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COMMENTARY

Starting from the end: The cemetery as a learning venue

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Abstract

Medical students encounter patient deaths throughout their training and tend to cope with death under the pretence of curing to fight off the imminence of death, rarely pondering the true meaning of mortality. This assumed numbness often makes them harsh, insecure, and somehow oblivious to the human plight of patients and their families. The Covid-19 pandemic has made the need for reflection on mortality even more significant. This commentary discusses a cemetery visit as part of the clinical ethics training of medical students. On this "existential trip", students address their perceptions, fears, and beliefs about death and dying, opening their eyes to the reality of the profession of medicine. This form of experiential learning aims to awaken students to the inevitable fate they share with their patients, dispelling the illusion of being infallible physicians, thus helping shape empathetic future physicians sensitised to the unuttered distress of dying patients and their caregivers.

Keywords: *experiential learning, medical ethics, death, cemetery, existential distress, reflection*

"The fact of death is unsettling. Yet there is no other way to live."

- Paul Kalanithi, "How long have I got left?" [1]

Introduction

The confrontation with mortality is an inevitably intense existential experience uncovering the bare reality of our finite existence. For medical students and physicians, this encounter is constantly around the corner, a lived experience that is part and parcel of their professional lives. Often, they have to escort patients across the threshold of death, navigating the biological complexities of dying, as well as the profoundly personal (often unspoken) existential anxieties that come with it. Patients and family members who are aware of the precariousness of their situation, have a heightened sensitivity to the emotional nuances of these interactions. They perceive the difference between blunt and cold pronouncements and empathy and genuine expression, between detached clinical observation and true human connection. The shadow of relinquishment, specifically by pronouncements of "Do Not Resuscitate/Intubate" or palliative care, add to the patient's and family caregivers' sense of isolation and fear. Having worked in the wards for quite some time and taught ethics in the confines of classrooms, one thing became clear to me: empathy and understanding are not innate gifts but need to be cultivated through experience, reflection, and a willingness to confront our own mortality. Hence, a form of learning is needed that engages with life and death at a visceral level. The idea of learning at the tomb side came to mind, not as a ghastly exercise, but as a potentially transformative pedagogy. By confronting the tangible reality of mortality, the lives that have come before and the pains that emerge and, at times, linger obstinately, medical students might cultivate a deeper, more authentic understanding of the human condition, fostering the genuine empathy and compassion patients need on life's final journey. Medical schools across the globe have witnessed several changes in their curricula overtime. What remains common is that first year medical students, for the first time, face their first patient — the cadaver.. Literature [2,3,4,5] on the importance of the anatomy course abounds, and reveals how this course often desensitises students and pushes them, albeit unintentionally, into viewing the patient as a disease, a number, or a case, instead of a human being with all the complexities that this entails. In general, medical students in Lebanon enter medical school with one main objective — at least, as they state in their applications — that of curing disease and saving lives. They envision themselves becoming superheroes in a white coat who fight the enemy (death), and cure patients from their physical ailments. Yet, curing does not always happen. Medical students have to face the deaths of their patients, more often than cure: when prolonging ailment and disease is often a source of discomfort. Yet almost all physicians in the world, particularly young ones, are prey to a subconscious illusion: immortality. As they wear their white coats, auscultate with their stethoscopes, or use the scalpel, they feel so powerful that the idea of personal death often eludes them. Studies linking the moral erosion of medical students and the white coat abound, reporting that instead of being donned in humility, it fuels in them a feeling of boundless quixotic power, which eventually turns into an illusion of supremacy over illness [6]. It is this moral erosion which turns the patient into a number or a disease in the mental eye of the clinician and tarnishes the profession of medicine. At least, students rarely ponder over their own mortality, where death is viewed as "the other", just like the dying and their families. This assumed haughty numbness makes them harsh and somehow oblivious to the human plight of the patient and his family.

