AN ANALYTICAL STUDY OF EUTHANASIA IN BUDDHISM: A CASE STUDY OF BUDDHADASA BHIKKHU’S DEATH

MR. SUPRE KANJANAPHITSARN

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN RELIGIOUS STUDIES

GRADUATE SCHOOL OF PHILOSOPHY AND RELIGION
ASSUMPTION UNIVERSITY OF THAILAND
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ABSTRACT

This research illustrates the issue of euthanasia to enhance understanding on the subject matter as well as analyze and apply the acquired knowledge to remind people of all religions of having the right attitude towards death and preparing the way to confront death which occurs in all the time properly. The scope of this research is focused on euthanasia in Buddhism through analyzing the case of Buddhadāsa Bhikkhu's death with an aim of comparing various notions and opinions issued by various scholars.

The aim of this research is to analyze euthanasia in Buddhism through the original teachings in the Buddhist texts, mainly in Theravāda and various scholars' ideas; and also to critically analyze and comparatively evaluate the lesson of Buddhadāsa Bhikkhu's death to offer a practical method for adjusting attitudes of people of all religions towards death and a guideline for solving controversial issues of
euthanasia. I also want to assert that doctors should acknowledge and accept a patient’s right to refuse medical treatment and allow them to die naturally if the patient’s wishes does not violate the moral precept of their religious beliefs.

This research presents and illustrates the textual approach to qualitative research. The primary sources of my data were the ‘Pāli Canon’ (Tipiṭaka) and its ‘commentaries’ (āṭṭhakathā). Secondary sources were books by well-known scholars in the field of Buddhist bioethics. I categorized and analyzed all the collected data to present a clear picture of the issue of euthanasia from a Buddhist perspective. The case of Buddhadāsa Bhikkhu’s death and his interpretations of the application of Buddhist teachings are one possible way to resolve the issue of euthanasia and help Thai medical practitioners to prepare a system of proper hospice care that will assist patients in attaining inner tranquility, allowing them to die in peace naturally.
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LIST OF ABBREVIATIONS USED IN THIS THESIS

Buddhist texts:

A : Aṅguttaranikāya
D : Dīghanikāya
DA : Dīghanikāya Aṭṭhakathā or Sumaṅgalavilāsinī
Dhp : Dhammapada
KvuA : Kathāvatthupakkaraṇa Aṭṭhakathā
M : Majjhimanikāya
S : Saṁyuttanikāya
Vin : Vinaya Pitaka
VinA : Vinaya Aṭṭhakathā or Samantapāsādikā

For example: (D II 305)

D = Dīghanikāya
II = Volume II
305 = Page number

Other Abbreviations:

AMA : The American Medical Association
WMA : The World Medical Association
CHAPTER I

INTRODUCTION

1. Background and Significance of Research Problems:

In modern times, and with the rise of advanced medical sciences and technologies, artificial life-sustaining mechanisms/machines can prolong life, or even prolong death, with regards to patients who are in a coma or a persistent vegetative stage. Some patients can be kept alive against their will, whilst simultaneously being in states of pain and suffering (*dukkha*). Added to that, some patients, including their families and relatives, may experience pressures in terms of financing medical treatment. Some patients may choose to receive physician assisted suicide in order to save money of their loved-ones. Some family members, and relatives, may instead opt for the performance of euthanasia because they are spending too much of their own money, or they choose to release the patient from pain and suffering (*dukkha*). In cases like these, the uses of artificial life-sustaining technologies have introduced moral battles which concern the continuation, or the withdrawal, of medical treatment.

The prolonging of life, or the prolonging of the dying process, can cause suffering (*dukkha*) in a patient’s body and mind, and it can also be said that that can destroy human dignity, and be dehumanizing. Therefore, there has been a call for the introduction of the 'right of self-determination'. That is to say ‘request the medical practitioner to perform euthanasia’, either by injecting a lethal dose of drugs, or the withdrawal of medical treatment. The act of euthanasia, acted out by medical
practitioners, raises problems in relation to the medical, legal, ethical and moral issues. However, most conventional medical practitioners insist upon the ‘Hippocratic Oath’ being their ‘duty’. An ‘Oath’, which was written by Hippocrates, a man often regarded as the father of Western medicine, once quoted, “I would never give a deadly drug to anybody if asked for it, nor will I make such a suggestion to that effect” (Tulloch, 2005, p.31).

On the contrary, Margaret Pabst Battin, an associate professor of philosophy at the University of Utah, claimed that: “Many proponents of euthanasia argue that the Hippocratic Oath must be redefined, so that doctors may disconnect life-support systems of the brain dead and of terminally ill patients” (Bernards, ed, 1989, p.17). According to Margaret Pabst Battin’s idea, that then raises specific issues about; ‘Can the life of an unrecoverable patient be corrupted by a medical practitioner, in his performing euthanasia, or by his withdrawal of life-prolonging treatment?’

To revisit, and to have a clear understanding of the definition of euthanasia, the term euthanasia originated from the Greek word meaning a good death. The term euthanasia has been divided into various dimensions by philosophers. Based on the patient’s condition, it has been divided into two main types. Active euthanasia is intentionally causing a patient’s death by means of an action performed such as the administration of a lethal drug. Passive euthanasia is causing the death of a patient by withholding or withdrawing necessary and/or extraordinary medical treatment, food and fluids, which is allowing the patient to die (Gifford, 1993, p.1546). Based on the
patient's degree of voluntariness this has been divided into three types. Voluntary
euthanasia is euthanasia that is provided in response to the request for the ending of life
by a competent patient. Non-voluntary euthanasia is the decision to end an incompetent
patient's life by someone other than the patient. Involuntary euthanasia is the ending of
the life of a competent patient without his or her informed consent. In total, we can
identify six categories of euthanasia: voluntary active, voluntary passive, non-voluntary
active, non-voluntary passive, involuntary active and involuntary passive (AMA, 1992,
p.2230).

