaust - Witnessing the Unthinkable

> *"Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented." ~ Elie Wiesel, Holocaust survivor, 1986 Nobel Peace Prize acceptance speech*

Historical context: In 1945, Allied troops liberated Nazi camps and uncovered starvation, disease, and mass killing on a scale that stunned the world. Images of skeletal Jewish survivors and mass graves exposed what happens when whole peoples are treated as less than human, even as the U.S. had turned away many Jewish refugees before and during the war.

- **Camp liberations:** Soldiers, medics, and chaplains entered barracks crowded with emaciated prisoners and clear evidence of systematic murder.

- **Emergency care:** Military medical teams scrambled to provide food, fluids, and infection control to survivors whose bodies were too fragile for standard treatment.

- **Death after liberation:** Many prisoners died within days or weeks, with little time or structure for emotional, spiritual, or relational care.

- **Moral shock:** The camps, trials, and survivor testimonies deepened the belief that every person has inherent dignity, especially when powerless and near death.

Today's hospice and palliative care: Against this history of people deemed unworthy of rescue or refuge, hospice and palliative care insist that no one is outside the circle of care and dignity, especially those who are displaced, marginalized, or near death.

Sources: United States Holocaust Museum – Liberation of Nazi Camps; Holocaust Encyclopedia – Displaced Persons

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4. 1945–1946: Aftermath – Wounds Seen and Unseen

> *[Setting the stage in 1944] "We have accepted, so to speak, a second Bill of Rights under which a new basis of security and prosperity can be established for all—regardless of station, race, or creed. Among these are: … The right to adequate medical care and the opportunity to achieve and enjoy good health." ~ President Franklin D. Roosevelt, State of the Union Address, January 11, 1944*

Historical context: World War II ended with millions dead, many more living with disability and trauma, and families across the U.S. grieving. Medicine and government faced long-term responsibility for veterans' care, not just battlefield rescue.

- **Veterans Administration (VA) expansion:** 1946 law creates the VA's Department of Medicine and Surgery, formalizing a national veterans' health system.
- **Hospital demand:** Returning troops and new treatments drive rising demand for hospital beds, specialists, and rehab.
- **Disability and rehab:** Large numbers of injured veterans spur growth in rehabilitation medicine and prosthetics, with little matching attention to emotional or spiritual needs.
- **Psychological aftermath:** Long-term trauma, nightmares, and moral injury are common but remain stigmatized and rarely treated.
- **Families and grief:** Widows, children, and parents carry heavy grief with almost no structured bereavement support.

Today's hospice and palliative care: Born from lessons of war and its long shadows, hospices intentionally walk with aging veterans whose physical and emotional wounds have been carried for decades and into their own end-of-life care. NHPCO's "We Honor Veterans" program was created to provide compassionate care to these "Greatest Generation" veterans from World War II and continues today for later generations of veterans, now through The Alliance.

Sources:1944 State of the Union Address Text; Object 8: Public Law 79-293, The Department of Medicine And Surgery Act, 1946; We Honor Veterans

What chapters are we writing next?

1947-1956

posted in *Hospice & Palliative Care Today*, June 27, 2026

1. Hill–Burton Act and "Separate but Equal" Hospitals (1946–early 1950s)

Every new building is also a blueprint of who is welcome inside.

Historical context: The 1946 Hill–Burton Act sparked a postwar transformation of U.S. health care infrastructure, funding a nationwide boom in hospital construction to address the severe shortage of beds after the Great Depression and World War II. It expanded capacity by helping build or modernize thousands of hospitals, nursing homes, and clinics through federal–state matching funds and required facilities to provide some free or reduced-cost care. At the same time, to secure Southern support, the law explicitly allowed "separate but equal" facilities, using public dollars to maintain racially segregated, under-resourced care for Black patients. Black physicians and civil rights advocates quickly denounced these policies as a medical civil rights issue.

Today's hospice and palliative care: Today's hospice and palliative care must read Hill–Burton as both achievement and warning: systems can grow and still structurally shut people out. Because of structural racism, under-insurance, and justified distrust, many Black, Hispanic, and American Indian/Alaska Native patients reach us late—through emergency departments and at advanced stages of illness. If we expand hospice and palliative care without building in equity from the start, we risk creating the next Hill–Burton—celebrated for growth, remembered for who it left out.

Sources: Hill-Burton Free and Reduced-Cost Health Care; NPR: A Bygone Era: When Bipartisanship Led To

Health Care Transformation; Public Health, Racism, and the Lasting Impact of Hospital Segregation

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2. Cicely Saunders, David Tasma, and the Window that Opened Modern Hospice (London, 1948)

"I will be a window in your Home." The promise of David Tasma of Warsaw who died 25 February 1948 and who made the first gift to St. Christopher's Hospice

Historical context: In 1948, Cicely Saunders, then a young social worker, met David Tasma, a Polish Jewish refugee dying of cancer on a crowded London ward. His pain, loneliness, and searching conversations with her revealed how tragically standard hospital care was failing people who were dying. Before he died, he left her a small legacy with the promise, "I will be a window in your Home." His presence—while dying—shaped her beliefs about "total pain" and became a catalyst for her journey toward creating the first modern hospice, St. Christopher's, in 1967, in London, England.

Today's hospice and palliative care: Tasma's "window" invites hospice and palliative care to remember its heart: one person's story can reshape how we care for many. Whenever a clinician pauses to be fully present in the moment, and whenever a team makes room for a patient's story to guide the plan, that "window" reveals how clearly we see those we serve, and humanity in our larger world.

Sources: Dame Cicely Saunders; St. Christopher's plaque of David Tasma's Window

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3. From Home Death to Hospital Death (early mid 1950s)

Death moved from the home to the hospital, and the machines kept watch.

Historical context: By the 1950s, antibiotics, complex surgeries, and early ventilators had turned hospitals into high-tech centers of acute care. Death, once most often at home, increasingly took place in hospital wards and nursing homes, where clinicians could intervene longer and more aggressively, reshaping how families and communities experienced dying.

Today's hospice and palliative care: This move from home death to hospital death handed medicine powerful tools but also a culture of prolonging dying in ways that can deepen suffering. Hospice and palliative care stand at this crossroads, using hospital care to ease distress, clarify what matters most, and, whenever possible, help people spend their final days in ways that are truly person-centered—shaped by their own values, relationships, and preferred places of care.

Sources: History of Hospitals; World Health Organization – Palliative

What chapters are we writing next?

1957-1966

posted in *Hospice & Palliative Care Today*, June 28, 2026

1. 1950s – Baby Boomers and the Promise of a Longer Life

By 2030, all baby boomers will be age 65 or older.

Historical context: Postwar America celebrated survival and science. Antibiotics, the Salk polio vaccine, and expanding hospitals meant more children grew up and more adults lived longer. The Baby Boom (1946–1964) swelled the future elder population, while nursing homes and chronic-care facilities quietly expanded. Few grasped how many people would someday live for years with dementia, multimorbidity, and frailty.

Today's hospice and palliative care: We now meet that vast generation of Baby Boomers as "Senior Boomers." Longer life has become a stress test: rising elder census and healthcare needs, workforce shortages, and caregiver strain all trace back to those mid-century gains. Today's hospice and palliative care is helping redesign care for this aging majority—scaling home-based serious-illness care, supporting exhausted caregivers, and advocating for health systems and families to plan for predictable late-life living and dying.

