

End of life: the Buddhist view

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This is the fourth Viewpoint in a series about end-of-life issues for different religions.

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In many Asian cultures, Buddhism is acknowledged as the religion that has most to say about death and the afterlife. Buddhist teachings emphasise the ubiquity and inevitability of death, and for this reason, Buddhists tend to be psychologically prepared to accept impending death with calmness and dignity.

Buddhism imposes few special requirements on patients or physicians, and there is no reason why the terminal care of Buddhist patients should pose any specific problems. The only exception would be that if the patient is a monk or nun, it would not be appropriate for them to be on a mixed ward, and preferable for them to be treated by a physician of the same sex. Attitudes in this respect vary with the age and cultural background of patients, but nowadays there is increasing acceptance of treatment by physicians and nurses of the opposite sex, especially where medical resources are limited.

Buddhism is a flexible and moderate religion that has little time for rigid formalities. Concepts of taboo and religious purity have little, if any, part to play and religious law imposes no special requirements or limitations on medical treatment. There are no special hygiene, purification, or dietary requirements (many Buddhists are vegetarians but not all). Cremation is the most common way of disposing of the dead.

In practice, local custom will have a greater bearing on the physician-patient relationship than Buddhist doctrine. It is difficult to generalise about local customs, but provided the conventions of normal medical etiquette are respected, there is no reason why difficulties should arise. This is particularly so in the case of the many people from the developed world who have converted to Buddhism and who are unlikely to have any problems with the conventions of modern medical practice.

One point to note is that mindfulness and mental clarity are important values for Buddhists, hence the importance placed on meditation. Buddhism emphasises the importance of death with an unclouded mind wherever possible, because it is believed that this can lead to a better rebirth. Some Buddhists may therefore be unwilling to take pain-relieving drugs or strong sedatives, and even those who are not in a terminal condition might prefer to remain as alert as possible, rather than take analgesics that would impair their mental or sensory capacities.

Buddhist values

In Buddhism, there is no central authority competent to pronounce on matters of doctrine or ethics, nor is there a college or other body of Buddhist medical practitioners that exists to provide guidelines or codes of conduct for the health-care professional. Instead, individuals must follow their consciences, which should be informed by reflection on scriptural teachings, custom and tradition,

and the opinions of distinguished teachers. Despite the absence of central authority, there are fundamental moral values and principles that virtually all schools of Buddhism accept. Chief among these are compassion and respect for life, which underpin the Buddhist approach to medical ethics and have a considerable bearing on end-of-life issues.

Defining death

According to Buddhist teachings, a life in any one existence begins at conception and ends at death: in the interval between these events, the individual is entitled to full moral respect, regardless of the stage of psychophysical development attained or the mental capacities enjoyed. According to the most ancient authorities, death occurs when the body is bereft of three things: vitality (ayu), heat (usma), and sentiency (viññana). The problem for contemporary Buddhists is to express these three traditional indicators in terms of the concepts of modern medical science—eg, do they correspond to the modern standard of brain death? Although heat is straightforward, the other two indicators pose hermeneutical problems that make a simple resolution of the question difficult.¹ It is interesting that the ancient scriptures record that when the Buddha died, he was at first mispronounced dead by his attendant of 25 years, Ananda. Ananda was then corrected by a senior monk who stated that the Buddha had simply entered a profound state of yogic trance in which no vital signs can be discerned. If such physiological states do exist, and they are well attested in Buddhist literature, then the scope for error in determining death is clearly increased. Therefore, opinion among Buddhists is divided. Some think that brain death correlates with the ancient criteria whereas others do not.¹

In Japan, the criterion of brain death is deeply unpopular because of its association with cadaver transplants. Japanese Buddhists have been influenced by Confucian teachings concerning the importance of family relationships, and especially the importance of the bond between parents and children. Being a part of what is seen as the desecration of the corpse of a close relative causes deep unease.² Recent revelations about the pressure exerted to declare death so as to allow the first heart transplant have done nothing to calm this unease. Raymond Hoffenberg, the consultant who certified the donor as dead, recently admitted that he did so on no acknowledged criteria. Although Hoffenberg strongly supports the 1976 criterion of brain stem death as defined by the UK Conference of Royal Colleges and their faculties, characterising it as robust and reliable,³ there is increasing scepticism about the brain death criterion being a reliable test for human death.^{4–6}

Persistent vegetative state

By contrast with the problem of defining death, there is no disagreement between traditional Buddhism and modern science with respect to the status of patients in a persistent vegetative state. Patients in this state are sometimes said to exist in a twilight condition suspended between life and death, but in terms of both Buddhist philosophy and the current medical standard of brain death, it is clear that they are alive. They are not corpses, are not dependent on life-support machines, and are capable of remaining alive for many years if supplied with nourishment. This view is also undisputed legally.⁷

From the Buddhist perspective, the patient in a persistent vegetative state is a living human being who has sustained an injury to part of the physical organism. Such a patient should not, in principle, be treated differently from any other patient. The Buddhist analysis of the vegetative condition is that damage to a physical organ (the brain) prevents sentience (*viññāna*) from functioning in one of its primary modes, namely mental awareness (*mano-viññāna*). However, irreversible damage to the neocortex is no more significant for Buddhists than damage to any other organ when considering the ethics of treatment.