Under the laws and legislation of each country, the rights of a patient who would
like to act out euthanasia are accepted in some countries. The Netherlands was the first,
amongst a few others, which legalized voluntary euthanasia. However, the performance
of euthanasia by medical practitioners is only legal in cases of hopeless and intolerable
suffering. In addition, helping somebody to commit suicide without the agreement of
the medical practitioner, and without knowledge of euthanasia law, is clearly illegal.
There are conflicting questions as to how we make sure that the diagnoses of medical
practitioners are correct. It seems as if a person can give the right to kill to medical
practitioners. Medical practitioners use their full efforts and knowledge to cure patients,
or perhaps not, in certain circumstances. Medical practitioners may perform euthanasia
without medical treatment, and for reasons which may not be totally apparent.
Nowadays, under section 12 of the Thai National Health Act of 2007, that section legislates the right for the self-determination of a patient, in the final stages of his or her life, through an advanced directive or ‘living will’ as follows:

“A person shall have the right to make a living will in writing, in order to refuse public health services offered, and which are merely provided to prolong his/her terminal stages of life; or to make a living will to refuse those services in order to cease severe suffering from illness. The living will, under paragraph one, shall be carried out in accordance with the rules and procedures described in the ‘Ministerial Regulations’. Any act performed by public health personnel, in compliance with the living will, under paragraph one, shall not hold any persons accountable for any offence. Thus, no persons will be liable for the taking of any responsibility, whatsoever.” (The Council of State, 2007, p.4)

Professor Vitoon Eungprabhanth gave one definition of the rights of a patient as thus: “the rights of a patient, who has full consciousness, are to reject treatment that prolongs life or delays death, when preferring to die naturally, and with the prestige of a human being” (Eungprabhanth, 1994, p.177). He also insisted that the patient should have the right to reject medical life-prolonging instruments, in that:

“Scientific evolution and advanced medical technologies employ medical instruments that can prolong a patient’s life, but sometimes they cause that patient to fall in to a state where they ‘cannot be recovered or cannot die’. That is to say, the patient must receive the application of a respirator and, in turn, receive oxygen day and night. While the patient may not have consciousness, or may possess a small amount of consciousness meaning it is very hard to return to a normal state, this kind of rescue can be considered as dehumanization. Therefore, the patient should have a right to die by rejecting this kind of rescue, in order for them to fully avoid dehumanization in the dying process.” (Eungprabhanth, 1994, pp.92-93)

The researcher observe that his idea clearly supports section 12, in allowing persons to have the right to refuse medical treatment based upon their own wishes and
beliefs. In other words, section 12 also helps the medical practitioner to perform voluntary passive euthanasia, and 'legally'. However, a member of the National Legislative Assembly, Somkiat Onwimon argued, referring to section 12, suggesting that a patient must write an advanced directive, or a living will, in order to ask for his or her own death by refusing medical treatment. In fact, a comatose patient has no consciousness that can provide an advanced directive or a living will and, therefore, the permission for the right to die by refusing medical treatment. Moreover, it does not contain the consent of a patient to permit the attending doctor to stop all life-support systems lawfully. Those could be considered as 'performance of euthanasia'. That is to say, the patient vests the right to kill along with the doctor. Although the patient has his own rights, there still remain questions about what the conditions are that confirm that the patient will certainly die. There are no medical sciences that can provide confident answers for such, if and when a doctor decides to remove a life-support system.

Moreover, the adjunct professor Judge Vichai Ariyanutaka, Chief justice of the Labor Court of Thailand, offered his opinion in a seminar on the topic of euthanasia, in that: “the right to end life is a moral and philosophical problem. The correct principle is to firstly find moral and philosophical answers, and then the law should reflect a moral answer or a philosophical answer pertaining to social agreement” (Professor Jitti Tingsapat, Fund & the Medical Council of Thailand, 2000, p.13).

In Thai society, underpinned by the teachings of Theravāda Buddhism, a person consists of both 'bodily processes' (rūpa) and 'mental process' (nāma) which are
divided into ‘five aggregates’ (pañca-khandha) and these ‘five aggregates’ (pañca-khandha) are comprised of ‘bodily processes’ (rūpa), ‘sensation’ (vedanā), ‘perception’ (saññā), ‘mental formations’ (sañkhāra) and ‘consciousness’ (viññāna), which are all related to one another (S III 47, as quoted in Phra Brahmagunabhorn, 2008, p.162).

Whenever these ‘five aggregates’ (pañca-khandha) and their fifty-two components, comprised of twelve sense organs and objects, eighteen elements and twenty-two controlling powers, are exhausted, the person dies (KuvA I I).

Based upon Pāli Canon, ‘The Great Discourse on Steadfast Mindfulness’ (Mahāsattipatthāna Sutta) describes the word death (maranā) as follows:

“And what, bhikkhus, is ‘death’ (maranā)? The departing or vanishing, the destruction or disappearance; are they death? The completion of a life span, the dissolution of the ‘aggregates’ (khandha), the discernment of the body, and the destruction of the physical life-force of beings in this or that class of ‘being-this’. Bhikkhus, is that called death?” (D II 305, Jotika & Dhamminda, tr, 1986, p.32) ¹

In ‘The Middle-Length Discourses’ (Majjhimanikāya), it questions the three qualities of the death of a physical body as thus: “With regard to this body, your reverence, when three things cease; vitality, heat and consciousness, then does this body

¹ katamañca bhikkhave maranam: yañ tesam tesam sattanam tamha tamha sattanikāyā cuti cavanatā bheda antaradhānaṃ maccumaranam kālakiriya khandhānaṃ bhedo kālebarassa nikhepo jīritindriyassupaccho, idaṃ vuccatti bhikkhave maranam. (D II 305)
lie cast away, flung aside like unto a senseless wooden log?” (M I 296, Horner, tr, 1995, p.356).