Sources: Baby boom | Definition, Cause, & Facts; Hospice in America by the Numbers – 2026; The 2030 Problem: Caring for Aging Baby Boomers

2. 1963 – President John F. Kennedy's Death and Televised Grief

> *CBS TV News Bulletin: "From Dallas, Texas, the flash, apparently official. President Kennedy died at 1:00 p.m. Central Standard Time, 2:00 Eastern Standard Time, some 38 minutes ago." ~ Walter Cronkite, November 22, 1963*

Historical context: President John F. Kennedy's assassination in 1963 turned grief into a shared national broadcast. Continuous television coverage carried images of shock and ritual into living rooms, while millions sent condolence letters to a family they had never met. A largely private experience became a collective, media-shaped event, revealing how deeply people needed language, witness, and participation after traumatic loss.

Today's hospice and palliative care: This national crisis echoed the 1865 death of President Abraham Lincoln and foreshadowed how we mourn now: publicly, visually, and often online. Hospice and palliative teams can respond by creating intentional spaces for shared remembrance—memorials, story circles, digital rituals—and by helping families limit re-traumatizing exposure to images and coverage. Looking ahead, our work is to treat grief as both personal and communal, asking "Where is your loss being seen?" and shaping supports that reach beyond the solitary individual into community and digital life.

Source: YouTube - CBS TV News Bulletin, Walter Cronkite; NPR: How live TV helped America Mourn The Loss of JFK

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3. 1965 – Medicare, Medicaid, and Who Gets Care

> *"No longer will older Americans be denied the healing miracle of modern medicine." ~ President Lyndon B. Johnson at the signing of the Medicare and Medicaid Act, July 30, 1965*

Historical context: In 1965, Congress created Medicare and Medicaid, tying hospital and medical care for older and low-income Americans to federal law. Overnight, elders gained significant coverage, and Medicaid became the main safety net for nursing-home care. Two decades before "hospice" was a formal benefit, this legislation laid the financial tracks on which most late-life and end-of-life care in the United States runs, today.

Today's hospice and palliative care: Since 1966, more than 160 million people have been entitled to Medicare, and today nearly 2 in 5 Americans are covered by Medicare or Medicaid—a scale that makes these programs the backbone of serious-illness and end-of-life care in the United States. This reach is both gift and warning: hospice depends on these funds even as quality gaps, fraud, and long-standing inequities threaten public trust. Our task is to use this architecture for justice—strengthening integrity and equity so that care reaches those who have historically been left out.

Sources: President Lyndon B. Johnson's Remarks on the Medicare Bill; National Archives – Medicare and Medicaid Act (1965); Medicare and Medicaid by the Numbers – 60th Anniversary, 2025

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4. Martin Luther King Jr., speech to the Medical Committee for Human Rights, March 25, 1966

> *"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death." ~ Dr. Martin Luther King, Jr.*

Historical context: The 1946 Hill-Burton Act supported segregated hospitals. The landmark Civil Rights Act of 1964 outlawed discrimination based on race, color, religion, sex, or national origin. In theory, it ended segregation in public places and employment. In March 1966, speaking with the Medical Committee for Human Rights in Chicago, Dr. King named health care as a frontline of injustice.

Today's hospice and palliative care: King's words still test us. Hospice and palliative programs that overlook race, poverty, language, disability, or geography risk repeating the inequities he condemned. The call now is concrete and hopeful: know who is being missed, listen with communities at the margins, and shape policy and practice so that comfort, communication, and support at the end of life are signs of justice, not privilege.

Sources: Getting Martin Luther King's words right; Dr. Martin Luther King on health care injustice

What chapters are we writing next?

1967-1976

posted in *Hospice & Palliative Care Today*, June 29, 2026

1. A world watching death, injustice, and possibility

> *"Each time a man stands up for an ideal or acts to improve the lot of others or strikes out against injustice, he sends forth a tiny ripple of hope." ~ Robert F. Kennedy*

Historical context: In these few years, a new generation watches death, injustice, and wonder unfold in real time.

- Vietnam War body counts appear nightly on television, making distant deaths immediate and political.
- The assassinations of Martin Luther King Jr. and Robert F. Kennedy bring sudden public grief and deepen racial and political fractures.
- Civil rights, Black Power, and antiwar movements expose hidden violence and demand dignity for marginalized communities.
- College and teen rebellions challenge institutional authority, including how medicine handles truth, suffering, and dying.

- The Apollo 11 moon landing becomes a shared global triumph, expanding imaginations about what humanity can do together.

Into this contested landscape step Cicely Saunders, Elisabeth Kübler-Ross, and Florence Wald, each offering a different way to insist that every dying person is, in Robert F. Kennedy's words, "*a human being whom other human beings loved and needed,*" and should be cared for accordingly.

Today's hospice and palliative care: These years still echo in today's headlines—war, racial violence, protest, and breakthrough science all shape what people expect at the end of life. The question is whether hospice and palliative care will look away, or offer truthful, humane care that centers those most exposed to harm. Continue reading to see how three visionary leaders reimagined care for people who are dying—and why their work still matters now.

Sources: Robert F. Kennedy Quotes; History.com

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2. 1967, Dame Cicely Saunders opens St. Christopher's, the first modern hospice

> *"You matter because you are you, and you matter to the last moment of your life; and we will do all we can not only to help you die peacefully, but also to live until you die."*

Historical context: In 1967, Dr. Cicely Saunders opens St. Christopher's Hospice in London as a radical alternative to hidden, medicalized dying. She brings together meticulous pain and symptom control, attention to family and story, and a commitment to research and teaching. Hospice becomes a place where clinical precision and human presence are not opposites but partners.

Today's hospice and palliative care: Saunders' words still cut through noise and burnout. Her vision challenges us to treat pain, fear, and isolation as urgent equity issues, not optional extras. For teams and leaders, the question is simple and searching: what would it look like here—for this patient to "live until they die"?

Source: Cicely Saunders International; Cicely Saunders Quotes

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3. 1969, Elisabeth Kübler-Ross authors *On Death and Dying*

> *"People are like stained-glass windows. They sparkle and shine when the sun is out, but when the darkness sets in, their true beauty is revealed only if there is a light from within." ~ Elizabeth Kübler-Ross*

Historical context: While a generation watches death on their screens and protest in their streets, Dr. Elizabeth Kübler-Ross sits at the bedside, listens, and lets patients speak for themselves. Her work makes public what many already know: that people facing death want honesty, conversation, and connection, not secrecy and sedation. Her book *On Death and Dying* introduces the famous "five stages" language into public conversation.

Today's hospice and palliative care: Grief clinicians no longer treat grief as “stages.” Still, she opened the door to talking about the silenced thoughts “death and dying.” She affirmed that emotions near the end of life are real, varied, and worth hearing. Her legacy invites clinicians to move beyond delivering “bad news” toward ongoing, two-way conversations.

