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COMING HOME TO COMMUNITY: REFLECTIONS ON WHOLE-PERSON CARE IN A HOSPICE IN INDIA

Camille Munro, MD CCFP (PC)
Assistant Professor, Division of Palliative Medicine, Department of Medicine, University of Ottawa
The Ottawa Hospital, Ontario, Canada
camunro@toh.ca

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Community is often described as a place, a group, or a shared identity. Through my work in palliative care, however, I have come to see community as something more intimate. It is not only where we belong, but how we care for one another, how we bear witness to suffering, and how we remain human in the face of vulnerability. In whole-person care, community is expressed through emotional presence, shared meaning, cultural understanding, and spiritual connection—through relationships that allow healing to occur even when a cure is no longer possible.

My time volunteering at a hospice in the foothills of the Himalayas deepened this understanding. Community revealed itself in everyday acts: conversations at the bedside, shared meals, moments of celebration and grief, and quiet pauses between tasks. What surprised me most was not the strength of community itself, but how quickly I felt myself becoming part of it. This experience challenged my assumptions about belonging, expanded my understanding of whole-person care, and deepened my sense of how I wish to nurture and grow community in my own life and practice.

For me, community is not defined by proximity or similarity, but by presence and reciprocity—it is not simply something we receive, it is something we sustain together. Community is the experience of being seen and held—sometimes quietly, sometimes imperfectly—within a network of relationships that values connection. It carries a responsibility to show up—not only when it is convenient or professionally required, but when it is emotionally demanding. Community means that care is not delivered to a patient but shared with them.

It recognizes that illness does not occur in isolation; it ripples through families, caregivers, healthcare teams, and broader social structures.

Before my experience in India, I understood community largely within professional boundaries: interdisciplinary teams, institutional affiliations, and defined roles. While these remain important, my time in India revealed a more expansive, integrated vision of community—one where personal and professional identities coexist, and where care flows in multiple directions. I was not only a provider of care but also a participant in a community of care. My presence, listening, teaching and learning were all part of this reciprocal exchange. It reminded me that community thrives when we allow ourselves to be both givers and receivers.

One evening after a long day of home visits, I sat on the hospice rooftop reflecting quietly as the Ganga River flowed below. A nurse noticed my fatigue and wordlessly placed a cup of tea in my hands before sitting beside me. We shared a few minutes of silence, then returned to our tasks. In that small, unspoken act of care, I felt held by the same community I had come to serve.

I was born to Indian immigrants from Punjab, yet I often felt like an outsider within my own extended Indo-Canadian family; my Canadian-ness marking me as just a little different, even at home. One of the most striking aspects of my experience at the hospice was how quickly I felt welcomed into a deeply established community. Despite being an outsider—culturally, linguistically, and geographically—I was received with openness, trust, and generosity. I was invited into patient rooms, family conversations, staff discussions, celebrations, and moments of grief. The warmth and openness with which I was received, not just by the staff but also by the patients and families, created an immediate sense of belonging. What surprised me most was that community at this hospice did not rely on sameness. Staff members came from diverse backgrounds and disciplines—physicians, nurses, social workers, homecare nurses, volunteers, spiritual advisors—yet there was a shared ethos that transcended hierarchy and was more relational. Care was not fragmented by role but woven together by a collective commitment to the patient and their family.

I was also impressed by how extensive community was beyond the walls of the hospice. Through homecare visits, outreach programs, educational initiatives, and partnerships with organizations, the hospice functioned as a living network of care. Patients were not “discharged” from community; they remained connected through ongoing relationships. In visiting patients in their homes—some in modest dwellings or on the street—I witnessed community as an act of reaching outward. The homecare nurses embodied this beautifully. They brought medications and clinical expertise, but just as importantly, they brought time, listening, and presence. Their work illustrated that community is sustained not by grand gestures, but by consistent, compassionate attention.

One afternoon, I accompanied a homecare nurse to visit a young woman with tongue cancer living alone in a tent. The nurse gently assessed her pain, offered medications, and sat with her long enough to hear her story of displacement and loss. In the encounter, I saw how dignity can be restored not through resources alone, but through presence and recognition of personhood.

Whole-person care acknowledges that suffering is multidimensional—physical, emotional, social, spiritual—and that addressing one dimension without the others leaves care incomplete. At the hospice, community was the medium through which whole-person care was made possible. This was evident during group sessions facilitated by a volunteer psychiatrist, where patients were invited to express the emotions they carried about their illness. The creation of a safe, communal space allowed patients to feel less alone in their suffering. I was astonished by the way their vulnerability became the architecture of community. In sharing their fears, their grief, and their small joys alongside their suffering, they were constructing a space where everyone belonged—a space where a deeper communion emerges when we stop hiding our brokenness and discover the cracks are where the light of connection enters.

