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A Note on Medical Sciences, Good Death and Good Dying

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Abstract: This Note explores the distinction between “good death” and “good dying” in relation to advancement of medical sciences. Although advances in medical science have extended life expectancy, living longer does not necessarily ensure dignity, comfort, and/or psychological well-being at the end of life. We take a position that death is an event, whereas dying is a process shaped by symptom management, communication, family presence, psycho-social support, and ethical care. It further highlights the paradox that medical progress may prolong life while simultaneously widening the gap between longevity and quality of life, particularly among socially isolated older population. Accordingly, this paper calls for attention to palliative care, end-of-life, and dignity-based practice to reduce suffering in the final stage of life.

Keywords: good death, good dying, end-of-life care, palliative care, quality of life, aging population, medical school curriculum

INTRODUCTION

The concept of good death raises a contradictory narrative. There is no such thing as a “good death” as death usually accompanies with pains and fear. Anticipation of death causes immense stress for immediate family and loved ones who are watching them in struggle for last ounce of breath before they die. Accordingly, research subject should not be on “good death”, rather our conversation should focus on “good dying”.

Dying is a journey (process) and death is the outcome from the journey. Journey could be peaceful or painful and turbulent. Accordingly, we can manage “good death” only if we manage “good dying process”. We all accept death, but dying process differs by individuals, their behavior/anticipation, societal norm, region and national conversations.

It is a painful, dramatic and emotional experiences for everyone surrounding the patients who are in the dying process. How about the patients in question? There are few researches on how patients feel about their last breath in this planet (Kubler-Ross,1969). Wolf extended the above research to how patients who just expired feel about heaven (Wolff, 2021).

Increase in life expectancy, thanks in part to advancement of medical sciences, added another dimension to the journey toward the end of life. We live longer than any other generations. Extended life expectance brings a joy for life, but also it causes unanticipated misery for those who live longer alone with poor health condition neglected by family and abandoned by society. Those especially who live longer alone with many old-age health related issues regard “wonder” of modern medical advancement as causes of their misery rather than a gift of joy.

Prioritizing medical advancements and technological achievements is undeniably crucial for optimizing therapies and treatments; however, this general focus significantly puts aside the critical goal of alleviating suffering in dying patients (Kim, Kwon and Kim, 2026).

Extended life expectancy, precipitated by medical sciences advancement, but not emotionally supported by modern family structure, places those in their end-of-life cycle into deep depression to the point some of them wish to end their own life than prolong their misery. They are searching for “good death” rather than suffering from loneliness isolated from and abandoned by their family, friends and community. Many elderly people at this stage give up their will of living and looking for alternative way ending their life.

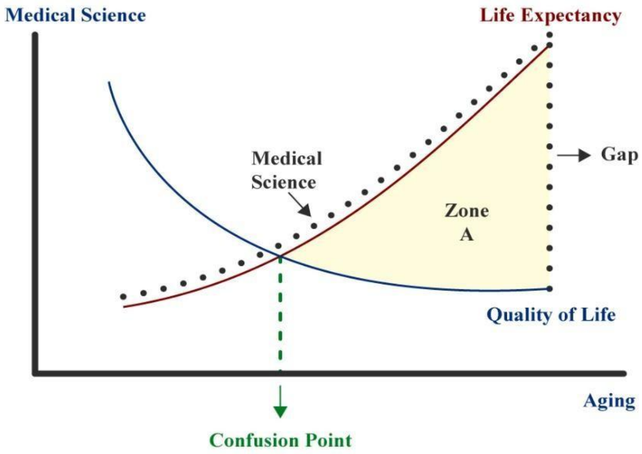

Figure 1: Medical Science, Drug and Misery of EOL (End-of-Life Care)

Adopted with approval from Cure vs. Care: Case in Korea (Kim, Kwon, and Kim, 2026).

Figure 1 above illustrates the paradoxical relationship between medical sciences, life expectancy and the degree of misery for older population who are at the end-of their life cycle. As the pace of medical science advancement accelerating, the life expectancy also increases along with the medical science path. Increase in life expectancy, however, does not accompany the quality of life of those in their “twilight” zone. As a matter of fact, research reveals the quality of life for those in their end-of-life cycle is deteriorating as fast as new innovation in medical sciences, but in opposed direction. The more “medical miracle”, the higher level of misery for the elderly population who are in their end-of-life cycle stage. The gap between these two opposing trends, however, is getting wider creating so-called “misery zone” (Zone A). The Zone A is getting wider as life expectancy increases along with medical science advancement.