Source: Biography – Dr. Elizabeth Kübler-Ross; Elisabeth Kübler-Ross: “People are like stained-glass windows …”

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4. Florence Wald, founder of the first U.S. hospice, 1974

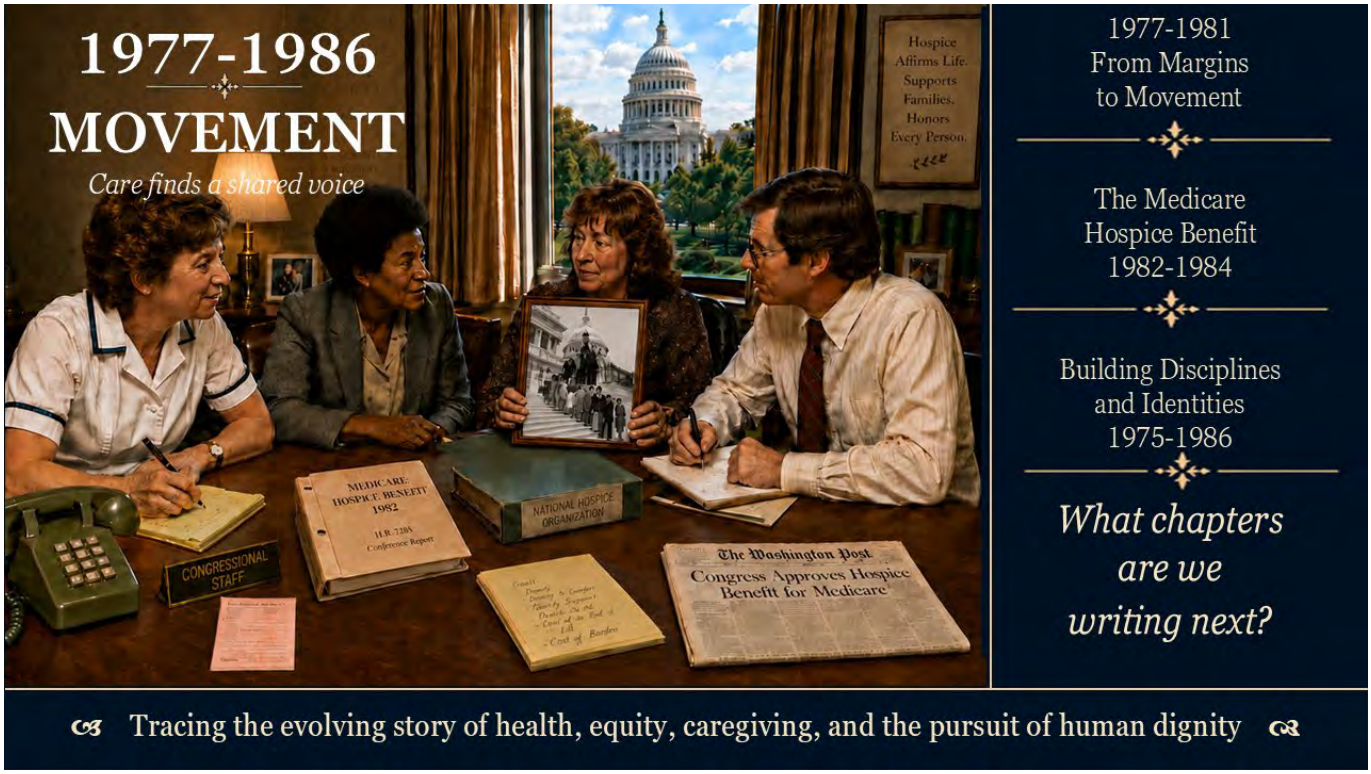
"We need to cure sometimes, but care always." ~ Florence Wald

Historical context: In 1963 Florence Wald—then dean at Yale School of Nursing—attended a lecture by Cicely Saunders and later studied with her in England. She eventually left academic leadership to build a model that combines home care, a free-standing hospice, family involvement, and team-based support for people who are dying. Hospice becomes, in her words, the “end piece” of a continuum of care, not a sign of medical failure. This first hospice in America opened in 1974, Connecticut Hospice in Branford.

Today’s hospice and palliative: Wald’s *“care always”* lives on through the remembered dying and grief experiences for the millions of hospice patients and families served across the United States since1974. Her *“care always”* sharply confronts today’s systems ruined by fraud. Her legacy pushes us to start palliative conversations earlier, center home and community-based care, and bring hospice principles into places where people still die with little support. The question for leaders today is not whether hospice belongs in the U.S. system, but whether it will remain a peripheral service or become a standard of care wherever serious illness and dying unfold.

Sources: Connecticut Women’s Hall of Fame; Connecticut Hospice - History; Death with Dignity: 50th Anniversary of America’s First Hospice

What chapters are we writing next?



1977-1986

posted in *Hospice & Palliative Care Today*, June 30, 2026

1. From Margins to Movement (1977–1981)

> *"Approaches to death and dying reveal much of the attitude of society as a whole to the individuals who compose it." ~ Cicely Saunders*

Historical context: By the late 1970s, "hospice" in the United States was taking root with compelling local programs, but with no solid policy or payment base. Federal interest grew through task forces and demonstration projects that tested hospice's impact on costs, quality, and family experience. In 1978 the National Hospice Organization (NHO) formed, giving these visionary programs a shared voice, emerging standards, and a sense of being a collective movement rather than isolated pockets of care.

Today's hospice and palliative care: This moment of care at the hospice bedside transforming into a national organization reminds us that growthful, sustainable innovation needs infrastructure, creativity, problem-solving, metrics, coalitions, and policy asks. Because of actions then and through the following decades, we are better *together*.

Sources: Cicely Saunders Quotes; Library of Congress National Hospice and Palliative Care

2. The Medicare Hospice Benefit (1982–1984)

Policy is biography written in law.

Historical context: In 1982, Congress created the Medicare Hospice Benefit, initially as a temporary test within Medicare. It authorized payment for an interdisciplinary hospice team, largely home-based, with a focus on symptom control, family support, and defined benefit periods tied to a terminal prognosis. By 1984, the benefit was effectively established as a stable feature of Medicare, shifting hospice from philanthropy's margins into the center of U.S. health care financing.

Today's hospice and palliative care: The pendulum has swung from the Medicare Hospice Benefits—"what is hospice?"—to today's horrendous abuses and fraud. Challenges are rampant: from the Medicare Hospice Moratorium of May 2026 to new payment systems and more, are we fragmenting or moving forward collectively? Our task now is to "write the next chapter," advocating for systems that preserve hospice's interdisciplinary, relationship-rich ethos while removing barriers that delay access and deepen inequities.

Sources: Medicare hospice benefit: Early program experiences; CMS.gov Hospice

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3. Building Disciplines and Identities (1976–1986)

Movements endure when they grow professions, not just programs.

Historical context: During these years, end-of-life care professionals were building a professional backbone, . Leading the way for end-of-life care in 1976, the Forum for Death Education and Counseling (now the international Association for Death Education and Counseling - ADEC) created one of the first interdisciplinary collaborations for dying, death, and bereavement. Specific to hospice, the National Hospice Organization (later the National Hospice & Palliative Care Organization and now the National Alliance for Care at Home) was founded in 1978 as the national voice for standards, data, and advocacy. Regional and discipline-specific groups followed: the Pennsylvania Hospice and Palliative Care Network (PHPCN) launched in 1980 as a statewide leader in hospice and palliative care education and advocacy, and by 1986 nurses formed the Hospice Nurses Association —later the Hospice and Palliative Nurses Association (HPNA)—to support hospice nursing as a specialty. Soon after in 1988, physicians established the Academy of Hospice Physicians (now AAHPM), confirming hospice and palliative medicine as a distinct medical community.

Today's hospice and palliative care: Today's hospice and palliative care still rest on the scaffolding these organizations built. NHO's legacy and its successors remind us that serious-illness care needs a coherent national voice, especially as policy and payment models shift. ADEC and PHPCN point to the importance of international and regional and interdisciplinary forums where death, grief, and serious illness are treated as shared human concerns, not just technical problems. The emergence of HPNA and, soon after, AAHPM shows how vital strong professional homes are for sustaining expertise, ethics, and advocacy in end-of-life care. For leaders today, their example nudges us to keep investing in professional communities—local, national, and discipline-specific—that can carry hospice and palliative values into whatever new structures health care invents next.