What is needed, therefore, is an awakening of medical students from their dogmatic slumbers by providing them with an opportunity to appreciate the inevitable fate that

they have in common with their patients. The cemetery can be the place of their first clinical ethics class.

The cemetery visit as a cure for hubris

With wars and pandemics escalating globally, deciding who gets the ventilator during scarcity, who should be triaged as a priority, is becoming ever more frequent and complex. I felt it would be beneficial for second year medical students to journey to the cemetery to walk as future professionals dealing with life and death and sense the silence of the dead and hear the whispers of the living to those who are no more. Numerous studies [7, 8, 9, 10] have addressed the experiences of medical students and trainees with the deaths of patients, including their perceptions and attitudes towards dying. Thus, the need arises for an inclusive approach towards death and dying in pre-clinical and clinical curricula [11,12,13]. While these studies have reflected on the impact of clinical and personal encounters with death, few have highlighted the importance of physicians pondering over their own mortality, something potentially essential early in their training. Thus we, at the Salim El-Hoss Bioethics and Professionalism Program (SHBPP), at the American University of Beirut, developed a new clinical ethics session which takes students from their class desks on a field trip to the cemetery for experiential learning of the meaning of facing death. Whitehead explains that what makes experiential learning a powerful pedagogical tool is that it moves the learner from the traditional passive stance of a classroom setting to a more engaged, emotional and conceptual level [14]. Aristotle's observation "for the things we have to learn before we can do them, we learn by doing them" [15] is built on two cornerstones — experience and reflection. Learning at the tomb-side was a challenging, bold idea not easily accepted by the medical education team. Their unwillingness was enhanced by the need for finance for booking a bus, ensuring students were well chaperoned, and preparing to address the emotional reactions of students in a culture where death is not easily accepted. The course proposal was first met with scepticism by the office of Medical Education, but we persisted and managed to gain approval to take up the challenge. As the first session of the Clinical Ethics and Patient Care module, part of the Physicians, Patients and Society 2 (PPS-2) course, which emphasises the biophysical, psychological, spiritual, humane and social factors in medicine, as well as an introduction to addressing ethical conundrums, the visit to a cemetery near the medical school campus was arranged. While this cemetery is dedicated to those of the Sunni Islamic faith, the choice of this location was made primarily for logistical reasons and facilitated approval procedures, since the Makassed Foundation which administers the cemetery has multiple ongoing collaborations with our programme and institution. The students were informed beforehand that they would be visiting an off-campus location with bus transportation provided, and they were requested to dress demurely.

On the bus, students were briefed about the purpose of the trip and asked to inform the instructor of any personal objections or issues because of which they could not proceed with the session. After a brief introduction, two fellow residents who were invited to chaperone the session shared personal stories of their first-hand encounters with the death of a family member and how their experiences impacted them and helped shape their attitudes and behaviour within medical practice. Students were then invited to share any relevant personal anecdotes. At the cemetery, the instructor, residents, and students were accompanied by the cemetery caretaker who provided a brief background about the cemetery and the burial and visit practices, highlighting the offering of prayers at the entrance to the cemetery. The students were invited to participate in placing a bouquet of fragrant boxwood branches, a local tradition used to honour the dead. They were then asked to disperse into small groups and visit a couple of graves while taking note of their impressions of the burial sites. Students were asked to look for any information they could find about the deceased, age, profession, socio-economic status, or any other details reflecting the life story of that person. After the exercise, students gathered in the condolences hall adjacent to the cemetery. The hall had actually been prepared to host condolences in a few hours after the class. As such, the setting was ready, the signs announcing the death of the departed, his photo on the condolence sheet, chairs organised and a big sign on the wall attesting to the finitude of existence. In the corner, a desk and microphone were ready for a sheikh to come and recite verses from the Quran when actual condolences began.

