

The Chinese University of Hong Kong  
The Nethersole School of Nursing  
**CADENZA Training Programme**

CTP003 – Chronic Disease Management  
and End-of-life Care

Ch 8 - End-of-life Care: concept of palliative care, grief  
and bereavement care

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香港賽馬會慈善信託基金  
The Hong Kong Jockey Club Charities Trust

# Lecture Outline

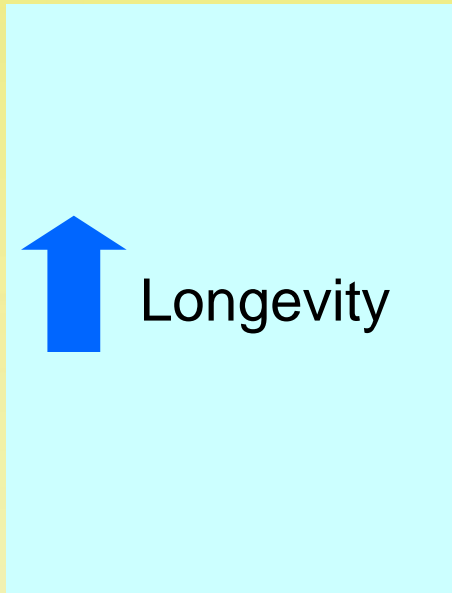
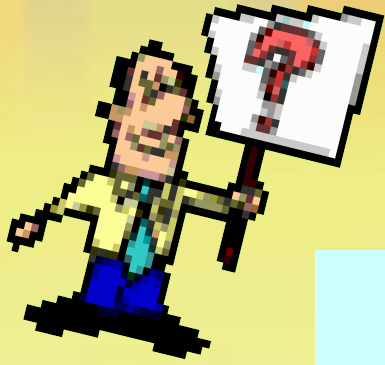
- The demography of care
  - changing populations
- Concept of palliative care
  - palliative care (PC)
  - hospice care
- Palliative paradigm
  - bio-psycho-socio-spiritual paradigm
- Grief and bereavement care
- End-of-life service in Hong Kong
  - challenges for future development of PC in HK

# The demography of care: changing populations

- Population ageing

- happening in European and other developed countries
- longevity of people is increasing
- proportion of population older than 65 years and surviving into very old age is increasing

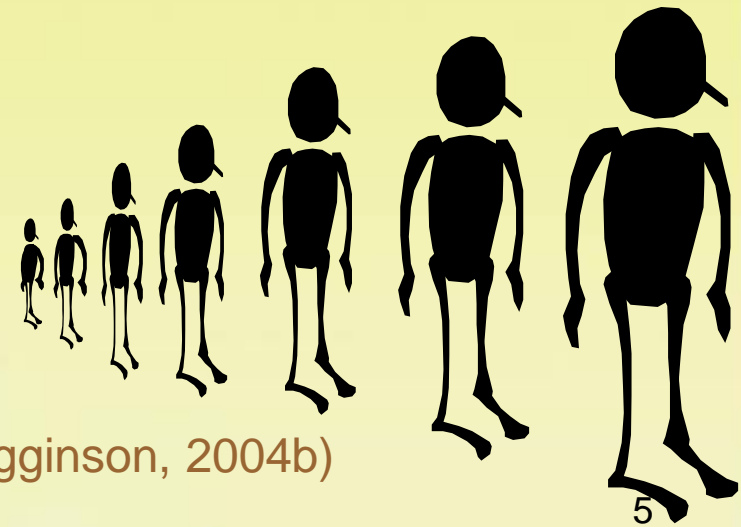
(Davies & Higginson, 2004b)




(Davies & Higginson, 2004b)

# Changing populations


- The changing pattern of disease
  - More people die through serious chronic diseases than through any other cause.
  - More likely to suffer multiple organ failure.
  - The top five predicted causes of death for 2020 will be:
    - heart disease
    - cerebrovascular disease
    - chronic respiratory disease
    - respiratory infections
    - lung cancer




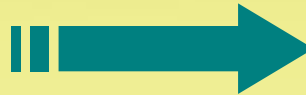
(Davies & Higginson, 2004b)



People live to late adulthood



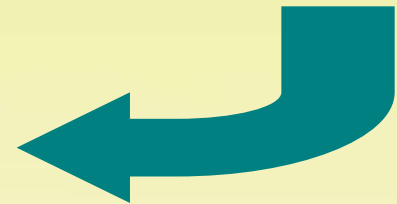
Chronic diseases become more common with age



People die at late adulthood following illness due to serious chronic conditions which cause a wide range of physical, psychological and social problems.




More people need help towards the end of life




# Changing populations

- The changing social structure

 Number of informal caregivers,  
especially women



 Health care systems need to provide  
effective and compassionate care  
at end-of-life for more people

# Therefore...

- Health care systems must be able to meet the needs of older people at the end-of-life by reducing their suffering, helping them to live comfortably and enhancing their quality of life for as long as possible.



(Davies & Higginson, 2004b)



# The need for palliative care

Older people commonly suffer from multiple medical problems

The combined effects of these medical problems are greater than any single disease and probably increase the need for care

Older people are more susceptible to adverse drug reactions and iatrogenic illness

Physical problems may have a psychological impact in older people.

(Davies & Higginson, 2004a)

# Concept of Palliative Care

- Definition of palliative care
- Difference between palliative care and hospice care

# Palliative Care

Defined in 2002 by the World Health Organisation as

*“...an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.” (p.84)*

(World Health Organisation, 2002)

# Palliative care.....

² provides relief from pain and other distressing symptoms

² affirms life and regards dying as a normal process

² intends neither to hasten nor postpone death

² integrates the psychological and spiritual aspects of patient care

² offers a support system to help patients live as actively as possible until death

² offers a support system to help the family cope during the patient's illness and in their own bereavement

(World Health Organisation, 2002)

# (Cont'd) Palliative care.....

<sup>2</sup> uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated

<sup>2</sup> will enhance quality of life, and may also positively influence the course of illness