Source: History of the National Hospice Organization; Association for Death Education and Counseling

Celebrates 50 Years of Advancing Grief Education and End-of-Life Understanding; Pennsylvania Hospice and Palliative Care Network; Celebrating HPNA's 40th Anniversary; AAHPM History

What chapters are we writing next?

1987-1996

posted in *Hospice & Palliative Care Today*, July 1, 2026

1. AIDS, Activism, and the Edges of Care

> *"It takes no compromising to give people their rights. It takes no money to respect the individual. It takes no survey to remove repressions." ~ Harvey Milk, killed 1978*
>
> *"Because of the lack of education on AIDS, discrimination, fear, panic, and lies surrounded me." ~ Ryan White, died of AIDS 1990*

Historical context: By the late 1980s and early 1990s, AIDS had become a defining crucible for end-of-life care. In cities like San Francisco and New York, community-based hospices, AIDS residences, and hospital AIDS units emerged to care for mostly young adults facing rapid decline, stigma, and abandonment. Activist groups, faith communities, and grassroots caregivers built networks of practical help and political pressure, insisting on pain control, honest communication, and partner inclusion when formal systems failed. These efforts forced hard questions about who "deserved" care, what dignity meant in the midst of discrimination, and how to honor both fierce fighting for life and the need for a peaceful death.

Today's hospice and palliative care: AIDS-era caregiving still challenges us. It reminds us that good end-of-life care is inseparable from justice work: confronting stigma, racism, homophobia, and poverty that shape how people live and die. It pushes today's hospice and palliative teams to meet serious illness at the margins—homelessness, incarceration, substance use, immigration status—not just in well-resourced homes. And it invites us to hold together two truths: people have a right both to aggressive treatment when wanted and to a supported, relational death when cure is no longer possible.

Sources: New York City AIDS Memorial – HIV/AIDS Timeline of Crisis, Response, and Resilience; Pastoral Care and Public Memory: The AIDS Crisis

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2. High-Tech Medicine and the Meaning of "Not Yet" (Late 1980s–1990s)

> *"I'm one of those people that think Thomas Edison and the light bulb changed the world more than Karl Marx ever did." ~ Steve Jobs*

Historical context: Desktop computers, word processors, and cheap printers replaced typewriters, speeding hospice and hospital documentation, care plans, and teaching materials. Early electronic records and billing systems began linking basic clinical data. Fax machines became the workhorse for referrals, DNR orders, and discharge summaries across hospitals, nursing homes, and hospices. At the same time, email, the early internet, and first telemedicine pilots showed that lab results, images, and consults could move quickly across distance, foreshadowing today's connected infrastructure.

Today's hospice and palliative care: Those tools evolved into EHRs that let teams respond quickly—sharing notes, meds, and goals-of-care plans across hospitals, hospices, and nursing facilities. Used well, they support rapid symptom response and safer handoffs; used poorly, they turn clinicians into data clerks and pull attention from the bedside. Social media now amplifies education and advocacy but also spreads misinformation and risks privacy, demanding firm ethical boundaries. Artificial intelligence is the newest force: promising early-warning flags, chart summaries, and language support, yet also carrying bias and transparency risks. The future task for hospice and palliative care is to harness these technologies to deepen presence, coordination, and equity—never to replace judgment, relationship, or the courage to sit in silence at the end of life.

Sources: Technologies to Support End of Life Care; The History of the Fax Machine; History of EHRs in healthcare technology; The ethical dimensions of utilizing Artificial Intelligence in palliative care

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3. Pushing Life, Reframing Dying

> *Modern medicine can often add time to a life; the harder question is whether we are adding to its meaning or only to its suffering.*

Historical context: By the late 1980s and early 1990s, medicine was saving and extending more lives through organ transplantation, cancer therapies, and increasingly sophisticated heart surgery and devices. At the same time, high-profile cases and experiences—patients living months on artificial hearts or in ICUs with little chance of recovery—exposed how "rescue" could also prolong dying, disability, and family anguish. Earlier cases like Karen Ann Quinlan (mid-1970s) and later ones like Nancy Cruzan and others kept reverberating in this era, sharpening debates about feeding tubes, ventilators, and who decides when "enough" has been reached. The 1990 Patient Self-Determination Act emerged in that context, legally affirming the right to accept or refuse treatment and to use advance directives—not as an attack on progress, but as a safeguard against unwanted prolongation of suffering.

Today's hospice and palliative care: This history warns us away from simple stories—neither "technology is bad" nor "more is always better." Our daily work lives in the tension: celebrating transplants, targeted therapies, and ICU rescues that return people to living, while also naming when interventions are now only extending burden. Palliative care and hospice become the place where this dialectic is spoken out loud: helping people use advance directives and shared decision-making to say both "yes" and "no" to treatment, grounded in their values, culture, and relationships. For the future, the ethical task is to keep pairing innovation with honest prognostic conversations and person-centered care, so that the power to push life longer never outruns our courage to reframe dying well.

Sources: The history of organ transplantation; Patient Self-Determination Act Technology and Death; The Evolution of Health Care Advance Planning Law and Policy

What chapters are we writing next?

1997-2006

posted in *Hospice & Palliative Care Today*, July 2, 2026

1. Trauma, Responsibility, and the Pursuit of Human Dignity

> *"We have seen the decency of a loving and giving people who have made the grief of strangers their own." ~ President George W. Bush, Address to a Joint Session of Congress and the American People, September 20, 2001*

> *"We just need some help out here. It is just so pitiful. Pitiful!" ~ Charles Evans, child survivor of Hurricane Katrina, NBC News, September 2, 2005*

Historical context: The Columbine High School shootings on April 20, 1999, in Littleton, Colorado, marked the beginning of a new and deeply unsettling era of mass shootings and community trauma in the United States. The attacks of September 11, 2001 brought sudden, massive loss of life and demanded extraordinary courage from firefighters, police officers, emergency responders, and civilians who ran toward danger, many dying to save others. Four years later, Hurricane Katrina exposed how unevenly protection and rescue were distributed, as Black communities in New Orleans endured delayed evacuations, collapsed infrastructure, and days-long waits for food, water, and medical care. For many, Katrina confirmed that failures to respond to Black Americans' suffering were part of a long history in which some neighborhoods and lives were treated as less urgent to save.

Today's hospice and palliative care: Hospice and palliative care operate within larger systems of emergency preparedness, response, recovery, and mitigation. Local programs must plan for disrupted communications, unsafe roads, damaged homes and facilities, evacuation of medically fragile patients,

interrupted access to oxygen, medications, and equipment, and the safety of staff whose own families and communities may also be in crisis.

Sources: Columbine High School massacre; The White House - President George W. Bush - Address to a Joint Session of Congress and the American People; Toxins and Health Impacts: Health Effects of 9/11; NBC News: Little Charles Evans Pleads for Help After Katrina; Hurricane Katrina 19 Years Later: What Policies Have Changed

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2. Hospice Grows Up

> *"There are stories that tell about holding people while they cry with the pains of this world, and then there are other stories that show the possibility of really coming full circle, of being transformed. "*
>
> *Rabbi Tsvi Blanchard, opening quote in The National Hospice Organization's "Guide to Hospice Care" - The Hospice Choice – In Pursuit of a Peaceful Death, 1998*

Historical context: In the late 1990s and early 2000s, hospice moved from experiment to expected option. Admissions rose into the hundreds of thousands annually, and the share of Medicare decedents using hospice climbed into the 20–25% range. Hospice in nursing homes and for non-cancer diagnoses increased, and national/state conferences and public-facing materials (like NHO's *Hospice Choice* guide) helped families recognize hospice as a pathway toward "coming full circle," not just a last resort. In 2000 NHO integrated "& Palliative Care" into its name, thus NHPCO.