Discussion

The purpose of this exercise was to draw students' attention, albeit indirectly, to the fact, that while people from different backgrounds and socio-economic status are buried in the cemetery, they all "end up in the same place" (in the cemetery) and face a similar destiny by virtue of human mortality. They were also accompanied to an open grave to appreciate the size and loneliness of the grave as well as the journey into nothingness. As a folk story goes, a sultan once asked members of his court to have his casket carried on the shoulders of physicians, to keep his hands dangling from the casket and to spread his money and jewelry on the road to the cemetery. The point being to tell the world that doctors can never halt death, that humans come empty handed into the world, accumulate wealth, and then leave, once again empty handed — a lesson in life and humility. The graveside visits lasted 20 minutes, after which students were asked to convene in an adjacent hall, where funeral services are usually held. Inside, the floor was opened for discussion, whereby a number of students shared their findings, first thoughts, and comments about the exercise. Student reflections echoed similar realisations with regard to

mortality, the meaning of death, and the impact it leaves. The few excerpts below capture the essence of the students' experiences during this activity:

> *"I noticed that I had been unconsciously seeking graves that looked 'special' […] but to my surprise, I was really not able to make anything of the person buried beneath that grave. It suddenly hit me that even in death we as people tend to seek things that stand out, when in fact the end result is really the same. It didn't matter whether the person was rich or poor, old or young, famous or unknown; everyone was under the same dirt, and nature was doing what nature does. As I stood there, I gazed at a grave for what felt like an hour, and I just thought: some time from now, someone will be staring at my grave, maybe even thinking about their own mortality. […] That's really what life is all about: be as good as you can to as many people as you can, this life is passing through you just as much as you are passing through it. Memento mori, always." – Student A*

> *"It was said 'there are multiple causes that end at the same result of death'. I say no one is an exception to this, including myself and every physician colleague. The important thing is to remind ourselves of this truth with every patient encounter." – Student B*

> *"It is crucial for us medical students to get to know death, its consequences, its ambiguity, and its eternal scar on humankind. This visit to the cemetery triggered so many existential questions and introduced us to the concept of death from a humanitarian perspective, instead of a medical one." – Student C*

> *"[This experience] is enlightening and makes us not just more self-conscious and aware of life's ephemerality, but also empathetic and aware of others' lives and feelings too." – Student D*

The visit to the cemetery is a reminder of mortality and finitude, both one's own and that of others. It also serves to help future physicians appreciate that the family is also a patient by extension. The moment of clinical death is not the actual end since the family still experiences the ripples of the existence of the deceased, taking time to realise the finality of the situation and heal from the loss slowly. As one student simply put it:

> *"This trip […] helped me merge matters of the brain and science with matters of the heart. It harmonized them in a way that I can't imagine being a good doctor without being in touch with my sensitive and caring self. It shaved all the science that piles up when I look at a patient and reminded me that at the end of the day, I am dealing with a human, someone's parents, sibling, spouse, child, not a worksheet".*

The cemetery as the first learning venue for aspiring doctors meant experience and reflection, in addition to introspection, which allowed them to comprehend the patient not as a distant "other", but a possible "me", who needs to be understood, empathised with, and cared for before that day comes. Often, medical students and physicians find themselves having to work with patients on the verge of death. The existential dimension of death is one of the most important and delicate aspects of any conversation. Patients question whether the discussion is authentic or not, whether the physician is truly empathetic, and whether there is some salient form of abandonment in case these patients are labelled "Do Not Resuscitate"/ "Do Not Intubate", or placed in palliative care. Consequently, the conversations fail in their intended effect [11,12,13], at times even having the opposite effect, and the patient/family are left with painful unuttered distress, which may be referred to as "existential distress", that lingers.