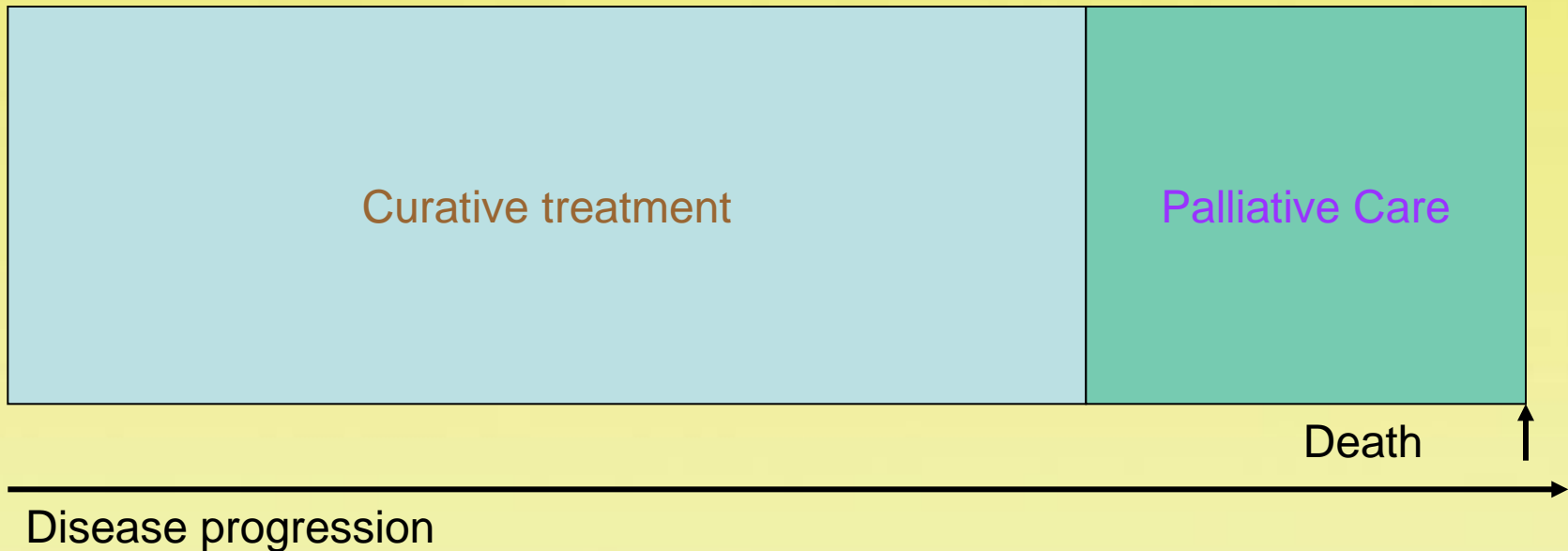
<sup>2</sup> is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications

(World Health Organisation, 2002)

# Difference between Acute Care and Palliative Care

	Acute Care	Palliative Care
<b>Objective</b>	Quantity of care,	Quality of care
<b>Philosophy</b>	Curative, add days to life	Palliative, add life to days
<b>Goal</b>	Disease management	Symptom control
<b>Treatment depends on</b>	Lab values, investigation result	Patient discomfort and expectation
<b>Results measured by</b>	Curative rates, improved lab values, discharge to home	Free of pain and discomfort, peaceful death
<b>Death regard as</b>	Failure	Inevitable, natural
<b>Unit of care</b>	Patient	Patient, family and significant others

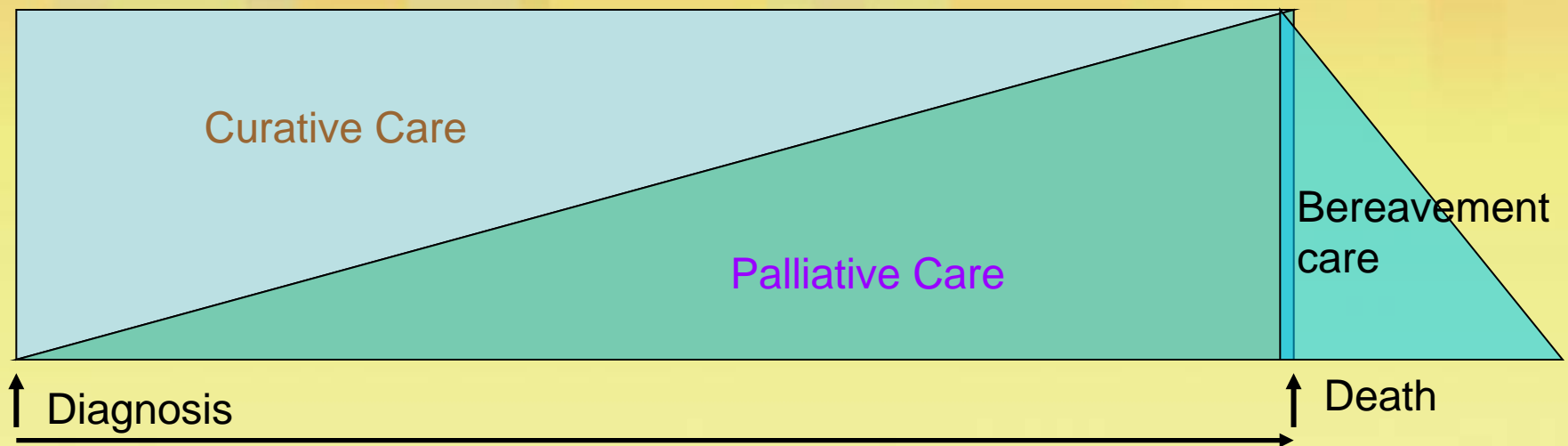
# Traditional concept of palliative care



- Palliative care is relevant only to the last few weeks of life – when no treatments are of benefit to the patient.

(Lynn & Adamson, 2003)

# New Concept of Palliative Care



Disease progression

- Palliative care starts after the disease is diagnosed.
- The involvement of curative treatment decreases as illness progresses, while that of palliative care increases with approaching end-of-life.
- Support is provided to the family during the entire period.
- Bereavement care is provided for the family and significant others after the death of the patient.



# Delivery of Palliative Care

- Hospital in-patient
- Hospice in-patient
- Home care
- Outpatient
- Day care
- Palliative consultative services



(Hospital Authority, 2008)

# Palliative interdisciplinary care team members

- **Core members:**
  - patient and family
- **Other important members:**
  - doctors
  - nurses
  - clinical psychologists / counsellors
  - social workers
  - pastoral care workers
  - rehabilitation team PT / OT
  - dietitians
  - volunteers

# Palliative Care vs. Hospice Care

Are palliative care and hospice care the same?