For Buddhists, all people, regardless of their physical condition, are worthy of compassion, and to exclude patients in a persistent vegetative state from this view and withdraw the basic necessities of life would be arbitrary and unjust. Even unconscious patients can remain the focus of human emotions and be recipients of compassionate concern. They provide an opportunity for others to exercise goodwill, and through benevolent treatment of them, others can affirm solidarity with them even under the most adverse conditions.

Seen in these terms, caring for these patients is not a pointless exercise but an affirmation of the bond of social communion. To reject and abandon them would be a denial of the universal compassion, which Buddhism greatly emphasises. The provision of food and hydration should, at least presumptively, be continued. However, this provision does not extend to patients with secondary complications.

Euthanasia

Euthanasia is the intentional causing of the death of a patient by act or omission in the context of medical care. Here, we are concerned only with voluntary euthanasia, which is when a mentally competent patient freely requests medical help in ending his life. No terms are synonymous with euthanasia in early Buddhist sources, nor is the morality of the practice discussed in a systematic way.^{8–12} However, given that monks were active as medical practitioners, circumstances occasionally arose when the value of life was called into question. These circumstances are outlined in certain case histories preserved in the Monastic Rule (*Vinaya*), a

corpus of canonical literature whose main purpose is to lay down the regulations governing monastic life.¹³

The cases relevant to euthanasia are recounted under the rubric of the precept against the destruction of human life (the third *parajika*; one of the four most serious offences in the monastic code that are punished by lifetime expulsion from the monastic community). In the 60 or so cases reported under this rubric, about a third are concerned with deaths that took place following medical intervention of one kind or another by monks. In some of these instances, the death of a patient was thought desirable for quality of life considerations, such as the avoidance of protracted terminal care (*Vinaya*, volume 2, p 79)¹³ or to minimise the suffering of patients with serious disabilities (*Vinaya*, volume 2, p 86;¹³ no motive was given in this case, but since it concerns the care of a patient with amputated limbs, it seems reasonable to regard it as a case of mercy-killing).

The Buddha included this precept in the monastic code to prohibit conduct of this kind on discovering that several monks had either killed themselves or asked others to kill them after developing disgust for their bodies, an attitude not unknown in ascetic traditions. After some monks convinced a patient that death was a better option for him than life, the Buddha expanded the definition of the precept to include incitement to death:

“Should any monk intentionally deprive a human being of life, or look about for a knife-bringer [to help him end his life], or eulogise death, or incite [anyone] to death saying ‘My good man, what need have you of this evil, difficult life? Death would be better for you than life,’—or who should deliberately and purposefully in various ways eulogise death or incite [anyone] to death: he is also one who is defeated [in the religious life], he is not in communion.”

Vinaya, volume 3, p 72¹³

This amplification of the scope of the precept is particularly important in the context of euthanasia, since the weight of the case for allowing euthanasia rests on the postulate that death would be better than life, especially when, to quote the precept, life seems “evil and difficult”. The prohibition on taking life would therefore seem to extend to both the assistance of suicide (including physician-assisted suicide) and euthanasia.

Compassion

However, as noted earlier, compassion is also an important Buddhist moral value. This is particularly so when linked to the concept of the *Bodhisattva*, a Buddhist saint distinguished by self-sacrificing compassion for others. Some sources reveal an increasing awareness of how a commitment to the alleviation of suffering can create conflict with the principle of the inviolability of life. Compassion, for example, might lead a person to take life in order to alleviate suffering, and is one of the main grounds on which euthanasia is commonly advocated.