Even though there is a Buddhist proverb: “Let a man sacrifice his wealth for the sake of his limb. Let him sacrifice his limb for his life’s sake. But, with respect to righteousness, let him part with his wealth, limb, life and all” (Phra DevaDilaok, 2007, p. 37); that does not mean Buddhism teaches that one either hastens death, nor saves life, at all costs. Buddhism would admit autonomy of the individual, based upon the teachings of the law of kamma, in that the individual has freedom, and must be responsible for his or her own moral choices; and with a freedom that warrants limitation by the principles of precepts. The first precept of a layperson is to abstain from destroying living beings; not only other’s lives, but also the inclusion of one’s own life. The Buddha also established the third ‘rule pertaining to the expulsion from monkhood’ (párájika), as appeared in ‘The Book of the Discipline’ (Vinaya) saying, “Whichever monk should intentionally deprive a human being of life, or should look about so as to be his knife-bringer, he is also one who is defeated and is not in communion” (Vin III 70, Horner, tr, 1992, p.123). These precepts for Buddhist monks should be applied to the field of euthanasia, because these precepts are directed at the medical practitioner who lends assistance to the patient in the ending of his or her life;

\[\text{yādā kho āvuso imaṁ kāyaṁ tayo dhammā jahanti: āyu usmā ca viññānaṁ, athāyaṁ kayo ujjhito avakkhito seti yathā kaṭṭhaṁ acetanaṁ-ti. (M I 296)}\]

\[\text{yo pana bhikkhu saṅcicca manussaviggham jīvitā voropeyya satthahārakaṁ vássa parīyeseyya, āyaṁ pi pārájiko hoti asaṁvāso. (Vin III 70)}\]
and that also includes the competent patient who requests others' help in the ending of
his or her life.

Sompan Promta, one of Thailand's leading Buddhist philosophers, supported
the pro-euthanasia movement, and he used the idea of the act of utilitarianism, when
applying it to Buddhist ethics, such that; a person's act is a morally right one if it
produces happiness and pleasure, and permits the abandonment of pain, in being greater
than any other act that the person could perform at that time. He claimed that euthanasia
has only one disadvantage, when being 'sinful' (pāpa) in terms of killing, as follows:
“For one who performs euthanasia there is only one negative possible result, and that is
in the sin of killing a human being. However, one could commit a necessary sin if there
are greater benefits” (Promta, 1992, p.184). He mentioned that Buddhism should permit
the performance of euthanasia for disabled infants and incurable patients, who must use
life-support machines to prolong their lives. That would be considered as a necessary
sin, in order to build greater benefits, such as; relieving peoples’ pain and removing the
heavy burden of financial problems from which their families, and relatives, also suffer.

He argued as follows:

“Disabled infants cannot live naturally. They must use life-support
technology to survive, and they differ from the dead in only one case -
which is their breath. These infants and persistent vegetative patients are
not different. The use of modern medical technologies to prolong their
life is not wrong in the Buddhist perspective but, at the same time, it is
disadvantageous for these patients, and their ancestors. If their families
and relatives request euthanasia, Buddhism assumes that law should be
legalized.” (Promta, 1992, pp.183-184)
Chapter I: Introduction

The researcher does not agree with his viewpoints. The researcher insists that no one should judge the quality of another's life. The researcher does not think that Buddhism sees euthanasia as lawful, because of the principle of Buddhism which regards the prohibition of taking life.

Besides, Somparn Promta claimed that the withdrawal of unnecessary and extraordinary medical treatments does not interrupt the law of kamma; but that it means to allow everything to continue naturally. In contrast, Pinit Ratanakul, founding Director of the College of Religious Studies at Mahidol University, insisted that attending doctors should not perform euthanasia because their actions corrupt the course of kamma, and make bad kamma arise from the occurrence of 'hatred' (dosa) feelings within mind. If they allow the results of past bad kamma to take place then the 'suffering' (dukkha) is reduced, until the bad kamma effect is completely expended. He also gave a guideline to consider the issue of euthanasia, to find a best Buddhist solution, within the frameworks of the doctrines of kamma, Buddhist psychology, and the teachings of 'compassion' (karunā), as follows:

"Within these frameworks, a doctor ought not to interfere with the workings of kamma through the means of euthanasia, neither by actively taking a patient’s life nor by withdrawing life-support systems. The advice of Buddhism to a person with an incurable disease is to be patient and to perform good deeds, in order to mitigate the effects of their past bad kamma. In health care, compassion implies two obligations doctors have towards their patient; namely, to do all they can within their power to enhance the well-being and health of their patients; and to reduce further harm to those patients in preventing and alleviating any harm and suffering." (Ratanakul, 2000, pp.174-176)
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The researcher agree with him that ‘compassion’ (karuṇā) is used to help relieve the ‘suffering’ (dukkha) of patients and their families, and prepare hospice care that ensures a good death. However, Damien Keown, a prominent Buddhist ethics expert, explained that Buddhism does not encourage people to preserve life at all costs, as follows:

“To seek to prolong life beyond its natural span via recourse, and to continue to elaborate technology when no cure or recovery is in sight, is to live in a state of denial of the realities of human life. The Buddha himself declined to extend his life, although he reports that this option was open to him. Accordingly, in terms of the Vinaya, it would seem justifiable to refuse piecemeal medical treatments that do nothing more than postpone the inevitable for only a short time.” (Keown, 1999, p. 268)

In October 1987, the World Medical Association made a declaration about euthanasia, in that:

“Euthanasia, which is the act of deliberately ending the life of a patient, either at the patient's own request, or at the request of close relatives, is unethical. However, this does not prevent the physician from respecting the wishes of a patient to be allowed the natural process of death to follow its course, in the terminal phases of sickness.” (WMA, 1987)

When considering the above declaration, we see that the WMA rejects any form of active euthanasia. However, its declaration accepts an individual’s right to die naturally by refusing medical treatment, as in the case of Buddhadasa Bhikkhu who was the most creative and controversial interpreter of Buddhist doctrine in modern times. He preferred a peaceful death by natural ways, although he himself had suffered a stroke. While being fully competent and before he was ill, he wrote a living will, and had always spoken about his wishes to his disciples in that, in the case of an incurable coma,
he did not want to prolong his life by using extraordinary treatments; such as tracheotomy and respirators. After he lost consciousness, Nipon Pongvarin, a leading neurologist at Siriraj hospital, persuaded the monk's disciples to send him for admittance to Siriraj hospital, just after 1 a.m. on 29 May 1993. There, the attending doctors decided to use life-prolonging treatments, such as feeding tubes, to save his life. Although these treatments were against his will, the disciples deemed it necessary to accept this treatment, in order to save their master's life. Nitipat Jearakul, one of his attending doctors, wrote in his memo thus:

"Nipon and I planned a makeshift treatment. In the afternoon, we had a meeting to decide if we should send Master Buddhadasa for admission to Siriraj Hospital. Nipon came to talk with me about preparing to go to Bangkok. However, when asking for my opinion, I thought it better for him to stay at Suan Mokkh. We all arrived at Siriraj Hospital at 1.05 a.m. on 29 May 1993, and sent him to the Respiratory Care Unit (RCU)."