# Hospice Care

- The term "hospice" is derived from the Latin root word *hospse* , mean "given to hospitality".
- In the past, it referred to a resting place for travellers along pilgrim routes, where those who were sick, poor ,and weary from travelling were taken in and received care.
- In modern-day society, hospice means a system of specialised care that provides shelter and comfort for those facing the difficult journey of death.

# Palliative Care $\neq$ Hospice Care

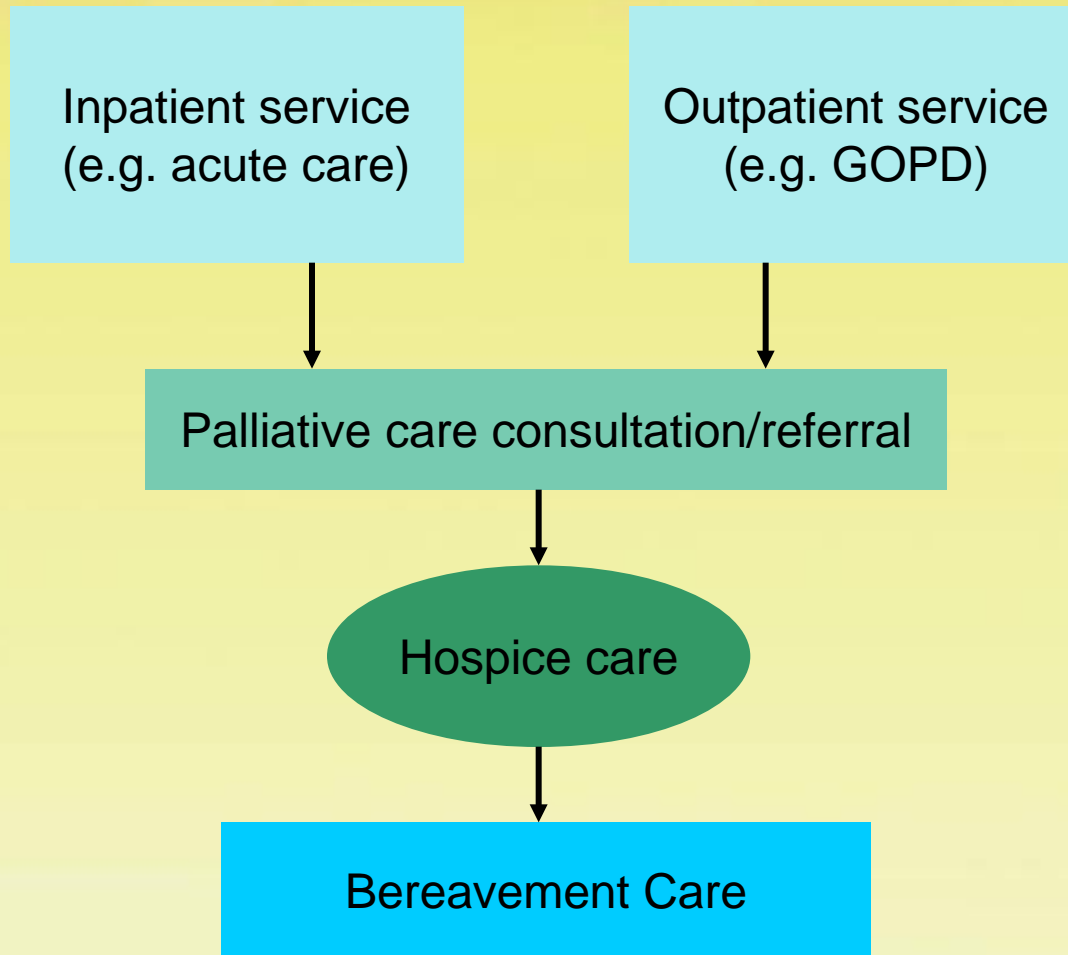
- Palliative care is associated with the hospice philosophy and extends the traditional hospice approach of care to a broader approach of services for the terminally ill in the modern health care system.

(Kuebler et al, 2002)

- Curative treatment can be obtained through palliative care, but not through hospice care.

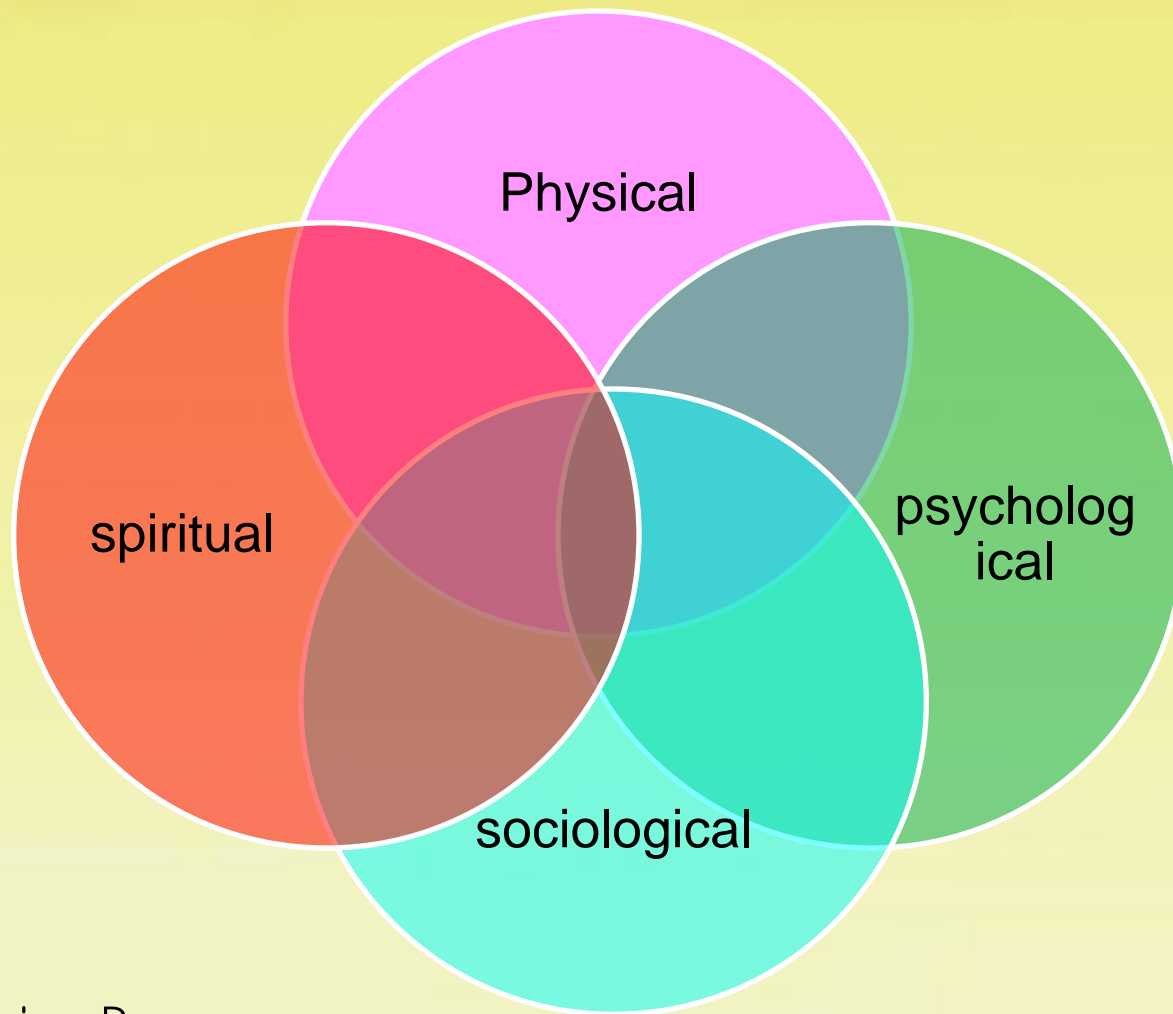
(Wittenberg-Lyles & Sanchez-Reilly, 2008)