The question of mercy killing arises in the Monastic Rule, in the first of the cases to be reported after the precept against killing was declared (*Vinaya*, volume 2, p 79).¹³ In this case, the motive for bringing about the death of the patient is stated to have been compassion (*karuna*) for the suffering of a dying monk. According to the influential fifth-century commentator Buddhaghosa, those found guilty in this situation took no direct action to terminate life, but merely suggested to a dying monk that death would be preferable to his present condition (*Samantapasadika*, volume 2, p 464).¹⁴

Despite this apparently benevolent motive—ie, to spare a dying person unnecessary pain—the judgment of the Buddha was that those involved were guilty of a breach of the precept. What had they done wrong? In Buddhaghosa's analysis, the essence of their wrongdoing was that they "made death their aim" (*marana-atthika*). It would therefore appear immoral, from a Buddhist perspective, to embark on any course of action whose aim is to destroy human life, irrespective of the quality of the individual's motive. We may therefore conclude that while compassion is always a morally good motive, it does not by itself justify whatever is done in its name.

Must life be preserved at all costs?

Does the foregoing mean that Buddhism teaches that life must be preserved at all costs? At one point in his commentary, Buddhaghosa has a brief but interesting discussion about the situation of terminally ill patients, in which two contrasting scenarios are mentioned:

"If one who is sick ceases to take food with the intention of dying when medicine and nursing care are at hand, he commits a minor offence (*dukkata*). But in the case of a patient who has suffered a long time with a serious illness the nursing monks may become weary and turn away in despair thinking 'when will we ever cure him of this illness?' Here it is legitimate to decline food and medical care if the patient sees that the monks are worn out and his life cannot be prolonged even with intensive care."

Samantapasadika, volume 2, p 467¹⁴

The contrast in Buddhaghosa's discussion appears to be between the person who rejects medical care with the express purpose of ending his life, and the person who resigns himself to the inevitability of death after treatment has failed and the medical resources have been exhausted. The moral distinction is that the first patient seeks death or "makes death his aim", to use Buddhaghosa's phrase, whereas the second simply accepts the inevitability and proximity of death and rejects further treatment or nourishment as pointless. The first patient wishes to die; the second wishes to live. However, the second patient is resigned to the fact that he is beyond medical help.

This example suggests that Buddhism does not believe there is a moral obligation to preserve life at all costs. Recognising the inevitability of death, of course, is a

central element in Buddhist teachings. Death cannot be postponed forever, and Buddhists are encouraged to be mindful and prepared for the evil hour when it comes. To seek to prolong life beyond its natural span by recourse to increasingly elaborate technology when no cure or recovery is in sight is a denial of the reality of human mortality, and would be seen by Buddhism as arising from delusion (*moha*) and excessive attachment (*tanha*).

In terminal care, and in cases where persistent vegetative states have been conclusively diagnosed, there is no need to go to extreme lengths to provide treatment if there is little or no prospect of recovery. Thus, there would be no requirement to treat subsequent complications—eg, pneumonia or other infections—by administering antibiotics. Although an untreated infection might be seen to lead to the patient's death, it would also be recognised that any course of treatment that is contemplated must be assessed against the background of the prognosis for overall recovery. Rather than embarking on a series of piecemeal treatments, none of which would produce a net improvement in the patient's overall condition, it would often be appropriate to reach the conclusion that the patient was beyond medical help, and allow events to take their course. In such cases, it is justifiable to refuse or withdraw treatment that is either futile or too burdensome in light of the overall prognosis for recovery.

The hospice movement

Rather than introduce euthanasia as an option in terminal care, Buddhism would support the ideals of the hospice movement. The San Francisco Zen Center has offered facilities for the dying since 1971, and started a full-scale training programme for hospice workers in 1987. In 1986, the Buddhist Hospice Trust was founded in the UK. Although not a hospice, this organisation exists to explore Buddhist thinking on matters relating to death, bereavement, and dying. It also provides access to a network of volunteers who visit the dying and bereaved at their request.

Conclusion

The care of Buddhist patients in the end-of-life phase should pose few special problems for the physician. Buddhism teaches that death is an integral part of life, and by virtue of their belief in rebirth, Buddhists believe that death is an experience they will undergo many times. The paradigm example of meeting death is that of the Buddha, who died in a serene and mindful state aged 80 years. However, the definition of death is problematic, and physicians should not assume that the criterion of brain death will be accepted by all Buddhists. Japanese patients, in particular, are likely to reject it, along with the practice of cadaver transplants (transplants from living donors should not pose a problem). Nutrition and hydration should presumptively be continued for patients in persistent vegetative states,

but there is no requirement to treat secondary complications.

Euthanasia is rejected by most Buddhists as contrary to the First Precept, which prohibits intentional killing. This applies even when motivated by a compassionate desire to relieve suffering. However, in this respect, Buddhism adheres to the principle of the middle way (*majjhima patipada*),¹⁵ and the prohibition on euthanasia does not imply a commitment to vitalism, namely the doctrine that life should be prolonged at all costs. The withdrawal of medical intervention when the end is nigh is accordingly not seen as immoral.

Conflict of interest statement

I declare that I have no conflict of interest.

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