One of the saddest images of SARS-CoV-2 pandemic in Italy was the fleet of military trucks transporting the coffins of coronavirus victims out of Bergamo as the local crematoriums could no longer keep up with the dead. COVID-19 has denied dignity to the dead: it isolated people from their loved ones right before they died, and then it did not allow any family or friends around while being buried or cremated. SARS-CoV-2 pandemic hit Italy very hard, with 247,158 cases and 35,132 deaths as of July 30, 2020. According to the International Long-Term Care Policy Network [1], up to 57% of deaths from the virus occurred at long-term care facilities, a number that might be largely underestimated.

Besides some unavoidable strategic mistakes that were made due to the little experience in dealing with the new virus, the demographics and background disease in the population living in long-term care facilities in Italy have undoubtedly played a pivotal role [2]. As reported by the Italian Institute of Statistics, out of 382,634 residents in Italian long-term care facilities, 75.2% were older than 65 years and 57.1% were not self-sufficient [3]. Data of an epidemiological study [4] showed that the mean age of residents at the time of death was over 85 years. 74% of deceased residents had more than two morbidities, more than a half (55.0%) were suffering from very severe dementia, with the worst cognitive status shortly before death. Since the mean length of stay before death was very short (6 months), long-term care facilities are places where people go (are sent) to die when they are highly dependent because of end-stage multimorbidities and advanced dementia, without any chance of shared decision about their end of life. This frail, multimorbid, severely cognitively impaired, non-self-sufficient population formed a very easy harvest for the SARS-CoV-2 to mow down. Would this scenario had been the same if we cared more for quality than quantity of life? Are we actually practicing a patient-centered and a narrative medicine approach when taking care of these persons? When caring for the older patient’s health, do we see dignity, namely autonomy, identity, and worthiness, as the core value of health? Lastly, can we honestly affirm that these patients would have not chosen to avoid medical cures aimed to lengthen life, had they better understood their medical choices and the tradeoffs they were going to deal with? No clinician, no specialty, no patient is immune from this problem, whose causes are manifold: fee-for-service payment, paucity of strong clinical evidences, fear of liability and subsequent defensive medicine when dealing with patient and patients’ relatives, who believe that there’s always one more test, one more treatment, one more journey of hope. End-of-life discussions in Italy are still too often a taboo subject, and public perception of death as a medical culpable failure is deeply rooted. As difficult as it is, this topic needs to be addressed to manage medical treatments and to reduce overuse of medical services for older, frail patients with serious, chronic conditions. Fostering and nurturing hope even at the end of life is significant, though it cannot translate to patients into increased pain and suffering. In the Atlantic Monthly in January, 1957, an anonymous American wrote “There is a new way of dying today. It is the slow passage via modern medicine. … If you are going to die, it can prevent you from so doing for a very long time” arguing that modern medicine “made dying … an ordeal which has somehow deprived death of its dignity.” [5]. If we want to restore dignity to death, cancel the 1957 Atlantic Monthly prophecy and never see again in Italy the tragic images of SARS-CoV-2 victims carried away by military trucks, we need to change the culture of medicine, stop lip service and effectively promote knowledge, training and access to palliative care, implement shared decision making and advanced care planning, and, overall, debunk the views of the power of medicine to prevent death as its foremost
purpose. Nowadays, whether SARS-CoV-2 is getting weaker and kills much less people than before is a matter of very heated debate among academic, prime time virologists in Italy. As a hospitalist, I sadly believe that SARS-CoV-2 just killed the ones who were to die: the multimorbid, severely cognitively impaired, non-self-sufficient older patients that we had sentenced to life in long-term care facilities, enduring the dying process pursuing quantity of life in spite of quality of life and the right to a dignified death.

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Compliance with ethical standards

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