# Palliative Care vs. Hospice Care



# Palliative Paradigm

# The palliative paradigm--- Bio-psycho-socio-spiritual paradigm





# Physical care

- Discontinuing active curative treatment is not synonymous with saying,



*"There is nothing more to be done."*



*"There is always something that can be done for the patient."*

(Smith, 2000)

# Physical care

- symptoms control and relief of distressing symptoms as identified by the patient
- enhance comfort and quality of life.
- **Good pain management** is crucial to optimize quality of life and ease physical, social, and spiritual pain.

(Smith, 2000)

# Physical care

## *Symptoms of patients in palliative care unit*

1. Weakness
2. Fatigue
3. Weight loss
4. Anorexia
5. Dyspnea
6. Xerostomia
7. Cough
8. Pain
9. Anxiety
10. Dysphagia
11. Confusion
12. Depression
13. Constipation
14. Nausea
15. Insomnia
16. Vomiting



(Ng & von Gunten 1998)

# Physical care

- **Daily care**

is also very important for the patient and could develop rapport during the care.



# Daily care

## Grooming:

- bathing everyday can provide comfort and refreshment, especially for bed-bound patients
- hair combing, shaving, etc. can also be done around bath time



(stoppain. org. Department of pain medicine & palliative care, 2005)

# Daily care

## Skin care:

- Pressure ulcers often occur in remaining in one position for long periods of time.
  - check the patient's skin for reddened areas every day
  - assist the patient to change position frequently
  - keep the skin clean and dry
  - gently massage and apply lotions

(stoppain. org. Department of pain medicine & palliative care, 2005)



# Daily care

## Mouth care:

- Good mouth care helps to prevent sores and may improve the patient's appetite.
  - cleanse with a soft toothbrush or a cloth twice a day
  - refit or remove loose dentures to prevent mouth sores
  - moisturising the lips and corners of the mouth can prevent cracking



(stoppain. org. Department of pain medicine & palliative care, 2005)

# Daily care

## Exercise:

- Active or passive exercise.
- Bathing is also a good time for exercise.  
Exercise the patient's arms and legs during or after bath time.



(stoppain. org. Department of pain medicine & palliative care, 2005)



# Psychosocial Care

Conscious or  
subconscious  
fear

Uselessness

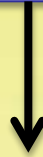
Hopelessness

Psychological  
distress



# Psychosocial Care

Conscious or  
subconscious  
fear



The biggest fear is of death itself

- ***Not knowing*** what it will feel like;
- ***Not knowing*** how it will happen;
- ***Not knowing*** what to expect next.



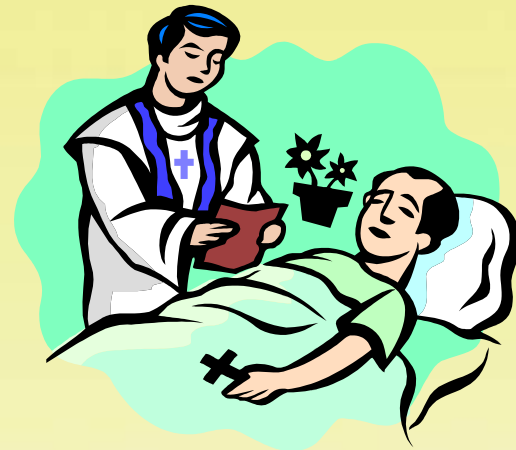
# Psychosocial Care

- Symptoms like *anxiety*, *anger*, *insomnia*, *depression*, and *other physical complaints* may be exhibited.
- Dr. Elisabeth Kübler-Ross identified five common reactions: *denial*, *anger*, *bargaining*, *depression* and *acceptance*. These are what she called the "*stages of death and dying*".

# Stages of Death and Dying

When people are dying, they go through a series of stages when certain feelings or emotions override all others. The stages are:

- denial
- anger
- bargaining
- depression
- acceptance



(Charles, Corr, & Nabe, 2009)

# Denial -- shock and disbelief

- Disbelief in the facts.
  - May use another reason to “explain” the situation.
  - Functions as a buffer for unexpected shocking news.
- (Smith, 2000)



# Anger -- hostility and resentment

- Rage, envy, resentment may appear.
- May often ask "Why me?".
- May displace the anger at random: doctors, nurses, family, God, and so forth.
- May result in outbursts and unreasonable demands.

(Smith, 2000)



# Bargaining -- looking for a way out

- An attempt to defer the inevitability of death.
- Promises of good behaviour in order to bargain for longer life. Promises sometimes associated with *quiet guilt*.
- Often happens with God(s).

(Smith, 2000)



# Depression -- no longer able to deny, patients experience sadness and loss

- A normal reaction after realisation of great loss.
- Important to experience and express sorrow to facilitate the state of acceptance.