Seniors become confused at a certain point in their life where the life expectancy curve (once considered a joyful journey) intersects the quality-of-life curve which is deteriorating over the life span (confusion point). Medical advancement failed to anticipate the serious consequences it creates, misery of quality of late life. The biomedical model is often rigidly adapted and perpetuated, further sidelining the humanistic aspects of care (Kübler-Ross, 1969: Linois *et al.*, 2025).

BARRIERS TO GOOD DYING

Medical school curriculum is blamed for not-to-care of isolated seniors. Curriculum is loaded with so-called “technical knowledge” to prolong senior’s life span (Patterson et al., 2023). Medical profession in their medical school training has not been exposed to humanistic side of care under the pretext of “that is not their areas of training”. Extending human-life without care of the consequences creates inhuman abandonment of seniors. Curriculum in the medical schools has seldom addressed this late life human misery that they help to have created.

Another key barrier is the limited interest among medical professionals in topics related to end-of-life care (Alanazi et al., 2024). Research reveals a significant variation in the type and content of EOL training in U.S. medical schools. With an explosive increase in aging population, knowledge about death, dying, loss, grief, and end-of-life (EOL) care is an essential skill for most physicians. Yet, EOL education has been minimally incorporated into medical school curricula in the United States; there is a significant need to better prepare medical students for the unique challenges of improving patient wellbeing at end-of-life (Patterson et al., 2023).

One study even reveals a troublesome finding that the senior medical doctors who have an extensive experience in dealing with death and dying are more reluctant to discuss the topic claiming that it is not their domain to discuss with patients in dying and family of such patients (Kübler-Ross, 1969). If senior physicians with years of experiences in dealing with patients in imminent death or dying are reluctant to discuss his/her patient’s medical status openly with patient and his/her family, it creates additional anxiety and emotional stress for patients and their family.

A lack of uniform definition of “good death” poses a significant challenge to addressing a framework for future research in this important area.

LITERATURE REVIEW ON “GOOD DEATH” VS. “GOOD DYING”

Is there such thing as “a good death”? Death is not a process. It is a moment of truth where life ceases to exist. Death does not have pain and discomfort. As soon as one is born, he/she marches toward unavoidable journey toward death, our final destination. Medical sciences along with so-called “miracle/wonder” drugs may have prolonged our life expectancy. However, a longer life expectancy does not necessarily create “joy of life” for those who suffer from social isolation (Kim, Kwon and Kim, 2026).

A patient who faces imminent death seldom experiences/feels pains due in part with bombardments of “wonder” drugs. Yet, they do feel and aware of the process of “dying”. Person in a dying bed feels how he/she wishes to be treated by the care-givers, family, friends and community. They feel pains (to be relieved mainly by wonder drugs) and loneliness (to be relieved by family) and discomfort (to be relieved by care givers). In many occasions, however, they feel lonely from isolation. Therefore, the real focus of our research should be on how we manage the dying person by providing comfort and minimize their psychological pain from isolation, e.g. more on death doulas and less on medical intervention.

When patients are in this stage of dying, they seldom ask for additional medical intervention. Rather they seek for community of care givers who help them feel easy emotionally and comfortable physically for the last few days in their life. One research (Meier *et al.,* 2016) discovered that the top three themes across all stakeholder groups on dying patients include preferences for dying process (94% of reports), pain-free status (81%), and emotional well-being (64%). According to the Institute of Medicine report published 19 years ago, a good death is one that is “free from avoidable distress and suffering for patient, family, and caregivers, in general accord with the patient’s and family’s wishes, and reasonably consistent with clinical, cultural, and ethical standards.” It should be pointed out, however, that this concept has received some critique in several disciplines, including medicine, psychology, theology, sociology, and anthropology. In particular, concern has been raised that there is no such thing as an external criterion of a good death and that it is more dependent on the perspectives of the dying individual.

On the other hand, Curtis, Downey and Engelberg (2013) define good death as “the degree to which a person’s preferences for dying and the moment of death in agreement with observations of how the person actually died, as reported by others.” Meier *et al.* (2016) expanded definition of good death to 11 core themes: preferences for a specific dying process, pain-free status, religiosity/spiritualty, emotional well-being, life completion, treatment preferences, dignity, family, quality of life, relationship with HCP, and other. The top three themes across all stakeholder groups, according to their study, were preferences for dying process (94% of reports), pain-free status (81%), and emotional well-being (64%).

