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HOW TO IMPROVE "DEATH QUALITY" WHEN LIFE QUALITY IS DIMINISHING?

THE TRUTH IS THERE IS NO TRUTH ... (Friedrich Nietzsche)

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Purpose: **Improved medical technology has resulted in sharp increase in the average length of survival since patients with chronic/terminal diseases are first classified as "non-curative", until death. The "usual end of life" involves serious physical & mental suffering & disability for a long time. Providing "Quality of Life" to patients and families (P&F) during end of life period seems a paradoxical, sarcastic task and deserves unique preparations & assimilations for all members of interdisciplinary teams (IDT), patients and families. Since 2003, the Geriatric-Palliative (GP) department (Hospice) at the Shoham Geriatric Medical Center was trying to achieve two goals: To provide the best comprehensive palliative care to P&F suffering from cancer/non-cancer incurable diseases. To become a leading center for teaching geriatric palliative care.**

Methods: **Our approach is based on a modification of the Maslow's theory of needs insisting on the changing priorities of needs. For dying people, money, propeties, status & entertainment become irrelevant. Basic physiologic needs that, for healthy people seem insufficient and taken for granted (breathing, eating, sleeping, talking, functioning, sphincters' control, lack of pain) - become desirable goals and their achievement perceived as maximal Quality of Life. Our major principles/goals: Facing no cure and imminent death – we should concentrate on qualities that can reallistically be preserved or improved; promoting tight connections to home-care units prefering that the patient dies with dignity at home; when this becomes unbearable for community teams, P&F – the patient is referred to the GP department (not to hospitals); building a geriatric palliative educational program for IDT of different professions in a variety of fields aimed at improving specific therapies, communication skills & care for P&F; Promoting team's pride assimilating the notion that their activity is self-enriching, unique "holy task", indispensable, and makes a real difference for P&F before and after death; Accepting P&F as part of the team in identifying patient's needs, determining treatment policy and preparing for the innevitable death - physicaly, mentaly and spiritualy; repeated discussions for adjusting expectations; active means against polypharmacy; continuity of therapy around the clock; concentrating on permanent pain & symptom relief using medical, psychological and spiritual means even during the period of berievement.**

Results & Conclusion: **In 3/2007, most goals have been achieved using several educational programs to our IDT and improved connections to community home-care units. The feedback questionnaires reveal increasing scores of satisfaction from IDT members, P&F (before and after death).**