

The High Cost of a Medicalized Death: Are We Heading in the Right Direction or Is It Time for a Change?

The medicalization of death refers to the process by which dying is increasingly viewed and treated as a medical issue, often leading to interventions that may not align with patients' desires or values.¹ This phenomenon has been shaped by historical, cultural, and systemic factors, resulting in a healthcare model that prioritizes hospital-based care at the end of life.^{2,3}

Every year, millions of people spend their final days in hospitals, hooked to machines and surrounded by strangers, rather than at home with loved ones. This is the reality of medicalized death—a phenomenon that prioritizes aggressive interventions over patient autonomy and dignity. Some people have argued that medicalization can provide necessary support and pain management for patients at the end of life, ensuring comfort and dignity. This perspective emphasizes the role of medical professionals in facilitating a "good death" through appropriate interventions.⁴ This editorial highlights the issue of medicalization in context of a developing country like Pakistan with limited resources and some possible solutions

Medicalization can rename normal variations in human experience, like menopause,⁵ or aging, as medical conditions. It can also involve expanding the boundaries of existing medical diagnoses to encompass a wider range of behaviors or experiences. The rise of the hospital-centric healthcare system has normalized this approach. Medicalization has transformed natural life processes, from birth to death, into medicalized events demanding intervention.⁶ While advancements in medicine have undoubtedly resulted in remarkable progress, this paradigm shift has often overshadowed the inherent naturalness and deep personal dimensions of these experiences. Birth, once a communal celebration, is now predominantly managed within the sterile confines of hospitals,⁷ frequently accompanied by unnecessary interventions.⁸ Similarly, menopause, a natural transition, is often pathologized as a deficiency disease. Getting grey hairs and aging gracefully is now frequently viewed through the lens of decline rather than being embraced as a natural stage of life. However, the biggest impact of medicalization is seen at the time of death, where the focus on prolonging life at all costs can lead to unnecessary expenses, a denial of the natural dying process, and a profound erosion of dignity.⁹

The emphasis on aggressive interventions for prolonging life through medical means may not align with the patient's wishes or quality of life. This has gradually shifted our understanding of death from a natural transition to a medical event, something to be fought and conquered, rather than accepted as an inevitable part of the human experience.¹⁰

Hospitals around the globe are buckling under the strain. Emergency rooms overflow, operating theaters hum with constant activity, and intensive care units are often functioning at capacity.¹¹ This is not only due to a rise in acute illnesses. A major portion of this burden results from the over-medicalization of death. This global phenomenon has transformed the natural transition of the final chapter of life into a costly, often dehumanizing, battle against an inevitable outcome. Beds that are desperately needed for patients with treatable conditions are often occupied by elderly individuals in their final stages of life, undergoing a relentless barrage of medical interventions that often serve only to prolong suffering rather than improve quality of life. The financial cost is obviously very high, but the emotional toll on families and the erosion of dignity for the dying are even more profound. It is time to confront this uncomfortable truth: we have medicalized death to an unsustainable degree, and the consequences are rippling through our healthcare system and our society. The exorbitant cost of ICU stays, often running into millions, is a stark illustration of this unsustainable burden.

The modern hospital, with availability of high-quality acute care and technological gadgets, has become the default setting for death. While medical advancements have undoubtedly saved countless lives,¹² the over emphasis on aggressive intervention has extended far beyond its appropriate boundaries. It is now encroaching upon the natural process of dying. This has resulted in death is viewed as a medical failure or an enemy which should be vanquished at all costs,¹³ rather than a natural conclusion to a life well lived. This mindset has led to a culture of aggressive, often inappropriate, medical interventions, pushing doctors into a defensive position where they feel compelled to "do everything," even when it offers little to no realistic benefit. The result is a tragic paradox: we spend vast sums of money to extend life

by a few days or weeks, often in a state of diminished capacity and increased suffering, while neglecting the crucial need for palliative care that focuses on comfort, pain management, and emotional support for both the dying and their families.