Today's hospice and palliative care: We inherit both this growth and its unfinished business. The stories that built hospice—as Rabbi Blanchard suggests—are about transformation as much as tears. That means ensuring excellence throughout our systems, teams, and payment models so that patients and families have the time together, support, and trust they need—for their grief, and for whatever transformations are possible at the end of a life.

Sources: The Hospice Choice – In Pursuit of a Peaceful Death; Important Questions for Hospice in the Next Century - 2000; National Hospice and Palliative Care Organization company history timeline

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3. From Hospice to Hospital Halls: Palliative Care Finds Its Name

> *"Death is unpredictable; this is why palliative care must be available to people at any stage of a serious illness – with or without curative treatment."~ Dr. Diane Meier, founder of the Center to Advance Palliative Care*

Historical context: In 1999, the Center to Advance Palliative Care (CAPC) was founded at Mount Sinai with Robert Wood Johnson Foundation support to move palliative care from rare pilot programs to a mainstream hospital service. Around 2000, fewer than a quarter of U.S. hospitals with 50+ beds had a palliative-care team; by 2003 that number had already risen to about 25%, with programs growing fastest in larger, nonprofit, academic, and VA hospitals. CAPC's early seminars, toolkits, and case studies helped hospitals build consult teams that brought symptom relief and goals-of-care conversations into ICUs, oncology wards,

and emergency departments—not just hospice units.

Today's hospice and palliative care: This hospital-based turn reshaped the landscape. Today, most larger hospitals have palliative-care teams, yet access still varies by region, hospital size, and ownership. For hospice, the rise of inpatient palliative care is both partner and challenge: it can foster earlier consults and smoother transitions, or keep patients in acute care too long. The future work is to knit these services together—hospital, home, nursing facility, clinic—so that "palliative care" describes a continuous thread of person-centered support, not a fragmented set of programs competing for patients and dollars.

Sources: Palliative care in hospitals; The Exponential Progress of Palliative Care Is a Tribute to CAPC on Its 25th Anniversary**;** The Case for Hospital Palliative Care; National Trends in Adult Hospice Use: 1991–1992 to 1999–2000

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4. From Experience to Evidence and Education

> *"Research and scholarship are essential to advance the science of hospice and palliative care and must inform clinical practice." ~ HPNA Value Statement: Role of Hospice and Palliative Nurses in Advancing Research and Scholarship, 2022*

Historical context: By the early 2000s, hospice and palliative care had generated enough data—and enough hard-won wisdom—that rigorous scientific research and compassionate clinical education became essential, not optional. Journals and curricula began to codify what bedside caregivers had long practiced: how to relieve suffering, support families, and honor dignity at the end of life.

- 1970 – OMEGA: Journal of Death and Dying
- 1984 – American Journal of Hospice & Palliative Medicine
- 1999 – Journal of Hospice & Palliative Nursing (JHPN)
- 1999 – Education for Physicians on End-of-Life Care (EPEC) Project
- 2000 – End-of-Life Nursing Education Consortium (ELNEC)
- 2005 – Journal of Social Work in End-of-Life & Palliative Care

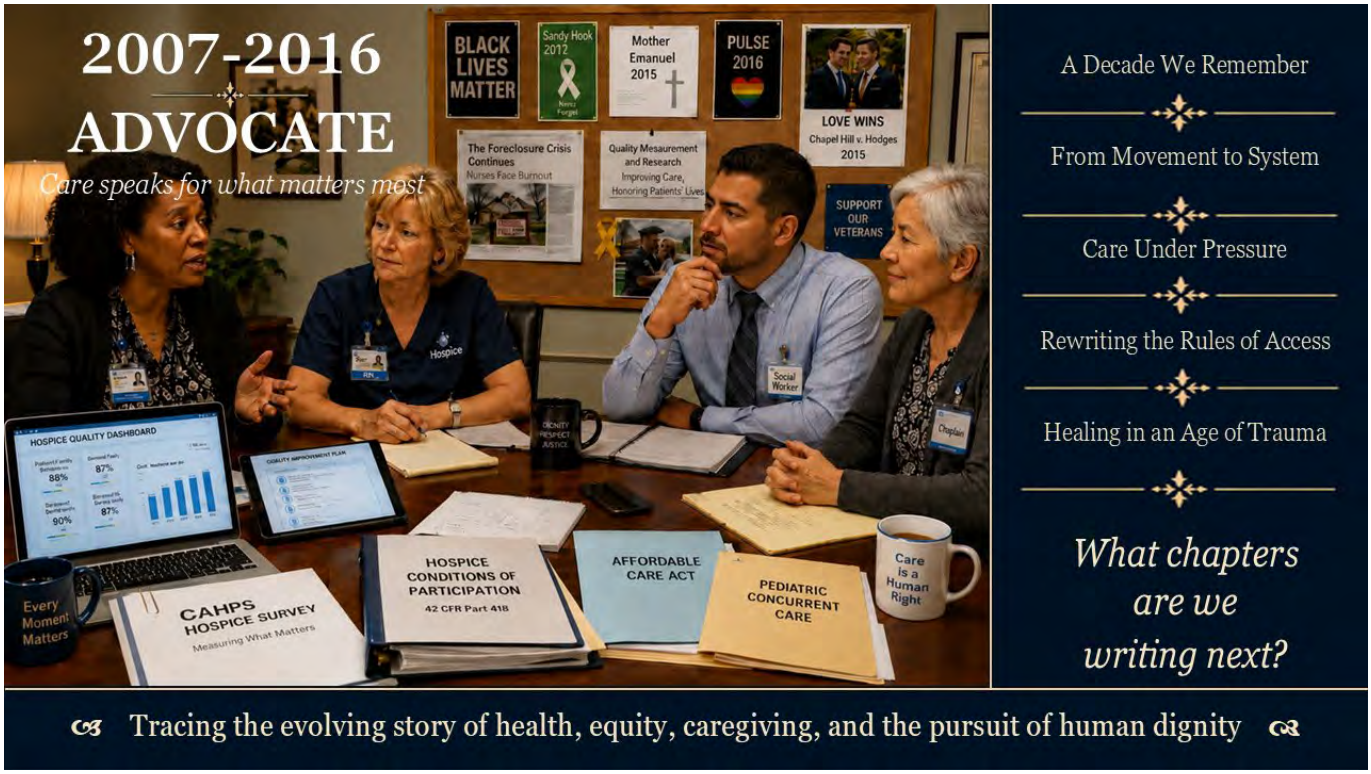
Together, these journals and curricula carried hospice's insights into broader palliative practice, turning bedside stories into research, syllabi, and a shared language.

Today's hospice and palliative care: Today, these resources live mostly online: journals searchable in seconds, national policies and guidelines updated rapidly, with webinars, on-demand courses, and podcasts offered by nearly every major hospice and palliative care organization. Clinicians can find decades of rigorous scientific research and compassionate clinical education—24/7—from almost anywhere via mobile devices. We must use these tools to lift quality and equity, while ensuring that instant access and AI-driven systems strengthen—rather than weaken—our commitment to relieve suffering and improve person-centered quality of life.