(Jearakul, 2012, pp.105-107)

Thereafter, some of his disciples wanted the attending doctors to stop all treatment, and send him back to his monastery to die in a natural way, as they had observed that these medical treatments had no hope of saving their master's life. However, the attending doctors refused their request, and strongly believed that the power of modern medical science could save Buddhadasa Bhikkhu's life. Pinit Ratanakul wrote in his work that:

"When, however, during this treatment, the monk still remained in a coma for a month, with no improvement, they began to doubt the wisdom of the doctors' decisions and wanted the doctors to stop such futile treatment; and to allow them to take the monk back to his temple to die a natural death, in peace. The doctors, however, insisted upon continuing the treatment, believing that through this modern medical
technology the patient's life could be saved.” (Ratanakul, 2000, pp.171-172)

However, this raised the issue of socio-political patronage and control over Thai ‘Buddhist monk community’ (*saṅgha*). As Somboon Suksamran mentioned, The King of Thailand has a duty to promote and protect Buddhism, and ‘Buddhist monk community’ (*saṅgha*). In the case of Buddhādāsa Bhikkhu, there were some reports that King Rama IX ordered the attending doctors to save the monk’s life, because he was very important according to his reputation as a leading Buddhist scholar, and because of his inspiration as a saintly monk in 20th century Buddhism.

San Hatteterat explained the symptoms of a persistent vegetative state person like Buddhādāsa Bhikkhu that: “a persistent vegetative state person cannot help himself, cannot communicate with others, and if we prolong their life they may stay in this state for months, years, or even over ten years” (Hatteterat, 2009, p.89). This shows us that a persistent vegetative state like Buddhādāsa Bhikkhu’s was not that of a dead person.

In my opinion, the wishes to stop life-sustaining treatments, as expressed by some of his disciples, are within the scope of passive euthanasia; although the doctors did not perform it, and did finally send him back to die at his monastery. Besides, the lessons learned from Buddhādāsa Bhikkhu’s death not only bring us to realize the significance of the issue of euthanasia, but also of the right to refuse treatment. However, many questions arise in the case of an unconscious patient. Even if a patient prepares a living will, when he or she is fully alert and mentally competent, how can we know they still have the same desires at a later date? For a patient who has not prepared
such a will, who should make that final decision? If a patient is in fear, while someone is performing euthanasia, how can a patient have a peaceful mind as death occurs?

Hospice care is offered to help a patient, and his or her family, to deal with all kinds of 'suffering' (dukkha), through physical, mental, moral and spiritual care, and in order to accept the natural end to life with a calm mind. We should prepare our minds to receive and understand death correctly, because we do not know when the moment of death will arrive. In addition, Phra Brahmagunabhorn (P.A.Payutto) said that: "In Buddhism, a good death is having 'mindfulness' (sati) and a peaceful mind at the time of death" (Geriatrics Institution, 1998, p.12). Furthermore, Buddhadasa Bhikkhu also said that: "To die in the right way, we must be brave with Dhamma, die having victory over death, and die realizing emptiness in the last seconds of life" (Buddhadasa Bhikkhu, 1984, p.98). Therefore, Buddhadasa Bhikkhu’s death and his teachings contain good lessons for all people, in every religion, in preparing the proper way to confront death.

1.2 Thesis Statement:

Buddhadasa Bhikkhu’s application of Buddhist teachings during his illness and the lessons learned from his death can both be applied as alternative practical guidelines for Thai medical practitioners to improve hospice programs, which heal the patient’s mind, and allow the patient to die in peace, naturally.
1.3 Research Objectives:

1.3.1 To study the problems of general euthanasia in connection with hospice care, euthanasia in Buddhism, as appeared in the Buddhist texts, including scholars’ perspectives.

1.3.2 To comparatively discuss concerns about euthanasia in Buddhism, regarding the case of Buddhadasa Bhikkhu’s death.

1.3.3 To critically apply the lessons learned from Buddhadasa Bhikkhu’s death to help Thai medical practice.

1.4 Preceding Relevant Researches:

Phra Athikarn Phaisarn Kittiphattho (Bamrungkawan), in ‘A critical Study of Application of Buddhist philosophy to heal patients’ minds’[^4], summarized that Buddhism relates to medical treatment with two points of view. Firstly, it is to maintain our life in a natural way. Secondly, the ethical side is to cure both physical and mental diseases by taking into consideration the actual benefits for patients. Buddhism emphasizes medical treatment, so the medical practitioner and the relatives should not only be using technology to cure illness, but should also understand the human

[^4]: Phaisarn Kittiphattho (Bamrungkawan), Phra Athikarn (2002). A critical study of application of Buddhist philosophy to heal patients’ mind. The Degree of Master of Arts in Philosophy. Graduate School. Mahachulalongkornrajavidyalaya University, Bangkok, Thailand.
condition, which consists of both the ‘bodily process’ (rupa) and the ‘mental process’ (nama).