(Smith, 2000)





# Acceptance -- acceptance of the inevitability of death with peace and detachment

- Devoid of feeling.
- Diminished interest.
- Sitting in silence may be most meaningful communication with people at this stage.

(Smith, 2000)



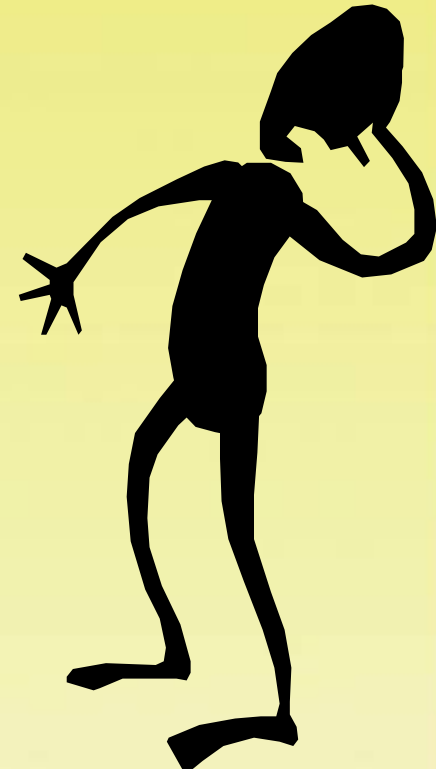


# Psychosocial Care

- Social distress
  - Usually involves very **basic** and **practical matters**.
  - Household and financial concerns are common.
    - e.g., a grandmother may worry about how the family will manage domestic affairs without her.
    - e.g., a husband may worry about how his wife will manage electrical issues without him.

# Psychosocial Care

- Source of distress
  - Loss of job, position, and control, etc.
  - ***not being able to function*** as his or her roles, like father or mother, husband or wife, or community member.



(Smith, 2000)

# Psychosocial Comfort

- Compassionate communication is **essential** at the end of life. *(We will discuss more about communications at end-of-life in chapter 9.)*
- Discussing issues **frankly** can facilitate psychological preparation for the patient. Issues include:
  - resuscitation orders
  - life support
  - arranging personal affairs

(stoppain. org. Department of pain medicine & palliative care, 2005)

# Spiritual Care

## Spiritual needs $\neq$ Religious needs

- Spirituality is a broader concept, reflecting more universal expectations.

(Smith, 2000)



# Spiritual Care

- Spiritual needs are
  - highly personal and salient to many people at the end of life
- When approaching death, people may find themselves returning to an earlier faith or searching for answers about the meaning of life, suffering, and death.



# Spiritual Care

- Some basic spiritual distress issues often reported by dying patients are:
  - *Unresolved issues of forgiveness*
    - e.g., forgiving or being forgiven
  - *Love*
    - e.g., to express love or know one is loved
  - *Belonging*
    - e.g., need for relationships

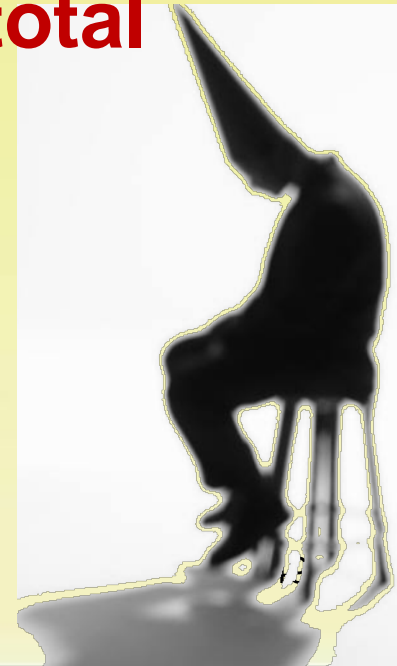




# Spiritual Care

- Many patients will experience pain in their **inner being, i.e. spiritual pains.**
- **Spiritual pains** may **magnify their physical pains.**
- Spiritual pain is definitely a factor **in total suffering.**

(Smith, 2000)



# Spiritual Care Interventions

- For example:
  - present with the patient
  - religious support. Arrange visit by clergy as desired
  - perform spiritual life reviews
  - encourage expression of feelings
  - assist the patient in reframing personal goals.
  - prayers, music or meditation as desired.



(Smith, 2000; stoppain.org. Department of pain medicine & palliative care, 2005)

# The palliative paradigm---

- Concerned with the individual holistically, as a whole, complete person.
- Holistic care approach
  - care for the patient and the family in a bio-psycho-socio-spiritual approach
  - aims to improve their quality of life

# Grief and Bereavement Care

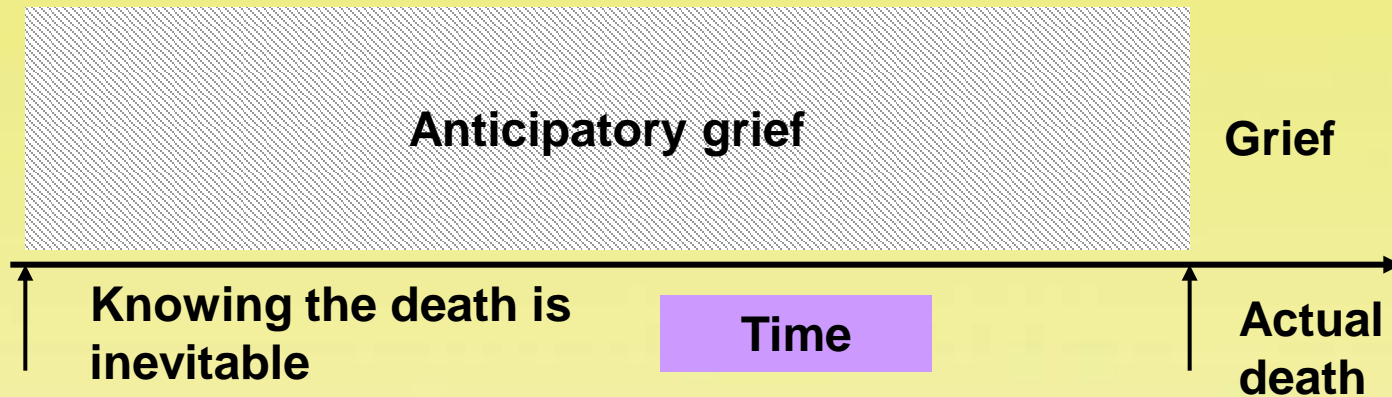
# Grief and bereavement care

- Grief
  - is the normal process of psychological, social, and somatic reactions to perceived loss
  - applies to any loss (e.g., divorce, job, self-esteem)
  - death is generally viewed as the ultimate loss