Sources: HPNA Value Statement Role of Hospice and Palliative Nurses in Advancing Research and Scholarship Dr. Betty Ferrell and the Extraordinary Pursuit of Worldwide Palliative Nursing Education; HPCC History; OMEGA – Journal of Death and Dying; American Journal of Hospice & Palliative Medicine; Journal of Hospice & Palliative Nursing (JHPN); Education for Physicians on End-of-Life Care (EPEC) Project; **E**nd-of-Life

Nursing Education Consortium (ELNEC); Journal of Social Work in End-of-Life & Palliative Care

What chapters are we writing next?



2007-2016

posted in *Hospice & Palliative Care Today*, July 3, 2026

1. A Decade We Remember: 2007-2016 in American Life

> *Between 2007 and 2016, Americans lived through crises, movements, and milestones that reshaped how we understand safety, justice, health, and the work of care.*

Historical context: For today's readers, these events are not abstract history; they are lived memory. Economic insecurity, smartphones and social media, wars and homecomings, health reform, repeated mass violence, racial justice movements, and changing family laws all shape how people suffer, hope, and seek help.

- Financial crisis and Great Recession (2007–2009)
- Introduction of the iPhone (2007)
- Election of Barack Obama, first Black president (2008)
- Launch of the iPad and rise of tablets (2010)
- Wars in Afghanistan and Iraq, with a major Afghanistan surge (2009–2014)
- Affordable Care Act (2010)
- Growth of mass shootings in everyday spaces (Virginia Tech 2007, Aurora 2012, Sandy Hook 2012, Mother Emanuel 2015, Pulse 2016)
- Emergence and growth of Black Lives Matter (from 2013)
- Obergefell v. Hodges: national recognition of same-sex marriage (2015)

- Intensifying political tensions and divisions (2007-2016)

And hospice and palliative care grew within this landscape—asked to respond not only to illness, but also to what it means to offer presence, fairness, and dignity in a country marked by both deep wounds and real efforts to heal.

Today's hospice and palliative care: Today's hospice and palliative care teams now serve people whose stories carry the weight of this decade—job loss and recovery, deployments and homecomings, smartphones and social media, health reform, public violence, and changing family and racial realities. Our work is to offer clear communication, steady presence, and fair access to comfort and support, so that families experience reliable care even when the world around us all feels uncertain.

Source: Financial crisis of 2007–08; Apple reinvents the phone with iPhone (2007); Barack Obama inauguration; Apple launches iPad (2010); Great Recession and its aftermath; Obergefell v. Hodges (2015); Black Lives Matter origins; A List of The Deadliest Mass Shootings in Modern U.S. History

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2. From Movement to System: Hospice and Palliative Care Become a Measured Presence in American Health Care

> *What began as a small movement for dignity and the promise that "you matter because you are you" has evolved into a nationwide system of care, committed to accompanying people and families through the challenges of dying—helping them live in ways that matter to them, and die as peacefully and comfortably as possible.*

Historical context: By 2008, hospice and palliative care had shifted from a small, values-driven movement to a recognized part of the U.S. health care system. That year's updated Hospice Conditions of Participation formally defined the health and safety requirements every hospice must meet, emphasizing interdisciplinary teams, quality oversight, and core services for the dying. In 2015, the CAHPS Hospice Survey began systematically capturing the experiences of bereaved family caregivers, transforming their narratives of communication, symptom relief, and respect into publicly available quality scores.

Today's hospice and palliative care: Hospice and palliative care now inhabit a measured, regulated landscape: organizations must comply with federal standards, report experience and quality data, and document care in real time, even as they continue the core work of walking with people and families through the challenges of end-of-life illness. The ongoing task is to ensure that metrics, surveys, and electronic records serve this companionship—supporting relief of total pain and peaceful dying. They must not overshadow the relational, spiritual, and moral heart of the work.

Sources: CMS Hospice Conditions of Participation Overview; CMS CAHPS Hospice Survey;

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3. Care Under Pressure: Different Hospice Models, Different Patterns of Care

> *As hospice care in the United States came to include both community-based nonprofits and rapidly growing for-profit and investor-owned organizations, different ownership models began to show different patterns—who is enrolled, how often teams visit, how long people stay, and how families describe their experience.*

Historical context: From the 2000s into the 2010s, hospice expanded and diversified. Long-standing nonprofit programs were joined by a rising number of for-profit and chain hospices, changing the structure of the field. Research found that, on average, nonprofits tended to provide more nursing and social work visits per patient day and had lower rates of live discharge, while for-profit hospices more often served longer-stay, lower-acuity patients and reported higher margins with fewer visits. Caregiver experience scores and recommendation rates also varied, suggesting that ownership models were linked to recognizable differences in how the benefit was used and felt.

Today's hospice and palliative care: Today, most families do not focus on whether a hospice is nonprofit or for-profit; they notice how present the team is, how well symptoms are controlled, and whether they feel supported and heard. For leaders and staff, the challenge is to face the data honestly—visits, live discharges, margins, caregiver experience—and use it to align business realities with hospice's core promise of reliable, whole-person care. The invitation is not to defend one model over another, but to ask, in every boardroom and team meeting: Are our patterns of care worthy of the trust people place in us at the end of life?

Sources: Nearly Half Of All Medicare Hospice Enrollees Received Care From Agencies Owned By Regional Or National Chains (2016); Differences Between For-profit and Non-profit Hospice Agencies in the US Medicare Population (2021); Private Equity-Owned Hospices; Hospice Medicare Margins: Analysis of Patient and Hospice Characteristics, Utilization, and Cost (2019 analysis using data from this 2007-2016 timeframe)

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4. Rewriting the Rules of Access: The Affordable Care Act, Aging, and Serious Illness

> *The Affordable Care Act changed more than coverage. It changed when and how some families could receive serious-illness care.*

Historical context: The ACA affected end-of-life care in specific ways. It created pediatric concurrent care, allowing children under 21 in Medicaid and CHIP to receive hospice while continuing disease-directed treatment, and it authorized hospice payment reform and demonstration projects tied to quality and accountability. Just as important, the ACA era helped shift palliative care from late rescue to earlier support in serious illness, by widening coverage, encouraging quality reform, and aligning care more closely with what patients and families needed over time.

Today's hospice and palliative care: The ACA era shifted the central question from whether hospice and palliative care exist to whether people can reach them early enough to matter. Coverage expansion, concurrent care, and broader reform helped open the door to palliative care alongside treatment, earlier in

the disease trajectory and closer to the realities patients and families were living. The enduring challenge is to make that earlier, fairer, better-informed access a lived reality across diagnoses, ages, and communities—not just a policy promise.

Sources: The Patient Protection and Affordable Care Act and Its Impact on Hospice (2010); 10 FAQs: Medicare's Role in End-of-Life Care (2016); Variation in state Medicaid implementation of ACA: The case of Concurrent Care for Children; The Affordable Care Act and End-of-Life Care for Patients with Cancer; Medicare's Hospice Benefit: Revising the Payment System to Better Reflect Visit Intensity

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5. Healing in an Age of Trauma: Repeated Violence, Black Lives, and the Work of Care

> *In a new era marked by mass shootings in the everyday spaces of schools, places of worship, grocery stores, movie theaters, music concerts, and LGBTQ+ and racial communities, and by the cry that Black lives matter, Americans were forced to ask what care looks like when safety itself is shattered.*

Historical context: From 2007 to 2016, mass violence became a recurring feature of American life. Key tragedies included Virginia Tech (2007), Aurora (2012), Sandy Hook (2012), Mother Emanuel AME Church (2015), and Pulse nightclub (2016); soon after came Las Vegas (2017) and Parkland (2018), showing the pattern continuing beyond the decade. In this same arc, Black Lives Matter arose after Trayvon Martin (2012) and grew through names like Michael Brown (2014) and Eric Garner (2014), highlighting how Black communities had long carried disproportionate risks and grief. These events widened awareness of racial injustice and, at times, widened visible gaps between communities, even as many people and institutions began working to bridge those divides in workplaces, health care, education, and culture.