Phra Maha Pisit Maṇivaro (Maneewong) studied ‘The Analytical Study of Maraṇassati in Theravada Buddhism’\(^5\). In that study, he found that the contemplation of death means to remind oneself that, for both human beings and animals, death can occur at any time. One should accept and consider that death is inevitable, so that one’s mind should not suffer through the worry and fear of death. The practice of ‘contemplation of death’ will help humans, at the end of their lives, to be reborn with all good deeds; and while terminating all bad deeds, because one maintains oneself in goodness. By being conscious of reminding oneself about death, it can be said that one is more suitably prepared for death, being well-versed in the teachings of Buddhism. This practice leads to the cultivation of wisdom and to the attainment of Enlightenment.

Phra Maha Wanchai Dhammajayo (Chungsamrong) studied ‘A Critical Study of the Concept of Death in Buddhadasa Bhikkhu’s view’\(^6\). He focused upon the principal of death in Buddhism, as interpreted by Buddhadasa Bhikkhu, and the influence of Buddhadasa Bhikkhu’s teachings in Thai culture; through his sickness, his death and his funeral. He also analyzed euthanasia, and the right to die, in the case study of Buddhadasa Bhikkhu, including the significance of the patient’s rights.

Pinit Ratanakul wrote the academic article ‘Ethics, Death and Dying’\(^7\), in order to propose that the whole area of death and dying, in today’s world, is filled with ethical dilemmas. He summarized, such that; doctors and nurses have hospice programs to allow people to die with dignity, and without severe, unbearable pain. They are not to hasten death or directly end life, and are not to permit active euthanasia as a general practice. They must preserve all patients’ lives under their care, but when death approaches they should turn their full attention to the compassionate care of the dying, in order to relieve the suffering of patients, and families, and ensure a good death.


Pinit Ratanakul published his academic article ‘To Save or Let Go: Thai Buddhist Perspectives on Euthanasia’ in the book ‘Contemporary Buddhist Ethics’, in which Damien Keown, a prominent bioethicist and authority on Buddhist bioethics, was an editor. He brought forward the case of Buddhadasa Bhikkhu to analyze and criticize the issue of euthanasia, and the right to refuse treatment. He suggested the frameworks of the doctrines of *kamma*, Buddhist psychology and the teaching of compassion, in order to find a Buddhist solution to the issues of euthanasia, in all its complexity. He insisted that active euthanasia, including assisted suicide, is against Buddhist teachings. For passive euthanasia, he insisted that this is more difficult to resolve in Buddhist terms. The intention of families and doctors to directly take a life may be motivated by selfishness, because of the more complicated factors involved, such as financial problems and scarce medical resources. This problem is a continuing ethical issue, and is more problematic for doctors who strongly believe in sustaining patients’ lives, as is their duty. However, he suggested hospice care as an option, to help patients deal with all kinds of unbearable pain and suffering, and to maintain life at a level of pain-relief that neither diminishes their faculties nor clouds their consciousness. Hospice care accepts death as one of the main tenets in providing special care for the dying, to help

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them to die in a conscious state naturally, and where the problem of the use of artificial life-supporting machines, to prolong a patient’s life, does not arise in.

Police Captain Utaiwan Laoprasurtsuk studied ‘An Analytical study of the Buddhist approaches to alleviate suffering (dukkha) during illness’, and he pointed out that two main levels of implication are recognized. Firstly, ‘worldly level’ (lokiya) physical sufferings from illness are taken care of. Secondly, the ‘supramundane level’ (lokuttara), or the elimination of all forms of ‘suffering’ (dukkha), is totally achieved.

According to Buddhist texts, the approach to health and illness problems encompasses both preventative and therapeutic measures. For the prevention of illness, the Buddha employed a combination of physical and mindful methods to promote health and to strengthen both the body and mind, and did so quite regularly. For treatment, there were two main treatment modes. The first one was ‘common treatment’, using what was generally available in those days, such as the use of herbal medicines, surgical methods and bodily relaxation. The second one was the employment of Dhamma power. The Buddha illustrated healing powers in the higher orders of Dhamma, such as the use of ‘the 37 virtues that partake of enlightenment’ (Bodhipakkhiya-dhamma) during illness.

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Such measures can still be employed efficaciously, even in the present day, as illustrated in the case study of Buddhadāsa Bhikkhu, and other famous monks in Thailand.

Sompam Promta\textsuperscript{10} wrote in his book ‘\textit{Buddhism and Ethical Problems: The Buddhist perspective in the problems of prostitution, abortion and euthanasia}’ that liberals use critical reasons to support euthanasia, whilst conservatives use religious doctrines to oppose them. He claimed that disabled children and incurable patients, who must use life-supporting systems to prolong their lives, are appropriate to perform euthanasia upon because Buddhism sees not that the prolonging of life of the physical body is necessary, but that the value of life itself is the ethical essence. However, he supported the use of applying Buddhist teachings to confront death peacefully, in that euthanasia is not necessary at all.

Suwaporn Naewchampa studied ‘\textit{Buddhist Integrated End-of-Life Care}\textsuperscript{11}, and summarized that the persons who are in charge of caring for patients have to keep in


\textsuperscript{11} Naewchampa, Suwaporn (2011). \textit{Buddhist Integrated End-of-Life Care}.

The Degree of Doctor in Philosophy in Buddhist Studies. Graduate School. Mahachulalongkornrajavidyalaya University, Bangkok, Thailand.
mind what are termed as ‘the holy abiding factors’ *(brahmaviahara)*, such as loving-kindness and compassion, individually realizing the world and life. The purpose of caring is to fill patients with complete mindfulness and clear-comprehension, provide them with a good quality of life and good health before their death, ensuring a purified mind in the last moments of life before death occurs, all so that they will be reborn into a good place after death. Finally, the greatest purpose is to achieve happiness from liberation. In practice, medicine and medical practices in modern day Thai society should be implemented together, so that patients will get access to their basic rights, such as; the right to get medical treatment as a human being, get acknowledgement and participation in the medical making decisions process, be given the opportunity of the seeking of spiritual needs and family participation, a peaceful and dignified death, and the expectation of being able to acquire the proper treatment of their body.