Community building is also a practice of self-awareness. In their wisdom, the hospice offered meditation sessions to the staff, recognizing that caregivers themselves are whole persons whose emotional and spiritual well-being directly impacts the care they provide. In palliative care, we carry so much—the weight of others' dying, the helplessness of watching suffering we cannot eliminate, the grief that accumulates day after day. This invitation to center ourselves, to recharge emotionally, was not self-indulgence. It was an acknowledgment that we cannot pour from empty vessels, that tending to our own well-being is essential to showing up fully for others.

Family meetings further illustrated the role of community in whole-person care. During one family meeting with a frail elderly woman with advanced Parkinson's disease, multiple generations gathered to speak openly about their fear of losing her. As they took turns sharing their love for her, their memories and anticipatory grief, the room softened. The presence of social workers, nurses, physicians, and family members created a shared holding space—one where no single individual bore the weight of suffering alone. We were there together to connect, to listen and to help the families and one another feel less alone.

Moments of celebration carried the same spirit of connection. During Holi festival at the hospice, patients, families, and staff gathered to mark the arrival of spring, honouring life even in the presence of death. By including patients and families in cultural and spiritual rituals, the hospice affirmed their identities beyond illness; the dying were not separated from the living, the sick from the well, the staff from the patients. This image has stayed with me: colour, music, and laughter filled the courtyard, reminding us that joy can coexist with suffering. This coexistence is at the heart of whole-person care—recognizing that humans need beauty, celebration, and connection.

Vulnerability also played a crucial role. Witnessing difficult conversations—such as discussions about prognosis or impending death—required emotional openness from both healthcare providers and families. Allowing myself to be present in these moments, rather than retreating behind professional distance, strengthened my sense of belonging. I was not merely observing community; I was participating in it. Community was also nurtured through reflection and meaning-making. Educational sessions, staff discussions, and shared learning experiences created opportunities to step back from clinical tasks and consider the deeper purpose of our work. Presenting to nursing students and healthcare professionals allowed me to contribute to the community's growth, reinforcing that community is sustained through both receiving and giving.

These experiences enhanced my sense that community is nurtured by shared purpose, vulnerability, and intentional presence. At the hospice, shared purpose was evident in the collective commitment to dignity, compassion, and patient-centred care. This alignment allowed relationships to form quickly and deeply.

One of the challenges of healthcare is the pressure of time—scheduled appointments, documentation demands, productivity metrics. My experience in India reminded me that community requires a deliberate slowing down. Time and space must be created, not found. Creating space is necessary for connection and that means being willing to pause—to sit, listen, and resist the urge to "fix." It involves recognizing that presence itself is a form of care. I learned time for connection is not merely a logistical issue but a value-based choice. In India, extended family meetings, long home visits, and unhurried conversations were prioritized, even within resource limitations. This intentional use of time communicated to patients and families that their stories mattered. It also fostered trust and deepened relationships. This lesson has influenced how I approach my work. In palliative care, taking the time, making eye contact, allowing silence, and being attentive to emotional cues are as important as any medical intervention.

Community is not about having everything we need; it is about sharing what we have, about creativity born of compassion, about refusing to let limitations become excuses for abandoning people. The hospice community also included those who have been marginalized—people whom society had abandoned: the person experiencing housing insecurity living in a tent, the frail elderly woman living alone, the grieving granddaughter who is unmarried and living in poverty. To care for the whole person is to attend to the relational spaces in which people live, suffer, and find meaning. Whole-person care requires that community be intentional about inclusion and responsive to vulnerability. This inclusivity challenges us to confront inequities and to extend care beyond comfort zones—opening doors, widening circles, and making room. Community is what happens when we stop performing our separateness and allow ourselves to be woven into the fabric of shared human experience.

Before my experience in India, I viewed community largely as something that supported care. I now understand community as care in and of itself. It is the context within which healing, meaning, and dignity become possible. Growing community begins with modelling the values we wish to cultivate: empathy, curiosity, humility, and respect. Community emerges through trust and shared humanity. It is sustained not by perfection, but by showing up, again and again.

My time at this hospice in India changed me. I arrived as a specialist coming to share expertise, and I left as a student who had learned invaluable lessons about community, wholeness, and care. As I move forward, I carry these lessons with me—that growing community is an act of hope, that it is a commitment to connection, that whole-person care is inseparable from community, and that in nurturing community, we nurture our shared humanity. I discovered that community is like coming home to a place I did not know I had been missing. ■

Biographical Note

Camille Munro is a palliative medicine specialist based in Ontario and Nova Scotia, Canada. Her clinical and academic interests include whole-person care, equity and inclusion in healthcare, and the relational dimensions of palliative practice. She also has an interest in global palliative care and reflective medical education, informed in part by volunteer work supporting the hospice and community-based care initiatives in India. She is deeply grateful to Dr. Taranjit Singh and the staff at Ganga Prem Hospice for the experiences that shaped this work. Outside of medicine, she enjoys spending time with her three adult children and her grandson, as well as reading, travelling, and being outdoors—especially by the ocean.