Today's hospice and palliative care: For hospice and palliative care, this period clarifies that serious-illness and end-of-life care unfold within a nation still wrestling with racial wounds and unequal safety. Many patients and families—especially Black families and other marginalized groups—bring histories of harm and mistrust into their encounters with care. Trauma-informed and equity-focused practice seek not only to avoid re-traumatization, but to help bridge long-standing divides by treating trust, fairness, and dignity as essential parts of the clinical work. The hope is that, at the end of life, care can become one place where the gaps between races are narrowed rather than deepened—where those who have been least protected in public life experience unmistakable respect and belonging as they die.

Sources: A List Of The Deadliest Mass Shootings In Modern U.S. History (2016); Sandy Hook Elementary School Shooting (2012); Black Lives Matter: Our History; 10 years after the deadly church shooting, a new history of 'Mother Emanuel'; NAACP: Racial Disparities in Hospice Care (2025)

What chapters are we writing next?

2017-2026

posted in *Hospice & Palliative Care Today*, July 4, 2026

1. COVID-19: Distance, Disparity, and the Demand for Presence

> *We are not all in the same boat.*
> *We are all in the same storm.*
> *Some are super-yachts.*
> *Some have just one oar.*
> *~ Damian Barr*

Historical context: In 2020, COVID-19 drove the largest spike in U.S. deaths in modern memory. Every person in the country lived through its disruptions: fear of contagion, lockdowns, visitor bans, masks, and daily counts of deaths. Visitor bans and infection-control rules meant many patients died without the people who mattered most at the bedside; families and friends kept vigil through phones and video screens as entire networks absorbed multiple losses and generations were cut off from one another. Workplaces and livelihoods were shaken, children and schools pivoted to remote learning, and conflicts over masks and vaccination widened already sharp political divides. The virus struck hardest in nursing homes, communities of color, low-wage essential workers, and people with serious illness, revealing long-standing inequities in exposure, employment, housing, and access to care.

Vaccines, developed with historically rapid science, brought real hope and protection, yet not evenly shared. Earlier epidemics in this series—the 1793 yellow fever, 1800s puerperal fever, and the 1918 influenza pandemic—likewise showed that place and injustice shape who suffers most and whose vigils and mourning are protected or cut off.

Today's hospice and palliative care: COVID-19 forced hospice and palliative teams to rethink what it means to "be there" when people are dying. Previously feared technologies brought new ways to connect and accompany. The intersections of science, need, service, ethics, and core humanity continue on. Our call to action is that pandemic readiness and these lessons about isolation, fear, and disruption must become shared hospice work—so that in the next crisis, all of us, especially those at highest risk, can count on connection, relief, and unmistakable dignity.

Sources: "We are not all in the same boat."; Pandemic Disrupted Historical Mortality Patterns, Caused Largest Jump in Deaths in 100 Years; Racial and ethnic inequities in occupational exposure across and between US cities; How COVID-19 is straining hospice care; Hospice, Hospice Partners, and Telehealth in the Time of COVID-19; COVID-19 Vaccine Equity for Racial and Ethnic Minority Groups

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2. "I Can't Breathe": Racism, Suffering, and the Work of Care

> *"George Floyd's pleas awakened this world that has been rendered comatose by fear of contagion and all of a sudden nothing mattered but justice." ~ Aysha Taryam*

Historical context: On May 25, 2020, the murder of George Floyd, recorded on a phone by a teenage bystander, ignited global protests against police violence and systemic racism. In the months that followed, leaders across public health and healthcare named racism as a public-health crisis, tying it to disparities in chronic disease, mental health, maternal mortality, and premature death. In this series' long timeline, his cry "I can't breathe" stands alongside the voices of Absalom Jones, Frederick Douglass, and the Cherokee Memorial—an unbroken line of testimony that bodies, communities, and grief have long been shaped by racialized injustice.

Today's hospice and palliative care: This moment widened "suffering" from private pain to harm created by unjust systems, including health settings where Black patients and other marginalized groups can face barriers to hospice use, undertreated pain, and fewer chances to die at home on their own terms. A decade of research using the NIMHD health-disparities framework has traced how structural racism, neighborhood risk, financial strain, communication gaps, and mistrust drive inequities in serious-illness and end-of-life care for Black Americans. Continuing this series' themes of Dignity, Recognition, and "Equity as Outcome," hospice and palliative care must treat anti-racism as clinical work: tracking disparities, earning trust, embedding cultural humility, and partnering with communities. Our call to action is that, at life's end, people least protected in public life will encounter unmistakable dignity and presence, not one more chapter of neglect. The graphic created for this 2017-2026 does not indicate "arrival" from past errors, but rather progress on our ongoing journeys: for systems, communities of care, families, and individuals.

Sources: Aysha Taryam's quote; George Floyd: 'Pandemic of racism' led to his death, memorial told; Understanding African Americans' experience with palliative and hospice care; A Decade of Studying Drivers of Disparities in End-of-Life Care for Black Americans: Using the NIMHD Framework for Health Disparities Research to Map the Path Ahead

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3. Workforce, Moral Distress, and Business Models: Who Stays, Who Leaves, and Who Decides?

The injury isn't just workload—it's values under pressure.

Historical context: In the 2020s, COVID-19 exposed how exhausted and morally distressed many health workers, even as Baby Boomers aged into higher need. Clinicians described the strain of caring with too few staff, scarce PPE, inequitable access, and rules that kept families away, echoing earlier chapters on Rights & Responsibility and "Business Models Shaping Moral Experience." At the same time, hospice consolidation, private-equity investment, fraud crackdowns, program closures, and expanding debates over Medical Aid in Dying reshaped who controlled resources and rules—and what counted as relief.

Today's hospice and palliative care: For hospice and palliative teams, capacity now clearly means supported people, not just licensed beds. Moral distress often arises when pressures to meet metrics conflict with what staff believe patients and families deserve, and when inequities, work–life imbalance, or MAiD requests collide with conscience. Younger workforce members name flexibility, psychological safety, and meaningful support as non-negotiable. Our call to action is to build real career ladders, mentoring, ethics consultation, and trauma-aware teams, while cultivating leaders whose business acumen protects the field's ethical center—even when mergers, acquisitions, or fraud pressures push the other way. When boards and executives design models that prioritize presence and integrity over volume alone, we help ensure that "all are created equal" is felt by patients and by the people who care for them, together.

Sources: Moral Distress Experienced by US Nurses on the Frontlines During the COVID-19 Pandemic: Implications for Nursing Policy and Practice; Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce; Compassion fatigue, watching patients suffering and emotional display rules among hospice professionals: a daily diary study; Hospice and Medical Aid-in-Dying: Addressing an Unethical Disconnect; The Seismic Shift in End-of-Life Care: Palliative Care Challenges in the Era of Medical Assistance in Dying; Does private equity acquisition impact the quality of care provided in US hospices?; California's hospice fraud crisis is flourishing in plain sight. Regulation needs to catch up

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4. #MeToo and Hidden Caregivers

"We hold these truths to be self-evident; that all men and women are created equal." ~ Elizabeth Cady Stanton and delegates of the Seneca Falls Convention, "Declaration of Sentiments" in July 1848

Historical context: Across this timeline, women's caregiving—watchers at the deathbed, enslaved midwives, settlement-house nurses—has been essential and often unpaid, performed without status or protection. Beginning in 2017, #MeToo and movements like Time's Up Healthcare exposed pervasive sexual harassment and abuse throughout workplaces and revealed the vulnerability of home-care workers, many women of color and immigrants, laboring alone in private homes.