Equally important are communication and empathy with caregivers and family members, those left behind after the death of a loved one, which can effectively reduce their distress over time. This is precisely why, at least in our tertiary care hospital, students of medicine are taught, that they have more than one patient. Namely, the patient and his/her family/caregivers [16]. Rolla was one such patient. She was diagnosed with cancer and got all the recommended treatment. Thankfully, her illness did not recur for a full year. One day, she felt terribly tired and overwhelmed with angst. She went to her oncologist, a saviour in her eyes, hoping that she would hear only good news. That morning, she was accompanied by her sister and a nurse to the doctor's office. They sat in front of him for the longest 10 minutes ever as he was talking over his phone in a jovial mood. While they were irritated by the wait and the sounds of their heartbeats reaching the end of the corridor, they convinced themselves that all was well, since the doctor was in a cheery mood. Then, as if noticing their impatience, he pushed his phone away from his ear in a sudden gesture, looked her in the eye and said: "Ah yes, your illness has recurred, and you are going to die". He then brought the phone back to his ear for a few more minutes. While discussing the nature of such a clinical encounter is beyond the scope of this article, suffice it to say that the importance of attending to conversations of end-of-life in their "existential dimensions, particularly in terms of their impact on the occurrence of these conversations, the nature of relationships and responses within these conversations, and the fluidity of meaning within these conversations" was simply absent [17]. What made this renowned physician so insensitive to the fear that the idea of death awakens in his patients and their families? What is it that made him forget that for him too, "breath might become air", to borrow from Paul Kalanithi [18]. In his book, Kalanithi reveals the turmoil of a doctor becoming a patient: "Death, so familiar to me in my work, was now paying a personal visit" [18]. Kalanithi stopped being aware of the extent to which his body had strength and when he attempted to gauge this, the consequences were devastating. He became a stranger to himself as his entire identity was irreversibly shaken. When his empathic and caring physician was away, he understood what it meant to

be reduced to a case, a number, a disease, by incompetent residents. Thus, he states, "What patients seek is not scientific knowledge that doctors hide but existential authenticity each person must find on her own. Getting too deeply into statistics is like trying to quench a thirst with salty water. The angst of facing mortality has no remedy in probability."[1] As Paulo Coelho once noted, "A brush with death always helps us to live our lives better."[19] Applied to medicine, this brush makes the physician more humane and understanding. More appreciative of the life–death spectrum. The hospital setting is not a kind place, the hospital is where we all go when we are facing, as patients and as doctors, our own and others' mortality. No one likes going to the hospital, often viewed as a gate to the fearful unknown. While every human already knows that he is mortal, it is only in such painful situations and settings that the reality of mortality hits us harder than expected, as if it is staring coldly and harshly into the eyes of the ephemeral beings that we are. Sudden illness alters the person's personal narrative and by extension, her personal identity. The fabric that constitutes the patient's life often negates the existence of death as imminent in an oceanic defence mechanism rooted in the collective mortal unconscious. It is this defence mechanism that keeps us going. Once end-of-life is formally declared, once a serious visit to the ICU marks an open parenthesis of the human narrative, this defence mechanism is shattered, though in varied time frames. Death, the enemy of life and everything sweet, surfaces like an invisible stain on the surface of the cloth, penetrating it like an unwelcome hole. The disease becomes the focus of the patient and his family; behaviours change to adapt to the grim newcomer [20].

The patient, being a multifaceted and multi-linked entity incorporates his family's reactions and behavioural changes into his routine and being. The patient's life is a fabric and woven together into his extended self is his family.

For the physician to view the patient as a monad, a complete and separate entity apart from his family is akin to pulling one thread out of the fabric and observing it. The single thread would tell you nothing about the textures, colours, or thickness of the fabric and reveal a lack of skill and professionalism. Future physicians need to revisit the way they view, or dismiss, death.

