will lift and reach to hold again
this broken world by letting go.

***Claude Barbre, PhD, LP**,* is a full professor at The Chicago School of Professional Psychology where he is a board member, training supervisor, and core faculty member. He is the Course-Lead Coordinator of the Psychodynamics Orientation and lead faculty in the Child and Adolescent Studies. Dr. Barbre served for 12 years as Executive Director of The Harlem Family Institute, a New York City school-based psychoanalytic training program. Author of prize-winning articles, books, and poetry, he is a five-time recipient of the international Gradiva Award in four separate categories and of other recent awards. He can be contacted at claudebarbre@earthlink.net. ❑

Dying (Not Only) in Times of COVID-19: Transfer of Dying Patients, its Causes, and Possible Remedies

Karsten Weber—Inst. for Social Res. and Tech. Assess.
Wolfgang M. George—TransMIT Inst. Health Services

Abstract: Death and dying are often not discussed openly in many societies; this has (negative) impacts on the way individuals are treated at the end of their lives. Using Germany as an example, it will be shown that the transfer of dying persons between different nursing and health care facilities leads to a deterioration of the quality of life of dying persons. Causes for the transfers will be identified and some indications for possible improvements will be provided.

Keywords: death, dying, end-of-life-transfers, ethics, Germany, quality-of -life

Introduction: Dying as Part of Life

Whoever wants to think or write about death can hardly get past the writings of the ancient philosophers, and then finds himself in the middle of the history of philosophy, which is still being pushed forward today. In his letter to Menoeceus, Epicurus writes: "Death, therefore, the most awful of evils, is nothing to us, seeing that, when we are, death is not come, and, when death is come, we are not. It is nothing, then, either to the living or to the dead, for with the living it is not and the dead exist no longer." It should be emphasized that this history encompasses more than just European

philosophy, for the world is much larger and many other philosophical traditions would not be covered by a merely Eurocentric perspective.

If one wants to deal not only with metaphysics, but also with practical and thus moral questions, then one can also ask: Can (and should) one provide and take precautions for the existence after death here and now? If death marks the end of one's existence, what does that mean for the shaping of one's life? Is there such a thing as a good death? How do you die well? This is followed by the question of whether there is a moral duty to help other people die well, which immediately provokes the question of whether there are limits to helping that must not be exceeded, even with the best of intentions. At different times, in different cultures and different countries, these questions have been answered in very different ways, even today.

From an even more practical point of view, however, there are many more basic tasks that are not easily solvable. The COVID -19 pandemic reveals, as if under a magnifying glass, what was already wrong before the pandemic when it comes to dying. Even under normal circumstances, the places and institutions in whose care people die are not optimally prepared to facilitate good dying. In the following, therefore, attention will be drawn to a pressing problem: Transferring patients between care facilities at the end of life. If one asks about good conditions for dying (not only) in times of COVID-19, then a central consideration must be how (unnecessary) transfers between care facilities can be avoided. Even if death is none of our business, as Epicurus said, dying is very much our business—as family members, friends, or, one day, we become the people dying. As a rather unwelcomed side effect, the enormous advances in medicine often prolong the time of dying and have transformed it into a highly organized and institutionalized process. The resulting threat is that the person, who should be centerstage during this last phase of life, fades into the background.

A final caveat: We address conditions in Germany exclusively in this text; not all statements will be relevant or applicable to other countries. However, it can be assumed that many of the following statements have a certain general validity. For example, the demographic conditions in Germany are comparable to those in other countries, the taboo on dying and death is not exclusive to Germany, and well-trained caregivers are scarce in many countries.

Transfers at the End of Life and Influential Factors

No matter which surveys you look at, the overwhelming majority of people living in Germany would like to die at home, but only 20% are dying there—three-quarters of all deaths take place in a hospital or nursing home, which can be seen in my (Wolfgang M. George) 2014 study, "Dying in inpatient care facilities: Description of the situation, connections, recommendations" in *Psychosozial Verlag* (the three German articles in this paragraph were translated into English), as well as my study with Dommer and Szymczak in 2013, "Dying in hospitals: description of the situation, connections, recommendations," in *Psychosozial Verlag*. If one understands the choice of one's own place of death as an expression of a person's self-determination, this discrepancy must be irritating. It occurs because the dying persons are often transferred both between different sectors of care, for instance, from a nursing home to a hospital, and/or within the respective care facility, such as from the general to the intensive care unit. About one-fifth of deaths in hospitals and about 25% of deaths in nursing homes are preceded by transfers as seen in my (Wolfgang M. George) 2017 study with colleagues Banat, Herrmann, and Richter, "Empirical findings on the practice of transferring dying people," in *MMW-Fortschritte der Medizin* Vol. 159 (pp. 6-14). These figures are based on a study in which 545 employees from hospitals (n=65) and care facilities (n=101) were surveyed.

Transfers take place because the physicians' professional image is still considerably influenced by the aim of a cure. The focus is therefore on treatment, which can be carried out only to a limited extent in, for example, nursing homes or home environments. Therefore, even patients who will undoubtedly die shortly are often transferred to hospitals or even intensive care units. Yet, the aim of curative treatment must be contrasted with the perspective that, from a certain point on, therapy should no longer be aimed at prolonging life, but at accompanying the process of dying and ensuring the quality of life. However, this change still seems to be difficult for many professional stakeholders.