# Grief and bereavement care

- Anticipatory grief



- is normal, but may not always occur
- refers to grieving that occurs from the time between knowing death is inevitable and the actual death event
- offers chances to resolve conflicts or unfinished business

# Grief and bereavement care

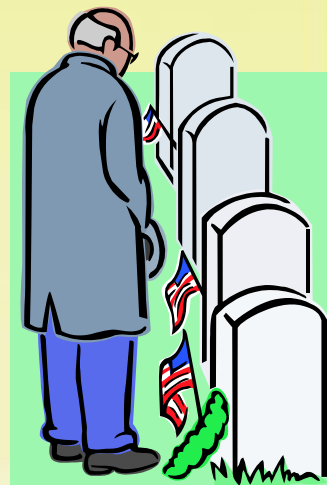
- Mourning

- refers to cultural reaction to - or outward social expression of - the loss

- Bereavement

- refers to state of deprivation following the loss of something held to be significant
  - can be positive or negative

(Smith,2000)



# Common responses to grief

## Psychological response:

- emotional outbursts
- frequent crying
- guilt
- anxiety
- hostility
- depression
- irritability
- helplessness
- social withdrawal

## Physical reactions:

- palpitation
- chest tightness
- gastrointestinal disturbances
- increase /decrease of appetite
- sleep difficulties
- dry mouth
- fatigue
- loss of sexual interest

## Cognitive:

- preoccupation with the deceased
- poor concentration
- dreams of the deceased
- Hallucinations
- sense of presence of the deceased
- confusion

(Smith,2000)



# Stages of Grief Resolution

- Four tasks of mourning
  - Task 1: to accept the reality of the loss  
*(help actualise the loss)*
  - Task 2: to experience the pain of grief  
*(help the bereaved to identify & express feelings)*
  - Task 3: to adjust to an environment in which the deceased is missing
  - Task 4: to emotionally relocate the deceased and move on with life
- May take place in any order

# 1. To accept the reality of the loss

- This task involves facing the reality that the person is dead and will not return.
- In order to assist the bereaved to fulfill this task, the bereaved:
  - should be encouraged to talk about the deceased,
  - Should attend the funeral and address the circumstances around the death.

## 2. To experience the pain of grief

- The bereaved need to allow themselves to feel the pain rather than suppressing their feelings. Suppression may lead to depression, physical illness, or aberrant behaviour.
- Encourage the bereaved to feel the pain and to know that it will pass.
- Caution:
  - not everyone's experience is the same; the intensity of pain may be different for different people

### 3. To adjust to an environment in which the deceased is missing

- The bereaved need to take up new roles formerly performed by the deceased
- The bereaved need to adjust to the changed dynamics in which the deceased is missing.

## 4. To withdraw emotional energy and reinvest it in another relationship

- Encourage the bereaved to form an ongoing relationship with the memories associated with the deceased, and continue with their own lives after the loss.
- Encourage the bereaved to reinvest their emotional energy in their present life.

(Worden, 2002; Behavioural Neurotherapy Clinic, 2005)

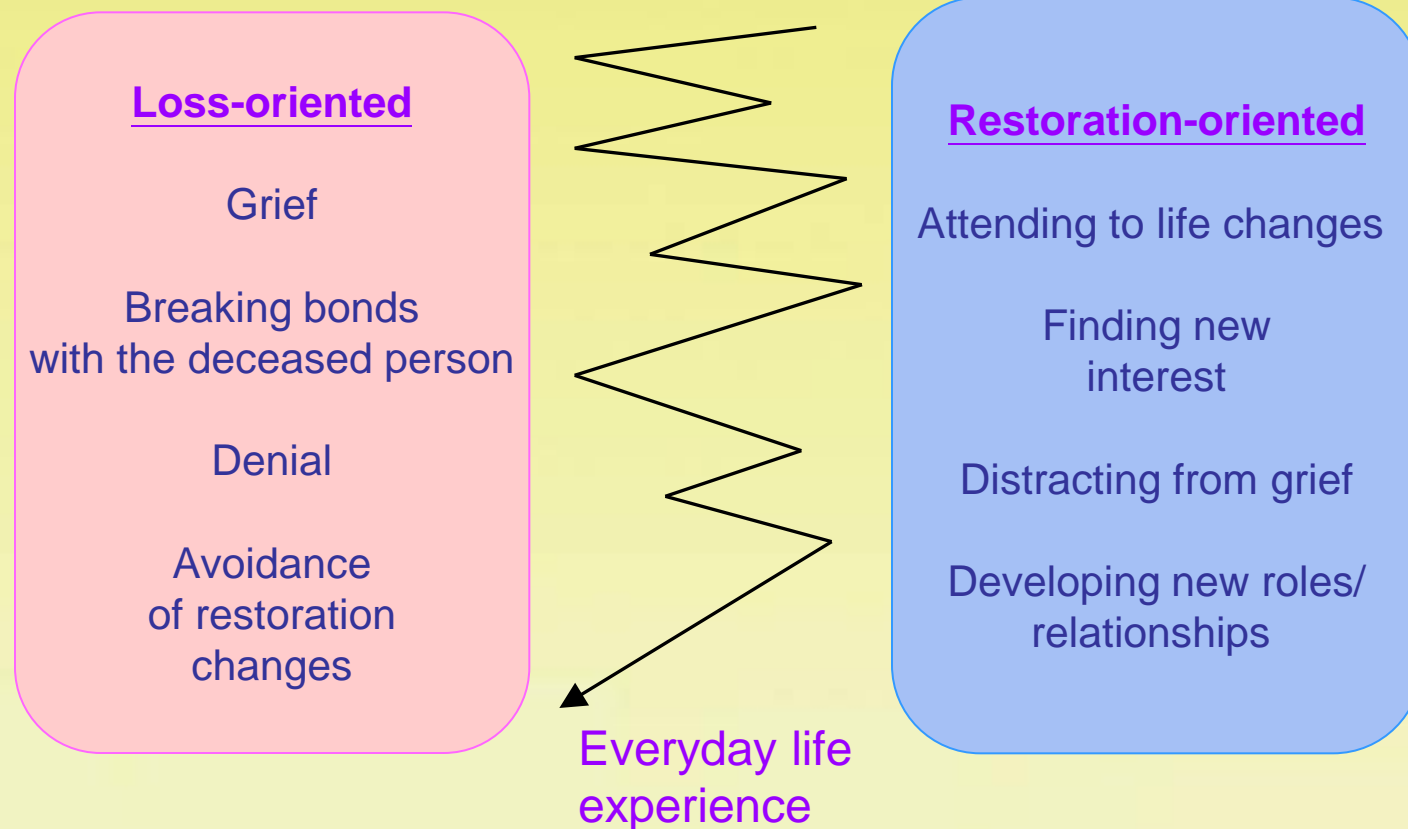
# A Dual Process Model (DPM) of coping with bereavement