Today's hospice and palliative care: In modern hospice, as in the wider direct-care workforce where nearly nine in ten workers are women, most frontline roles are held by women; their safety, pay, and voice directly shape the quality of care patients receive. We carry forward the catalysts for change ignited by Elizabeth Cady Stanton, Clara Barton, Lillian Wald, Cicely Saunders, Elisabeth Kübler-Ross, and Florence Wald, even as unequal and unfair treatment of women can persist. Our call to action is to make trauma-informed,

dignity-centered practice cover staff as well as patients: robust policies against harassment, real reporting protections, schedules and wages that honor caregiving at home, and leadership that reflects the workforce's diversity—because the promise that every life possesses worth must include the lives of those who show up, day after day, at the bedside.

Sources: A Declaration for the Rights of Women; Time's Up For Inequality And Harassment In Healthcare; Workplace Violence Prevalence and Reporting in Home Health Care; Verbal Abuse Against Home Care Aides: Another Shot Across the Bow in Violence Against Health Care and Other Workers; PHI Launches Institute to Address Inequities in the Direct Care Workforce; Lillian Wald; Study: Over 50% Of Home Health Workers Surveyed Experienced Workplace Violence

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5. Emergency Disasters: Climate Change and Community Violence

"Please take care of yourself and each other." ~ Lester Holt, anchor NBC Nightly News sign-off

Historical context: In the late 2010s and 2020s, emergency disasters—climate-driven and human-made—upended communities, families, and people already dependent on others for help. Hurricane Helene's winds and flooding devastated vast regions and cut power to millions, leaving medically fragile people at acute risk. In California, wildfires destroyed homes and businesses and displaced entire neighborhoods, including families with loved ones in hospice or reliant on fragile support systems. In Texas, children were killed in the Uvalde school shooting, and other children and counselors later died in flash flooding at Camp Mystic—layers of communal trauma and grief that show how "place" now includes storms, fires, and violence. These unretrievable losses change lives forever.

Today's hospice and palliative care: Serious-illness and end-of-life care can no longer assume stability; continuity must be planned across outages, evacuations, and sudden loss of safety. Hospice and palliative teams identify highest-risk patients, arrange backup power and oxygen, rehearse communication plans, and work with emergency management, schools, congregations, and local leaders so patients and caregivers are not forgotten when crises hit. Social media can fuel panic, yet it can also carry rapid check-ins, mutual aid, and virtual grief circles. Our call to action is to treat emergency readiness, trauma-aware support, and careful public communication as acts of dignity—so that even when disasters and violence shatter what felt secure, we still do all we can to keep people safe, comforted, and not alone.

Sources: Media Mondays / The Great Good-Byes; One Year After Hurricane Helene: Lessons in Resilience, Recovery, and Renewal; Seeking A Peaceful Death Amid The Flames; Uvalde school shooting; Texas floods: Camp Mystic says 27 children and staff dead; The impact of climate change on hospice and palliative medicine: A scoping and narrative review; Beyond place-based: the role of virtual communities via social media in young adult recovery

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6. Technology, Data, and the Meaning of Presence: Moving Faster Than Meaning

"I'm in favor of progress; it's change I don't like." ~ Mark Twain

Historical context: Across this series, technology and data have repeatedly reshaped presence. Mortality tables and public health records made hidden suffering visible, yet could also reduce lives to categories. Electric light, telephones, cars, computers, and later telehealth changed how care reached the bedside, extending vigilance, speeding response, and connecting people across distance and time. From 2017–2026, COVID-era payment changes pushed telehealth, remote monitoring, and AI toward the center of serious-illness care, while cybersecurity, privacy, and algorithmic bias exposed new fault lines of trust. Across that long arc, the question remains the same: whether technology and data deepen human presence or distract from it.

Today's hospice and palliative care: For hospice and palliative teams, technology and data now shape presence itself. Telehealth, electronic records, and real-time monitoring can widen the room—bringing care to rural patients and far-away family—yet they can also flatten nuance, widen digital inequities, and tempt clinicians to mistake dashboards for reality. Data can reveal inequity, symptoms, and unmet need, or turn people into scores if clinical judgment and listening fall away. The task is not to resist innovation, but to guide it with ethics and compassion, so that every new tool helps clinicians notice sooner, respond more wisely, and remain more faithfully present to the whole person.

Sources: Mark Twain, "I'm in favor of progress ..."; Payment and Coverage Parity for Virtual Care and In-Person Care: How Do We Get There?; Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings; National Death Index; Exploring Artificial Intelligence in Hospice and Palliative Care: An Integrative Review of Technological and Clinical Approaches; The HIPAA risks of remote work in hospice administration; Telehealth Group Interactions in the Hospice Setting: Assessing Technical Quality Across Platforms

What chapters are we writing next?

Epilogue

This book stands as one chapter in a larger declaration—a collective statement, written over centuries, about how seriously we take the suffering and dying in our midst.

Our 1776 Declaration of Independence was crafted by individuals who spoke for many. Today's clinicians, leaders, policy makers, caregivers, and communities carry similar responsibilities when we choose whose pain is relieved, whose grief is tended, whose choices are honored, and whose dignity is protected. Today—every hospice plan of care, every palliative consult, every family meeting, every policy vote, and every act of presence becomes part of our unfinished record of what this country believes a human life is worth.

The 2026 entry of this book does not show arrival. It reveals a field under pressure and a society still deciding what compassion requires. Today, we face—expanding care amid overloaded capacity; grief that begins before and continues long after death; moral distress; assaults on diversity, equity, and inclusion; regulations reshaping care; Medical Aid in Dying's deep ethical tensions; trauma entering the room more often; disasters that do not pause death; technology moving faster than meaning; and business models shaping moral experience—make clear that our work ahead matters. It is complex, contested, and urgent.

There are blind spots in these pages, just as there are blind spots in the systems we have built. Some stories of suffering and courage remain under-recorded. Some communities still struggle to be seen, heard, trusted, or served. Some forms of care remain invisible because they happen in kitchens, shelters, prisons, understaffed nursing homes, borderlands, and overburdened homes rather than in celebrated institutions. We have not figured it out. We continue praying *"God mend thine every flaw"* when singing our beloved "America the Beautiful." We must accept and take action that such mending requires changes not only in sentiment, but also in policy, funding, education, staffing, access, and moral courage.

So, this Epilogue is not a conclusion so much as an invitation to the next witnesses. Each reader has some power—whether local or national, clinical or civic—to influence how serious illness, dying, and grief are met. As we celebrate 250 years of American need, service, and hope, may we carry forward clear convictions: that how we respond to those who suffer and those who are dying remains one of the truest measures of who we are, and of the country—and global community—we are still becoming.

What chapters are we writing next?
Not chapters of certainty, but of deeper seeing.

Not chapters that pretend we have arrived,
but chapters willing to widen care, tell the truth, and
meet suffering with greater courage, equity, and humility.

~ Joy S. Berger, DMA, FT, BCC, MT-BC
Composing Life Out of Loss, Founder/Author/Owner
Hospice & Palliative Care Today, Editor in Chief

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