Due to staff shortages and the resulting excessive demands on existing personnel, there is a high rate of transfers before long holidays or weekends. Given the precarious situations in many hospitals, it is not surprising that transfers are made to intensive care units, which are much better equipped. The often rather inadequate qualifications of the personnel involved in the care of dying pa-

tients, for example regarding end-of-life care, have an aggravating effect. Lack of communication between the stakeholders involved, poor transfer of information between emergency physicians, care management centers, and nursing homes, as well as the lack of involvement of general physicians, make the transfer even more difficult for the dying person. Insufficient communication and ignorance lead to conflicts of competence in multi-professional care teams, which can result in the inability to act. Due to a lack of nursing documentation, the medical on-call service often does not know the medical history of the dying person sufficiently well, so transfers to the hospital are often made as a precautionary measure. No one likes to be held responsible for the death of a person.

Another reason for transfers can be that Specialized Outpatient Palliative Care teams are often only bi-professional (nursing and medical staff) since other specialists are not financed by the cost bearers like, for instance, health care insurance. As a result, services such as psychological support, social services, physiotherapy, or pastoral care are not considered. Finally, in palliative emergencies, there is often pressure from relatives who do not want to accept death and demand curative treatment, leading to hospital admissions.

These are just some of the factors on the part of care providers that lead to stressful transfers. But there are other factors because transfers can originate from the dying person's wish to be surrounded by loved ones and not die alone. If this wish cannot be guaranteed at the current place of residence, this often results in a transfer. A fundamental need of dying persons is also freedom from pain; palliative medicine has been trying to meet this need for some time. In this respect, palliative care departments and hospices are certainly better up to this task than the home environment or even nursing homes. A transfer to palliative care departments and hospices might therefore seem reasonable but may compete with other wishes of the dying person.

Often, dying people see their death and the process leading up to it as a failure or burden on other people, particularly regarding their relatives. Therefore, the role of family members and even friends in the context of the dying process must not be disregarded. Attending to the dying can manifest itself in stressful trauma of family members and friends that is difficult to overcome, especially in the dying person's last days and hours. The relatives' fear of no longer being able to help the person in need of care increases and is

often exacerbated by the burden of decisions to be made, most often under the condition of a lack of knowledge. This situation is worsened by uncertainty, fear of death, and being alone on the part of the next of kin. In addition, relatives are threatened by the danger of social isolation since intensive care of the dying is very time-consuming and most often reduces mental and physical strength that are necessary for maintaining one's own social contacts. This "social death" is accompanied by the risk that caregiving relatives will develop depression. This particularly affects women since the care of the sick and the dying is mostly still women's business.

Conclusion: What Can Be Done?

All the aspects mentioned above are by no means exhaustive of the factors leading to transfers. The death of a person puts many other people in an exceptional situation or emergency that can be extremely stressful. Moral condemnation of those, particularly family members, who arrange the transfer of a dying person, would therefore be inappropriate. As in other medical and caring contexts, a closer look reveals that transfer decisions involve numerous conflicting interests, moral claims, and medical as well as social requirements. In most cases, there is no really good solution to the dilemmas that arise because so many different demands, interests, norms, and values compete and conflict with each other.

The discussion presently seems to be tilting toward emphasizing the autonomy of dying persons and their wishes. Historically, this has not always been the case and need not remain so. Given the already ongoing problem of funding all the measures that would be necessary to be able to offer the necessary care services while preserving autonomy, it is at least conceivable that questions of distribution and justice could once again come to the fore.

The COVID-19 crisis shows us in all clarity that society's approach to the processes of dying and death are deficient. We must learn to make the end of life a part of our lives again. Because death is very personal and, in a sense, it may be none of our business, but dying certainly is an issue of public concern.

Prof. Karsten Weber, PhD*,* is co-head of the Institute for Social Research and Technology Assessment and one of the three directors of the Regensburg Center of Health Sciences and Technology at OTH Regensburg, Germany. He also holds a honorary professorship for Culture and Technology at BTU Cottbus-Senftenberg, Germany. In his scholarly work, Prof. Weber is pri-

marily concerned with the individual and societal impact of new information and communication technologies. He can be contacted at Karsten.Weber@oth-regensburg.de. ***Prof. Wolfgang Michael George, PhD***, is head of TransMIT Institute of Health Services and provider of the German Palliative Care Certificate. He holds an honorary professorship for Ethics and Health Technology Assessment at THM Technische Hochschule Mittelhessen, Germany. He can be contacted at george@transmit.de. ❑

Red Coat

Ted Kooser—Former Poet Laureate

Had you lived longer, perhaps
you might remember, or pretend
to remember, holding my hand
at that funeral on the last day
I'd see you alive, the two of us
meeting in that crowded vestibule
by chance after so many years,
both of us looking for space
on the coat racks, finding none,
leaving our coats on, a topcoat
for me, sweeping red winter coat
with white scarf for you, how
the usher, not sensing the history
flowing into that moment, seated us
shoulder to shoulder in a pew
far at the back. Then you asking if
I'd hold your hand, and I did,
feeling all of those lost years
beginning to pass back and forth
through our hands as we sat
looking forward, proper, respectful,
then stood to sing, fumbling
the hymnal. Would you remember
even a little of that? But you
couldn't remember, as sometimes
I will, how after the funeral you
appeared from the back, walking
away, carefully, lame on your cane
over ice and a little new snow,