- Stroebe & Schut (1999) discovered there are two types of stressors in coping with bereavement that the bereaved has to face:
  - **loss- orientated**
  - **restoration-orientated**



# A Dual Process Model (DPM) of coping with bereavement

- The bereaved may experience **a process of oscillation** between loss- and restoration-oriented coping.



# A Dual Process Model (DPM) of coping with bereavement

- The process of oscillation is necessary for optimal adjustment after the loss.
- Each bereaved should find his/her own pace and oscillate between the loss- and restoration-orientation.

(Stroebe & Schut, 1999)





# Complicated bereavement

- In *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* abnormal grief reactions are referred to as "**complicated bereavement**".
- the intensification of grief to a level such that the person feels overwhelmed
- results in maladaptive behaviour,
- remains in a state of grief interminably without any progress towards completion



# Complicated bereavement

- There are four types of complicated bereavement:
  - chronic grief reaction
  - delayed grief reaction
  - exaggerated grief reaction
  - masked grief reaction

(Worden, 2002)



# Complicated bereavement

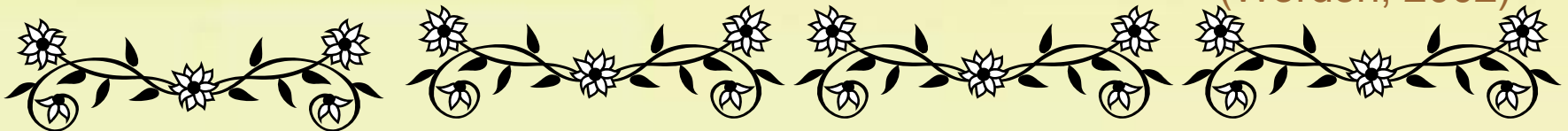
- Chronic grief reactions
  - in which the normal grief reactions continue for an excessive period of time without any progress towards completion
- Delayed grief reactions
  - in which the reaction occurs some period of time after the death



# Complicated bereavement

- Exaggerated grief reactions
  - in which a person is so overwhelmed by the symptoms of grief that major psychiatric disorders may develop
- Masked grief reactions
  - in which a person experiences physical discomfort that may not at first appear to be related to the loss

(Worden, 2002)



# Complicated bereavement

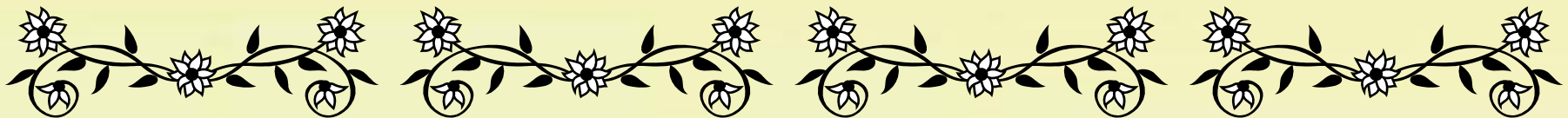
- There is no specific way to diagnose complicated grief.
- It is important to recognise when a person needs specialised help beyond the normal grief.
- Health care professional need to be alert to high-risk factors of complicated bereavement.

(Smith, 2000)



# Checklist for bereavement risk

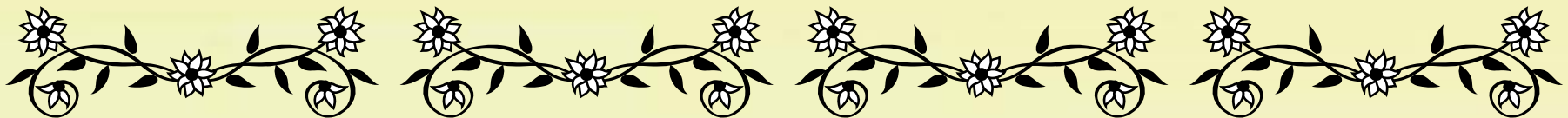
- Situational factors
  - financial problems
  - poor social support
  - heavy responsibilities
  - physical illness
- Relationship factors
  - dependence
  - ambivalence
  - multiple losses



# Checklist for bereavement risk

- Difficulty in coping
  - poor coping
  - mental illness
  - addiction
  - adult single child
  - having a child under 15
- Circumstantial factors
  - suicidal death
  - sudden death
  - painful death
  - survival guilt

(Hospital Authority, 2008)



# Ten ways to help the bereaved

1. Be present and attentive.
2. Do allow silence.
3. Don't fill the conversations with a lot of outside topics.
4. Do listen in a non-judgmental and accepting way.
5. Don't use clichés such as 'Think of all the good times', 'Time heals all wounds', and so forth.





# Ten ways to help the bereaved

6. Do mention the deceased name and encourage talk about the deceased.
7. Do offer practical and emotional support e.g., looking after children or cooking a meal.
8. Do allow crying.
9. Reassure that grief may take years to work through.
10. Acknowledge anniversaries and dates of significance for the bereaved.



(A safe place to heal, 2005)

# End-of-life service in Hong Kong

# Hong Kong end-of-life care service

- First set up in Our Lady of Maryknoll Hospital in 1982.
- Society for Hospice Care set up in 1986.