Death revisited

At the end of JK Rowling's *The Tale of the Three Brothers,* the youngest brother having attained a great age, willingly passes on the cloak of invisibility, which allowed him to elude death so far, to his son, "and then he greeted Death as an old friend, and went with him gladly, and, as equals, they departed this life." [20] Death is part and parcel of life, as cultures throughout history [21, 22, 23, 24] have accepted, with its own rituals. With the successes of modern western medicine, society veered away from that natural and traditional view of death; and both society and the medical profession began to view the physician's role as that of combating death. Extending life became the holy grail for the "knights of the white coat", bolstered by the rapid pace of technological advances in medicine, intubation, dialysis, to mention but a few. Gawande notes that "For all but our recent history, death was a common, ever-present possibility. It didn't matter whether you were five or fifty" [25]. Whether in a white coat or a hospital robe, we all share the essential fact of being mortal. We should stay aware that dying is a process that a patient undergoes with both their physical bodies, and while still alive, their consciousness. This is best illustrated when talking about palliative care at the end-of-life, which is a discipline involving both patient and caregiver, with care at the centre.

During the white coat ceremony in which students participate before their clinical years, they are adorned with the coat's glamour and asked to take a solemn oath Some physicians to be look at the coat wondering how to keep it clean and well ironed, thinking this is the reflection of professionalism and a mark of prestige. Others dream of the time when they will walk the hallways wearing it or stroll down the streets with their stethoscope dangling over it thinking: "I am a physician". However, the truth is that the coat will start making more sense when it is ragged, stained, and worn; when it will remind its wearer not only of her successes, but also of her failures. Not when it is shiny white and smells fresh, but when it smells of the first patient's hug, or is drenched in a patient's or his relative's tears. It says: "You were there, for him/her".

In an address to medical students during the white coat ceremony, I, as the then Director of the Medical Ethics Center, had reminded the class of 2014 that:

> *Your first coat will be a tapestry, a narrative that speaks of you as a physician who will (or will not) make a difference in the lives of patients, and in your own life: If you choose to be one who makes a difference, you will metamorphose from a "skilled technician" (sometimes wrongly called a "doctor") to a healer, and by that you will touch immortality.*
>
> *The oath you are taking is the first step on a journey; you are pledging to lead a life marked by ethics, honour and professionalism as a student and soon, a physician. Your coat is your witness to that. Wear it with pride, you have earned it. But also with humility: Who knows whose life will be leaning on you soon."[26]*