Vattakorn Ruangjindavalai studied *Euthanasia and Death in Theravāda Buddhist Philosophy*¹², and suggested that the guidelines for patients with incurable diseases who, at the same time, cause a tremendous amount of suffering and stress to those looking after them, should allow for the rejection of food and medicine, and that

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this should be permissible. On the other hand, for those who are responsible for the
above patients, allowing those patients to die is not permissible. Thus, it can be
concluded that at least one case of euthanasia is morally permissible in Theravāda
Buddhist ethics; that is passive euthanasia carried out under the will of the patients, and
for reducing the stress and suffering of those looking after the patients. The permission
for euthanasia to be acted out is closely connected to the principle of moral advantage
and the concept of death in Buddhism.

For this analytical study of euthanasia in Buddhism, the researcher would like to
consider and evaluate the lesson of Buddhadasa Bhiikkhu’s death to offer a guideline
for solving the problematic issues of euthanasia. The researcher would like to apply the
teachings of Buddhadasa Bhiikkhu towards illness and death for helping Thai medical
practitioners to improve the quality of hospice programs in order to assist patients to die
naturally in peace. This study also critically analyzes the factors and obstacles for the
application of Buddhadasa Bhiikkhu’s teachings in order to bring about the benefits of
preparing proper hospice care and for further research.

1.5 Definitions of Terms Used in the Research:

1.5.1 Assisted suicide is the act of deliberately assisting or encouraging another
person who commits, or attempts to commit, suicide.

1.5.2 ‘Compassion’ (kuruṇā) means the desire to remove pain, sorrow and suffering
of all beings.
1.5.3 Euthanasia is categorized as two main types.

1. Based upon the patient’s voluntariness.

1.1 Voluntary euthanasia is euthanasia that is provided to a competent person, upon his or her informed request.

1.2 Non-voluntary euthanasia is the provision of euthanasia to an incompetent person according to a surrogate’s decision.

1.3 Involuntary euthanasia is euthanasia performed without a competent person’s consent.

2. Based upon the patient’s death condition.

2.1 Passive euthanasia, also called negative euthanasia, is the withdrawal of unnecessary and extraordinary medical treatments, such as respirators and feeding tubes, or by simply discontinuing any medical treatment necessary to sustain life.

2.2 Active euthanasia, also called mercy killing or positive euthanasia, is the intentionally positive steps taken to end the life of a patient, typically by lethal injection.

1.5.4 A good death means a death without mental suffering, even if the body is in pain. Death is having ‘mindfulness’ (sati) with peace of mind.

1.5.5 Hospice care means end of life care provided by health professionals and volunteers, and which provides medical, psychological and spiritual support. The goal of hospice care is to help people who are dying to have peace, comfort and
dignity. The caregivers try to control the pain and other symptoms, so that a person can remain as alert and comfortable as possible.

1.5.6 ‘Intention’ (cetanā), for proving the purity of the first precept in Buddhism, that of abstaining from harming living beings, means a transgression committed consciously and deliberately.

1.5.7 *Kamma* (skt. *Karma*) means a volitional action or deed. In *Dhamma* language, it refers to three kinds of action. Bad action is called black *kamma*; good action is called white *kamma*; but the realization of ‘non-self’ (*anattā*) and ‘emptiness’ (*suññatā*) is the kind of *kamma* that the Buddha taught.

1.5.8 Physician assisted suicide occurs when a physician provides a patient with the medical means and/or the medical knowledge to commit suicide and the patient performs the life-ending act.

1.5.9 Suicide is the act of intentionally causing one’s own death. The cause of suicide is frequently attributed to a mental disorder such as depression, bipolar disorder, schizophrenia, misusing alcohol or drugs.

1.6 Research Scope:

The scope of research focuses upon euthanasia in Buddhism, through a case study of Buddhadāsa Bhikkhu’s death. It is also compared with the teachings in *Theravāda* Buddhist texts and scholarly views, in order to find the best Buddhist solutions as alternative practical guidelines for Thai medical practitioners, in order to help dying patients to die a peaceful death. The research information is collected from
primary and secondary sources, including internet sources which are directly related to the research objectives.

1.7 Research Methodology:

This research presents and illustrates the textual approach to qualitative research. The research methodology can be divided into five stages as follows:

1.7.1 The collection of data to be analyzed and categorized from the primary sources of the ‘Pāli Canon’ (Tipiṭaka), its ‘commentaries’ (āṭṭhakathā), along with the secondary sources being; books written and composed by well-known scholars, theses, dissertations, academic articles and essays.

1.7.2 Analyzing the raw data, as well as systematizing the collected and analyzed data, in order to present a clearer picture of the issues of euthanasia in Buddhism, the application of the lessons learned from Buddhāsā Bhikkhu’s death and his teachings, and to help Thai medical practitioners to encourage proper hospice care.

1.7.3 Constructing the entire outline of the research.

1.7.4 Critically discussing and interpreting the problems encountered.

1.7.5 Formulating conclusions and identifying significant areas needed for further research.
1.8 Expectations:

1.8.1 An understanding Buddhist teachings and the case study during the Buddha's period, including the judgment criterion of the Buddha, based upon the problems of euthanasia will be gained.

1.8.2 The practical methods that medical practitioners apply to dying patients, through the case study of Buddhadasa Bhikkhu's death will be explored.

1.8.3 To find the direct benefits for patients, medical practitioners and ordinary people when applying Buddhist teachings, including the case study of Buddhadasa Bhikkhu's death and his teachings, and how they are used as alternative illness solutions to find ways of preparing for a peaceful death, naturally.

