Bereavement Care for Sudden Death
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There were around 40,000 deaths in Hong Kong every year, with over 9,000 as unnatural deaths that mandated reporting to the Coroner’s Court. Unnatural deaths include occupational and vehicular accidents or accidents of any types, suicides, homicides, and acute medical conditions. These deaths are usually sudden for both the deceased and the family, and pose a different trajectory for grieving. Based on literature review and frontline experiences, the unique features of bereavement by sudden death - the unpreparedness, the possibility of traumatic witness, the secondary traumatisation of the necessary procedures, the possible ambiguous loss, as well as the intertwine of trauma and bereavement are discussed. With a mapping of the possible trajectory, bereavement care at different stages, addressing these unique features, is suggested and elaborated with illustrative case examples. Practical insights in provisions of bereavement care for such group are also highlighted.

Communication and end-of-life care in the intensive care unit
Dr. Esther Mok,
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In the recent decade, there are increasing recognition of importance and needs of end-of-life care in the intensive care setting. Communication has been reported as the unique skills for promoting high quality end-of-life care in all settings. However, there are limited guidelines guiding nurses to promote effective communication in ICU end-of-life care while family members identified it is the most important skill of clinicians in the intensive care unit. It is important to explore barriers of communication for grieving. Based on literature review and frontline experiences, the unique features of bereavement by sudden death - the unpreparedness, the possibility of traumatic witness, the secondary traumatisation of the necessary procedures, the possible ambiguous loss, as well as the intertwine of trauma and bereavement are discussed. With a mapping of the possible trajectory, bereavement care at different stages, addressing these unique features, is suggested and elaborated with illustrative case examples. Practical insights in provisions of bereavement care for such group are also highlighted.

Critical care doctors and nurses play an active role in assisting patients and families with end-of-life decisions. A communication framework and strategies on communication with families related to end-of-life care in ICU is proposed.
Family Therapy for Traumatic Death

Prof. Joyce Ma, Chinese University of Hong Kong.
Dr. Flora Mo, Alice Nethersole Tai Po Hospital.

A family has witnessed the death of their only son in a traffic accident. They experienced tremendous grief which brought the family on the verge of breaking down. After the tragedy her daughter experienced frequent nightmares which led her to the child and adolescent psychiatric service. The mother was very depressed and irritable. The family relationship was very much jeopardized by domestic violence. Because of the severity of the family situation the medical social worker referred them for family therapy in Chinese University of Hong Kong.

Through handling the marital crisis and the complex family dynamics, we came to understand how the tragedy has deeply traumatized each and every member of the family. Through their effort in the therapy their wound started to heal up bit by bit, the family started to reconciled with each other and were ready to move on with their lives. In this section how the family dealt with the grief through family therapy from both medical and social work perspectives will be discussed in this section.

Using Play Based Intervention with Bereaved Children

Ms. Brenda Koo Wing Sze,
Jessie and Thomas Tam Centre,
Society for the Promotion of Hospice Care.

"Toys are used like words by children, and play is their language."
Garry L. Landreth, 2005

All children play. They play at all times and all places. Children do not need to be taught how to play, nor must they be made to play. Play is a spontaneous, enjoyable, voluntary and aimless activity, in which, the child can flexibly choose how to play and how toys and materials to be used. According to Piaget (1962), in play, the child is dealing in a sensory-motor way with concrete objects that are symbols for something else the child has experienced directly or indirectly. Play is the child’s attempt to organize his experience. He may feel more in control and thus more secure, through the process of play.

Children have to deal with a number of novel experiences once a family member died. Play does not only provide a natural medium for bereaved children to express themselves, but also a way to organize the unchangeable reality to manageable situations.

In this workshop, the author will share her experience in applying child-centered play based intervention with local bereaved children. After the accomplishment of the workshop, the participants are expected to acquire:

1) a basic understanding on child-centered play therapy; and
2) a caring, sensitive and empathic ear to listen to children’s stories
End of Life Care for Old Age Homes
Dr Raymond Lo,
Consultant, Geriatrics and Palliative Medicine, Shatin Hospital; Chief of Service, Bradbury Hospice.

Care for the dying is a litmus test for our health and social services, and is a measure of society in looking after our sick and vulnerable citizens. There should be no ageism in this regard. Significant proportion of our older population spent their end of life in old age homes, and should receive appropriate support regardless of their diseases conditions and trajectories. Ageing and dying is a priority issue.

The residential care setting is different from country to country, and our local set up has its unique features to consider when applying palliative care principles in day to day care. Currently there are over 500 private old age homes and over 140 subvented and contract homes. The number of elderly residing in these long term care facilities has more than doubled during the last decade to more than 70,000 in 2007. Appropriate palliative support for old age home residents is a pressing issue.

Older people have palliative needs which can be similar yet different from the younger age groups. Pain is always a top concern by patients of all ages. Yet symptom profiles may be different especially in elderly with non-cancer conditions. Use of medications need to be with caution, especially with alternative opioids. Psychological well-being does not necessarily have to be poor for the elders in residential homes, but the social and family support is not guaranteed. Quality of life issues are equally relevant in older age groups, and existential issues such as dignity, meaning of life, self-perceived burden are pertinent issues in long term care setting. Our local data revealed that QOL scores of vulnerable elderly in old age homes could be poorer than dying cancer patients in hospitals.

Yet application of palliative care to old age homes needs to be well thought out and planned. Skills, knowledge and attitude of local old age home staff must be explored. Perception and concerns of all ranks of workers, including personal care assistants, have to be carefully considered. Support programmes need to be evaluated, with the outcome of interventions properly assessed. Shatin Hospital and Bradbury Hospice had implemented a palliative care at old age home project with promising results. The programme provided training as per the needs of old age home staff, and interventions were offered to clients requiring intensive support. Anticipatory grief workshops were held for elderly with psychosocial needs, and a randomised controlled trial was used to evaluate an initiative in early and better preparation for residents facing end of life. Experience and results of the programme were further discussed in the presentation.