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References

1. Kalanithi P. How Long Have I Got Left? *The New York Times.* 2014 Jan 24[Cited 2024 Sep 9];SR: 9. Available from: https://www.nytimes.com/2014/01/25/opinion/sunday/how-long-have-i-got-left.html
2. Stanford K, Rutland S, Sturrock CJ, Rutland CS. The Importance of Anatomy. *Front. Young Minds.* 2020 Dec;8:546763. http://dx.doi.org/10.3389/frym.2020.546763
3. Santana LI, Buchaim DV, Hamzé AL, Reis CHB, de Souza Bueno CR, et al. The History of Anatomy, its importance and new trends in the teaching/learning process. *Arch Anat Physiol.* 2022;7(1):001-004. https://doi.org/10.17352/aap.000018
4. Charkhat Gorgich EA, Sarbishegi M, Barfroshan S, Abedi A. Medical Students Knowledge About Clinical Importance and Effective Teaching Methods of Anatomy. *Shiraz E Med J.* 2017 Sep 16;18(12):e14316. https://doi.org/%2010.5812/semj.14316
5. Dempster M, Black A, McCorry N, Wilson D. Appraisal and Consequences of Cadaver Dissection. *Med Educ Online.* 2006 Dec; 11(1):4592. https://doi.org/10.3402/meo.v11i.4592
6. How moral distress leads to erosion of clinicians' moral strength in healthcare systems. University of Pennsylvania School of Nursing; 2019 [Cited 2024 Sep 25]. Available from: https://www.news-medical.net/news/20190923/How-moral-distress-leads-to-erosion-of-clinicians-moral-strength-in-health-care-systems.aspx
7. Hinzmann D, Wijnen-Meijer M, Corazza L, et al. Experiences of medical students and nursing trainees from unexpected death through simulation training. *BMC Med Educ.* 2023 Sep 14;23(1):667. https://doi.org/10.1186/s12909-023-04638-x
8. Ye WQW, Griffin C, Sverdlichenko I, Vegas DB. The impact of patient death experiences early in training on resident physicians: a qualitative study. *CMAJ Open.* 2023 Oct 31:11(5): E1006-1011. https://doi.org/10.9778/cmajo.20230011
9. Lisai-Goldstein Y, Shaulov A. Medical Students' Experience of a Patient's Death and Their Coping Strategies: A Narrative Literature Review. *Am J Hosp Palliat Care.* 2025 Apr;42(4):413-420. https://doi.org/10.1177/10499091241264523
10. Dharmatika IMP, Suhoyo Y, Prihatiningsih TS. Medical students' experiences with dying patients: identifying educational needs in the eastern context. Jurnal Pendidikan Kedokteran Indonesia: *The Indonesian Journal of Medical Education.* 2023 Jul;12(2):135-143. https://doi.org/10.22146/jpki.80697
11. Karlsson M, Milberg A, Strang P. Dying with dignity according to Swedish medical students. *Support Care Cancer.* 2006;14(4):334-339. https://doi.org/10.1007/s00520-005-0893-5
12. Smith-Han K, Martyn H, Barrett A, et al. "That's not what you expect to do as a doctor, you know, you don't expect your patients to die." Death as a learning experience for undergraduate medical students. *BMC Med Educ.* 2016;16:108. https://doi.org/10.1186/s12909-016-0631-3
13. Hull FM. Death, dying and the medical student. *Medical Education.* 1991Nov;25(6):491-496. https://doi.org/10.1111/j.1365-2923.1991.tb00103.x
14. Hoover JD, Whitehead C. An experiential-cognitive methodology in the first course in management: Some preliminary results. *Simulation Games and Experiential Learning in Action.* 1975;2. [Cited 2024 Sep 09]. Available from: https://journals.tdl.org/absel/index.php/absel/article/view/2787
15. Aristotle. *Nicomachean Ethics.* Ross WD, translator. Book 2 [cited 2024 Sep 09]. Available from: https://classics.mit.edu/Aristotle/nicomachaen.mb.txt
16. Bates AT. Addressing existential suffering. *BCMJ.* 2016 Jun[cited 2024 Sep 09];58(5):268-273. Available from: https://bcmj.org/articles/addressing-existential-suffering
17. Schulz VM, Crombeen AM, Marshall D, Shadd J, LaDonna KA, Lingard L. Beyond Simple Planning: Existential Dimensions of Conversations With Patients at Risk of Dying From Heart Failure. *J Pain Symptom Manag*. 2017 Nov;54(5):637–644. https://doi.org/10.1016/j.jpainsymman.2017.07.041
18. Kalanithi P. *When Breath Becomes Air.* New York: Random House; 2016. p. 121.
19. Coelho P. *The Zahir: A novel of obsession.* Costa MJ, translator. New York: HarperCollins; 2005.
20. Rowling JK. *Harry Potter and the Deathly Hallows.* New York, NY: Arthur A. Levine Books; 2007.
21. Anderson G. *Death: The trip of a lifetime.* Renaissance Books; 1998.
22. Rinpoche S. *The Tibetan Book of Living and Dying.* HarperSanFrancisco; 1992.
23. Ariès P. *The hour of our death.* Weaver H, translator. Alfred A. Knopf; 1981. Originally published: 1977.
24. Hoefler JM, editor. *Death and dying: Current controversies.* ABC-CLIO; 2015.
25. Gawande A. *Being Mortal: Illness, Medicine and What Matters in the End.* New York, NY: Metropolitan Books; 2014. p. 25.
26. Arawi T. [Speech]. [cited 2024 Sep 09]. Available from: https://www.aub.edu.lb/fm/shbpp/Documents/arawisspeech.pdf