The human cost of this medicalized death is immense. Individuals often spend their final days in the sterile, impersonal environment of the ICU, hooked to a machine via multiple tubes, separated from the comfort of home and the embrace of loved ones.¹⁴ This focus on prolonging life through medical means often overshadows the importance of addressing the emotional and spiritual needs of the dying. Conversations about end-of-life wishes are often avoided, leaving families unprepared and overwhelmed when faced with critical decisions. The result is a loss of control for the dying individual, a diminished sense of dignity, and a profound sense of grief for families who witness their loved ones subjected to interventions that may offer little more than a fleeting extension of life.

The financial cost of medicalized death can be high. In Pakistan, where healthcare resources are already limited, the overuse of intensive care units (ICUs) and aggressive interventions for terminal patients strains the system and diverts resources from those with treatable conditions. A significant portion of healthcare expenditures is spent on end-of-life care, often with little to no improvement in patient outcomes. The resources spent on futile treatments could be better allocated to expanding palliative care services, which are virtually nonexistent in most parts of Pakistan. By prioritizing comfort and dignity over aggressive interventions, palliative care aligns more closely with both Islamic values and the cultural preferences of Pakistani families.¹⁵

The root of the problem lies in a complex interplay of factors. Our cultural discomfort with death, coupled with the relentless pursuit of technological solutions, has created a system that prioritizes prolonging life at all costs, often without considering the quality of that life. Families, understandably, cling to hope, often unwilling to accept the inevitable. Doctors, faced with legal pressures and the emotional weight of end-of-life decisions, may feel compelled to offer aggressive treatments even when they are unlikely to be beneficial. The result is a vicious cycle of over-

medicalization, escalating costs, and diminished quality of life for the dying.

Breaking this cycle requires a fundamental shift in our approach to death and dying. We need to move away from the notion that death is a medical failure and embrace the understanding that it is a natural part of life. This requires fostering open and honest conversations about death and dying, empowering individuals to make informed choices about their end-of-life care.¹⁶ We need to expand access to palliative care and hospice services, ensuring that those nearing the end of life receive the comfort, support, and dignity they deserve. This means focusing on pain management, symptom control, and emotional and spiritual support, allowing individuals to live as fully as possible until the very end.

We must educate the families about the natural process of dying, providing counselling and emotional support at a difficult time of losing a dear one. This will likely help them understand when aggressive interventions are unlikely to be beneficial and when focusing on comfort and quality of life is the most compassionate choice.¹⁷ This requires a shift in our cultural mindset, moving away from the idea that "doing everything" is always the best approach and embracing the concept of "doing what matters most" for the individual nearing the end of life.

We would like to clarify that our recommendation for demedicalizing death is not about giving up on care but about reclaiming control at the end of the life. It is about recognizing that death is a natural part of life and that our goal should be to help individuals live as fully and comfortably as possible until the very end, surrounded by love and dignity, not trapped in a cycle of futile medical interventions. It means shifting our focus from fighting death to supporting life, even as it ebbs away. It is time for a change – a change that will benefit patients, families, and our healthcare system as a whole. Finally embracing a compassionate, holistic approach to end-of-life care allows us to honor life's final chapter with dignity, focusing on comfort and love rather than futile medical interventions.

REFERENCES

1. Lantz PM, Goldberg DS, Gollust SE. The Perils of Medicalization for Population Health and Health Equity. *Milbank Q* 2023; 101(S1): 61-82. <https://doi.org/10.1111/1468-0009.12619>