1.9 Theoretical and Conceptual Frameworks:

1.9.1 Theoretical Frameworks:

The principle of the right to life, as a fundamental right, is up for debate when concerning the issue of euthanasia; in that a human being has the right to live and, therefore, no one has the right to take a life. In 1966, The United Nations (UN) General Assembly adopted the International Covenant on Civil and Political Rights, to promote respect for the rights of all people, in every nation. In article 6.1 of this protocol, it was expressed that: “Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of life” (UN, 1976, p.174). Additionally, in article 7, it stated that: “No one shall be subjected to torture or to cruel, inhumane or degrading treatment or punishment. In particular, no one shall be
subjected, without their free consent, to medical or scientific experimentation" (UN, 1976, p.175). These are the natural rights which human beings should have, and they should be respected. However, these rights show that one has the righteousness to plan one’s own future, but that the rights do not include the right of how to die. Proponents of Pro-life movements argue against euthanasia, in that: “it is the duty of the State to protect life, and the physician’s duty to provide care and not to harm patients. If euthanasia is legalized, then there is a grave apprehension that the State may refuse to invest in health care (working towards Right to life)” (Math & Chaturvedi, 2012, p.899). They support the practice of palliative and hospice care as compassionate care for patients, as thus: “Palliative care actually provides death with dignity, and a death considered good by the patient and the care givers” (Math & Chaturvedi, 2012, p.900).

One of the most important Buddhist teachings, ‘compassion’ (kuruṇā), is used by some Buddhists as a justification for euthanasia, because a person suffering is relieved of their pain through good ‘intention’ (cetanā) carried out with ‘compassion’ (kuruṇā). This misunderstanding could create immoral actions. ‘Compassion’ (kuruṇā) in Buddhism is the desire to remove pain and ‘suffering’ (dukkha) of all beings, under the rules or the ‘precepts’ (sīla).

The researcher applies the first precept or abstaining from destroying living beings, to be a criterion for judging the problems and issues of euthanasia. This first precept consists of five factors, as follows:
1. Object: ‘there is a living being’ (pañña).

In Buddhism, it must considered through the three qualities of death as the ridding of; vitality, heat and consciousness. If a person has one of three qualities remaining then that person is still alive.

2. Knowing: ‘One knows that it is a living being’ (paññasaññīta).

3. ‘Intention’ (cetāṇā): ‘There is the volition thought of killing’ (vadhakacittāṃ). Here lies the important part in proving whether one kills or not. ‘Intention’ (cetāṇā), within the meaning of this precept, is a transgression committed knowingly, consciously, deliberately.

4. Effort: ‘the effort to kill’ (upakkamo), within the meaning of this precept, is one kills others with his own hand, kills with praise, helps to kill, or orders someone to kill.

5. Result: ‘the resulting death of a living being’ (tena maraṇāṁ).

For Buddhist monks (bhikkhu), the Buddha proclaimed the third ‘rule pertaining to the expulsion from monkhood’ (pārājika) as ‘intentionally cutting off a person’s life, searching for an assassin for him, praising the advantages of death or inciting a person to die.’ If a ‘Buddhist monk’ (bhikkhu) commits these actions then he has carried out a great ‘sin’ (pāpa), and he must end his time in the monkhood forever.
1.9.2 Conceptual Frameworks:

Introduction to Euthanasia and Hospice care

General euthanasia in connection with hospice care and euthanasia in Buddhism

The case study as appeared in the Buddhist texts

Scholars' perspectives

Euthanasia in the case of Buddhadasa Bhikkhu's death in comparison with the case in Buddhist texts and scholars' views

The right to refuse treatment, in the case of Buddhadasa Bhikkhu's death

Buddhadasa Bhikkhu's practice in his illness

The application of Buddhadasa Bhikkhu's teachings to prepare Hospice care

Factors and obstacles for the application of Buddhadasa Bhikkhu's teachings

Critical application of the lessons from Buddhadasa Bhikkhu's death

Apply the lessons learned from Buddhadasa Bhikkhu's death to help the Thai medical practice on euthanasia issue

Discussion concerning euthanasia, in the case of Buddhadasa Bhikkhu's death

General euthanasia in connection with hospice care

Conclusion and recommendations

References
CHAPTER II

THE STUDY REGARDING PROBLEMS OF GENERAL EUTHANASIA IN CONNECTION WITH HOSPICE CARE AND EUTHANASIA IN BUDDHISM AS APPEARED IN THE BUDDHIST TEXTS INCLUDING SCHOLARS' PERSPECTIVES

2.1 The study of problems of general euthanasia in connection with hospice care

In contemporary health care, the decision to end one's life has contributed to the debate regarding euthanasia practices among both the supporters and opponents in complex areas such as legal, ethical, religious, economic and socio-cultural aspects. It needs to be explained that the word 'euthanasia' comes from an ancient Greek word which comprises two components; the first being 'eu' (meaning 'well'), and the second being 'thanatos' (meaning 'death'), and which, when both combined, deliver a single word meaning a 'good death'. When discussing euthanasia, it can be categorized as two main types. The first type is based upon the patient's voluntariness, and is termed; voluntary, non-voluntary and involuntary euthanasia. The American Medical Association's (AMA) Council of 'Ethical and Judicial Affairs' gives the explanation for that, as follows:

"Voluntary euthanasia is euthanasia that is provided to a competent person, upon his or her informed request. Non-voluntary euthanasia is the provision of euthanasia to an incompetent person according to a
surrogate’s decision. Involuntary euthanasia is euthanasia performed without a competent person’s consent.” (AMA, 1992, p.2230)

The second type, based upon the patient’s death condition, is an active and a passive form of euthanasia. Eugenie Anne Gifford provided a definition that:

“Passive euthanasia involves allowing a patient to die by removing him/her from artificial life support systems, such as respirators and feeding tubes, or by simply discontinuing medical treatments necessary to sustain life. Active euthanasia, in contrast, involves positive steps to end the life of a patient; typically by lethal injection.” (Gifford, 1993, p.1546)

The combination of those two typical types of euthanasia can generate six different descriptions of that entity, which can thus describe euthanasia as being: voluntary active, voluntary passive, non-voluntary active, non-voluntary passive, involuntary active and involuntary passive.