# Hong Kong end-of-life care service

- **Bradbury Hospice (BBH)**, situated in Shatin, was built to house a specialist hospice unit in 1992
  - was transferred to Hospital Authority with effect from 1 April 1995
  - as at 31.3.2008, it has 26 beds
- **The Society for the Promotion of Hospice Care** is a charitable organisation founded in 1986
- 



# Hong Kong end-of-life care service

- Hospital Authority (HA)
- Non-governmental organisation (NGO)
  - Haven of Hope Holistic Care Centre
  - The Hong Kong Anti-Cancer Society Jockey Club Cancer Rehabilitation Centre
  - Society for the Promotion of Hospice Care



# Hong Kong end-of-life care service

- Referral network for inpatient palliative care in Hospital Authority (2/2008)

	Hospital	Bed no.
Kowloon (Central )	BH	15
Kowloon (West)	OLMH	29
Kowloon (East)	UCH	15
	HHH	24
New Territories (East)	BBH	26
	SH	20
New Territories (South)	CMC	26
New Territories (North)	TMH	35
HK (East & West)	RHTSK	10
HK (South)	GH	44
	Total:	244

# Hong Kong end-of-life care service

## • Hospital Authority standard referral form for palliative care

~ mainly for cancer patients

~ Shatin Hospital pilots  
end-of-life programme for  
older people

<b>HOSPITAL AUTHORITY</b>		To: _____ Hosp/Inst
<b>Standard Referral Form for Palliative Care</b> <i>(Please read 'points to note' at the back side before you complete this form.)</i>		
<b>Patient's Particulars (Address and Tel no. is essential)</b>		
Name: _____	Please either affix patient's gum label or fill in patient's particulars at the left.	
ID No.: _____		
Tel No.: _____		
Address: _____		
1.1 Referral for <input type="checkbox"/> Palliative In-patient Care <input type="checkbox"/> Palliative Home Care (Please specify the expected date of discharge _____) <input type="checkbox"/> Palliative Out-patient Care <input type="checkbox"/> Hospice Day Care <input type="checkbox"/> Palliative Consultative Service		
1.2 Where is the patient at present? Home _____ Hospital _____ Others (please specify) _____		
2.1 Diagnosis: Primary: _____ Metastasis: _____		
Diagnosis known to patient: Y <input type="checkbox"/> N <input type="checkbox"/> Diagnosis known to family: Y <input type="checkbox"/> N <input type="checkbox"/>		
Any Infectious Diseases: Y <input type="checkbox"/> N <input type="checkbox"/>		
If yes, please specify _____		
2.2 Medical History		
Surgical Operation: _____ Date: _____		
Chemotherapy given: Y <input type="checkbox"/> N <input type="checkbox"/> Date of Next Appointment: _____		
Radiotherapy given: Y <input type="checkbox"/> N <input type="checkbox"/> Date of Next Appointment: _____		
Other Relevant Information: _____		
3.1 Present Condition: (Please delete as appropriate)		
Mental State: Alert / Drowsy / Unconscious Orientated / Disorientated		
Mobility: Independently mobile / Mobile with aid / Bedbound		
Feeding: Independent / Dependent / Tube-feeding		
Other Relevant Points _____		
3.2 Present Medication (+ Dosage) _____		
4.1 Reason for Referral <input type="checkbox"/> Pain and Symptoms Control <input type="checkbox"/> Psychosocial Care		
Others _____		
4.2 Will the referring unit continue to follow up the case Y <input type="checkbox"/> N <input type="checkbox"/> If the answer is yes, please provide the date of next follow up _____ (Date/Month/Year)		
4.3 Patient's consent for referral (Verbal): Y <input type="checkbox"/> N <input type="checkbox"/>		
4.4 Please enclose Pathology report/medical report/discharge summary/other confirming evidence.		
5. Remarks _____		
6. Referring Doctor: _____ (Block Letter) _____ (Signature)		
Hospital/Unit: _____ Tel & Fax No. of Referring Doctor: _____ (Tel) _____ (Fax)		
Consultant of the Unit: _____ (Name) _____ (Tel)		
<b>For Palliative Care Unit:</b>		
7.1 Date of referral received: _____ Date of assessment: _____		
7.2 Remarks: _____ Sign: _____		

# Hong Kong end-of-life care service

- **NGO**

## Haven of Hope Holistic Care Centre

- in-patient service
- home care service
- integrated rehabilitation service
- respite care
- bereavement counselling
- psycho-social spiritual care
- resources centre
- volunteer service

<http://www.hohcs.org.hk/hcc.php>



# Hong Kong end-of-life care service

- NGO

## The Hong Kong Anti-Cancer Society Jockey Club Cancer Rehabilitation Centre

- cancer rehabilitation wards
- out-patient
- pharmacy
- physiotherapy centre
- palliative care centre
- day care
- volunteers' centre
- traditional Chinese medicine centre

[http://www.jccrc.org.hk/Big5/About\\_CRC.html](http://www.jccrc.org.hk/Big5/About_CRC.html)

# Hong Kong end-of-life care service

- Society for the Promotion of Hospice Care
- 賸明會 Comfort Care Concern Group
- Maggie's Cancer Caring Centres
  - hospice and palliative care
  - bereavement care
  - life and death education

# Self assessment of your beliefs about death and dying

<http://www.thirteen.org/onourown/terms/tools/index.html>

**on our own terms**  
moyers on dying

home | end-of-life tools | care options | final days | therapy & support

## End-of-Life Tools

**How to prepare yourself and your family**

Glossary | Resources  
Talk About It | Help Guide

**T**

- Talk About It
- Community Action
- Resources
- About the Series
- Site Map
- Credits

**Dying: A Financial Guide**

Can you cover the expenses of a loved one's final days? Get some tips on paying for care.

**PATIENT TOOLS**

- [A Guide to First Steps](#)
- [A Guide to Advance Directives](#)
- [What Treatment Is Best For You?](#)
- [Taking a Spiritual Inventory](#)
- Self-Assessment of Your Beliefs About Death and Dying**

**COMMUNITY TOOLS**

- [How to Share the Care](#)
- [How to Be with a Dying Person](#)
- [A Doctor's Guide to Diversity](#)

**Test Your Knowledge**

What do Americans fear most about death? What are the leading causes of death? [Find out.](#)

**Requires Real Player**

**From the Series**

- The Need to Plan: Program 1**  
Dr. Pat Caralis, University of Miami/Jackson Medical Center
- Discussing Advance Directives: Program 2**  
Dr. Diane Meier, Hertzberg Palliative Care Center, Mt. Sinai School of Medicine with Bill Moyers
- Hospice and Support: Program 1**  
Terminal Esophageal Cancer Patient Dr. Bill Bartholome and his wife, Pam Roffol Dobbies

"Each person's dying is unique and we have to follow them. They have to make the decisions . . ."

— Frank Ostaseski, Director, Zen Hospice Project  
Program 2: A Different Kind of Care

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## The End of Chapter 8

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