2. Field D. Palliative medicine and the medicalization of death. *Eur J Cancer Care (Engl)* 1994; 3(2): 58-62. <https://doi.org/10.1111/j.1365-2354.1994.tb00014.x>
3. Van Dijk W, Faber MJ, Tanke MA, Jeurissen PP, Westert GP. Medicalisation and Overdiagnosis: What Society Does to Medicine. *Int J Health Policy Manag* 2016; 5(11): 619-622. <https://doi.org/10.15171/ijhpm.2016.121>
4. Koksvik GH, Richards N, Gerson SM, Materstvedt LJ, Clark D. Medicalisation, suffering and control at the end of life: The interplay of deep continuous palliative sedation and assisted dying. *Health (London)* 2022; 26(4): 512-531. <https://doi.org/10.1177/1363459320976746>
5. Munshi A, Garg R. The Medicalization of Menopause: Understanding the Evolution of Treatment Approaches. *J Midlife Health* 2024; 15(3): 133-134. https://doi.org/10.4103/jmh.jmh_153_24
6. Garber J. The medicalization of death: What does it mean and what can we do about it?. Available at: <https://lowninstitute.org/how-death-became-medicalized-and-what-we-can-do-about-it>
7. Niino Y. The increasing cesarean rate globally and what we can do about it. *Biosci Trends* 2011; 5(4): 139-150. <https://doi.org/10.5582/bst.2011.v5.4.139>
8. Visser GHA, Ubom AE, Neji K, Nassar A, Jacobsson B, Nicholson W, et al. FIGO Childbirth and Postpartum Hemorrhage Committee*. FIGO opinion paper: Drivers and solutions to the cesarean delivery epidemic with emphasis on the increasing rates in Africa and Southeastern Europe. *Int J Gynaecol Obstet* 2023; 163(2): 5-9. <https://doi.org/10.1002/ijgo.15111>
9. Akdeniz M, Yardımcı B, Kavukcu E. Ethical considerations at the end-of-life care. *SAGE Open Med* 2021; 9: 20503121211000918. <https://doi.org/10.1177/20503121211000918>
10. Hannig A. Demedicalising dying: medicine must accept death as a natural part of life. *BMJ* 2024; 387: q2703. <https://doi.org/10.1136/bmj.q2703>
11. Angus DC, Barnato AE, Linde-Zwirble WT, Weissfeld LA, Watson RS, Rickert T, et al. Robert Wood Johnson Foundation ICU End-Of-Life Peer Group. Use of intensive care at the end of life in the United States: an epidemiologic study. *Crit Care Med* 2004; 32(3): 638-643. <https://doi.org/10.1097/01.ccm.0000114816.62331.0>
12. Mahara G, Tian C, Xu X, Wang W. Revolutionising health care: Exploring the latest advances in medical sciences. *J Glob Health* 2023; 13: 03042. <https://doi.org/10.7189/jogh.13.03042>
13. Gellie A, Mills A, Levinson M, Stephenson G, Flynn E. Death: a foe to be conquered? Questioning the paradigm. *Age Ageing* 2015; 44(1): 7-10. <https://doi.org/10.1093/ageing/afu116>
14. M.R. Rajagopal MR, Rattanani J. The medicalisation of death: Isolation of the dying is cruel. <https://www.southasiamonitor.org/perspective/medicalisation-death-isolation-dying-cruel>
15. Abdullah R, Guo P, Harding R. Preferences and Experiences of Muslim Patients and Their Families in Muslim-Majority Countries for End-of-Life Care: A Systematic Review and Thematic Analysis. *J Pain Symptom Manage* 2020; 60(6): 1223-1238.e4. <https://doi.org/10.1016/j.jpainsymman.2020.06.032>
16. Sutherland R. Dying Well-Informed: The Need for Better Clinical Education Surrounding Facilitating End-of-Life Conversations. *Yale J Biol Med* 2019; 92(4): 757-764.
17. Keeley MP. Family Communication at the End of Life. *Behav Sci (Basel)* 2017; 7(3): 45.

Corresponding Authors:

Prof. Imran Ahmad
Department of Neurology, Quetta institute of Medical Sciences , Quetta, Pakistan

Co-Author:

Prof. Farooq Azam Rathore
Department of Rehabilitation Medicine, Quetta institute of Medical Sciences , Quetta ,Pakistan