According to an Institute of Medicine report, a good death is one that is “free from avoidable distress and suffering for patient, family, and caregivers, in general accord with the patient’s and family’s wishes, and reasonably consistent with clinical, cultural, and ethical standards.” (Field and Cassel,1997). However, this concept has received some critique in several disciplines, including medicine, psychology, theology, sociology, and anthropology. In particular, concern has been raised that there is no such thing as an external criterion of a good death and that it is more dependent on the perspectives of the dying individual. As noted above, literature has been focused mainly on “good death” rather than “good dying”. Emphasis on good death is frozen in time space on outcome oriented, while focus of “good dying” rests on process how patients wish to spend their rest of life until such time that their life expires. These two areas of research are different in approach and emphasis. Accordingly, research outcomes render dramatic different results and implications in death and dying. Research focus on difference between good death and good dying requires different resource requirements, different set of emotional supports, and different national policies in managing aging population.

SUMMARY AND CONCLUSIONS

As population is aging and living longer than any other periods, issues dealing with aging population and subsequent death and dying require a serious and honest national discussion apart from emotional narratives of this journey. Discussion on death and dying is beyond emotional plain field. It is a process that we should prepare and address to minimize pain and suffering that older people face in their final phase journey in life.

This Note attempts specifically to address differences between “Good Death” and “Good Dying”. The former describes the end of life, a momentous event, whereas the later describes a process that a patient has to go through from initial diagnosis of terminal illness to the end of life (EOF). The process could be a short or it could be a long and painful journey. Healthcare provider’s responses to each of the two episodes are different in scope, intensity, and resource requirements. Patients in “good death” desire to be surrounded by community of family, friends, and religious who minimize the sense of isolation and loneliness in dying bed. Patients in “good dying” would like to be fully informed of the process, e.g. where they are heading with complete and comprehensive information that provides them with anticipatory outcomes.

This Note attempts to highlight a serious gap that currently exists between medical school curriculum in this important issue and the reality of dying process. A lack of and/or absence of adequate training in this important part of their mission at medical school would hamper the most important mission and obligation that they were trained for; reliving physical as well as emotional pain and make their patients comfortable during the last phase of patient’s journey. Healthcare professionals should be aware of and trained for emotional aspect of dying process which is to some extent more important than death itself.

REFERENCES

Alanazi, MA., Shaban MM., Ramadan OME., Zaky ME., Mohammed HH, and Amer FGM. (2024). Navigating end-of-life decision-making in nursing: A systematic review of ethical challenges and palliative care practices, BMC Nursing, 23(1): 467. Available at: doi: 10.1186/s12912-024-02087-5.

Curtis, R., Downey, L., and Engelberg, R. (2013). The quality of dying and death: Is it ready for use as an outcome measure? CHEST, 143(2): 289-291. Available at: doi: 10.1378/chest.12-1941.

Field, MJ. and Cassel, CK. (1997). Approaching Death: Improving Care at the End of Life. Washington (DC): National Academy Press (US). Available at: DOI: 10.17226/5801.

Institute of Medicine (1997). Approaching Death: Improving Care at the End of Life. Washington, DC: The National Academies Press.

Kim, Sung-Ho, Kwon, Ik-Whan G. and Kim, Hanjun (2026). Cure Vs. Care: Case in Korea, British Journal of Healthcare and Medical Research, 13(1): 183-189. Available at: https://doi.org/10.14738/bjhr.1301.19835.

Kübler-Ross, Elisabeth (1969). On death and dying: what the dying have to teach doctors, nurses, clergy and their own families. Scribner (New Yok)

Lionis, C., Phellas, C., Samoutis, G., Anastasaki, M. (2025). Practical end-of-life recommendations for primary care to support dying with dignity. Academia Mental Health and Well-Being, 2(2):1-10.

Meier, E., Gallegos, J., Montross-Thomas, L., Depp, C., Irwin, S., and Jeste, D. (2016). Defining a Good Death (Successful Dying): Literature Review and a Call for Research and Public Dialogue. American Journal of Geriatric Psychiatry, 24(4): 261–271.

Patterson, L., Decker, A., Weaver, R., Bolkan, C., King, A., and Roman, A. (2023). Death and dying education in US medical school: a scoping review. Innovation in Aging, 7(Supplement 1): 311.

Wolff, Catherine (2021). Beyond: How Humankind thinks about Heaven. Riverhead Books.