Euthanasia is often associated with assisted suicide and physician assisted suicide, however, they differ. Assisted suicide is when one or more persons provide information, guidance, and means to help another person intentionally take his or her own life while physician assisted suicide is when a medical practitioner assists a patient in taking their own life. Kaiser Mahmood, the lecturer in philosophy, GC University, argued that the difference between voluntary active euthanasia and physician-assisted suicide as: “In voluntary active euthanasia, it is the physician who ultimately kills the patient. In physician assisted suicide; it is the patient who ultimately kills himself, albeit with the assistance of the physician” (Mahmood, 2006, p.38). The American Medical
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Association’s (AMA) Council on Ethical and Judicial Affairs indicates the sharp difference between euthanasia and physician assisted suicide that:

"Euthanasia and assisted suicide differ in the degree of physician participation. Euthanasia entails a physician performing the immediate life ending action (e.g. administering a lethal injection). Assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g. the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).”

(AMA, 1992, p. 2231)

Those who support euthanasia may consider it as a merciful practice of ending a life in order to release a patient from an incurable disease or long-term suffering. The National Hemlock Society (NHS) was established in California in 1980. This organization has called for legalizing euthanasia, whereby the medical practitioner could withhold or withdraw life-supporting means and thereby voluntary euthanasia would allow terminally ill patients to die peacefully.

The value of life is one of major problem issues in the euthanasia debate. From a religious perspective, life is the gift of Creator or God. The moral code of many religions is the prohibition against taking life. Christianity shares the same belief as Judaism in one of Ten Commandments that it would be wrong to take life as: “You shall not murder” (Exodus 20:13). Likewise, the word of Allah in The Quran mentioned that: “Do not kill one another” (Al-Nisa’ 4:29). Buddhism also has the precept of abstaining from destroying living beings (D III 235, as quoted in Phra Brahmagunabhorn, 2008, p.175). Judith A. Boss, a scholar in social ethics, proposed
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that: “Pythagoreans also opposed euthanasia on the grounds that the gods are our keepers and we are the possessions of the gods. To kill ourselves is to sin against the gods” (Boss, 2002, p.201). The researcher supports the ethical perspective of Pinit Ratanakul, who states that:

“We might think that another who is suffering unendurable pain therefore ought to die because we are paternally imposng our values upon them. We would not want to go on living in such circumstances. But this does not mean that life, even a painful life, is meaningless to them.” (Ratanakul, 2007, p.152)

Another problem issue is that depression is major reason for requesting euthanasia to stop suffering of terminally ill patients. We need the kind of compassionate care which provides control of pain, of other symptoms and of psychological and spiritual problems along with a good quality of life for the patients and their families, therefore, hospice care is an answer. Kaiser Mahmood insisted that:

“The only humane alternative to euthanasia is hospice and hospice is opposed to the legalization of euthanasia” (Mahmood, 2006, p.38).

Hospice is derived from the Latin words ‘hospes’ and ‘hospitium’, which refers to a rest-house for guests and hosts. The idea of hospices originated during the Crusades, around 1080, as a shelter for terminally ill travelers on their long journey to the Holy Wars where they were treated by Crusaders. The first modern hospice, St. Christopher’s Hospice was built in a residential suburb of London by Dame Cicely Saunders who began her work with the terminally ill in 1948 and introduced the idea of holistic hospice care for the dying to the United States during a 1963 visit to Yale
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Hospice care is a form of palliative care. The World Health Organization (WHO) gave the definition of palliative care in 2002 as follows:

“Palliative care is an approach which improves the quality of life for patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems; physical, psychological, and spiritual.” (Wright, Hamzah, Phungrassami & Claudio, 2010, p.3)

Palliative care services can be offered as whole-person care that relieves symptoms of a disease or disorder whether or not it can be cured. This care can be appropriate for anyone at any stage of a serious illness, whether that illness is potentially recoverable, chronic or life-threatening. Hospice is a specific type of palliative care for a patient who is clarified by two physicians to likely have six months or less to live if the disease from which they suffer follows its usual course. Hospice care is always palliative, but not all palliative care is hospice care. The National Hospice Organization (NHO) defines the hospice philosophy as follows:

“Hospice affirms life. Hospice exists to provide support and care for persons in the last phases of incurable disease so that they might live as fully and comfortably as possible. Hospice recognizes dying as a normal process whether or not resulting from disease. Hospice neither hastens nor postpones death. Hospices exist in the hope and belief that, through appropriate care and the promotion of a caring community sensitive to their needs, patients and families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.” (Cundiff, 1992, p.7) (See more details in Appendix A)

The hospice perspective views death as a natural stage of life. The hospice specialists' team, which includes doctors, nurses, psychological and spiritual counselors,
social workers and volunteers, works with the patient and family to provide a compassionate result, allowing the patient to die a dignified death. David Cundiff, medical doctor in public health, suggested informing both the patient and family adequately about the actual condition of the disease and the prognosis. If the patient or family member requests active euthanasia, the medical practitioner should refuse and should try to change their minds. He gave an example of recommendation for an incurable cancer patient that: "Though we do not have a treatment that can cure the cancer, we have good treatments available to help control your pain and to handle any other troublesome complications of the disease or its treatment" (Cundiff, 1992, p.54).

The hospice provider must eliminate fear of abandonment and improve the quality of all aspects of the patient’s life as much as possible. Hospice programs also provide more than comfort and dignity relative to the patient's death, including bereavement support for family members or loved ones. However, there are two interesting issues of hospice program in association with passive euthanasia; the first issue is the withholding or withdrawal of life-prolonging machines; and the second is the debate regarding non-nutrition and non-hydration.

Regarding the issue of the withholding or withdrawal of artificial life-sustaining technology, hospice care providers allow death to occur naturally without the use of life-support machines to prolong life. This does not mean they seek death for the patient, rather the use of machines wastes expensive health care assets in order to needlessly prolong pain and suffering. However, it is necessary to first discuss the use
Chapter II: The study of problems of general euthanasia in connection with hospice care and euthanasia in Buddhism as appeared in the Buddhist texts including scholars’ perspectives of life-support technology with the patient and family as it relates to the issues of overall prognosis and quality of life. Entering a hospice program, a terminally ill patient continues to receive palliative treatments for pain relief and psychological and spiritual support to dispel fear and anxiety. For a conscious and competent patient, it is morally acceptable to not start life support at his/her request.

In the case of a patient who is placed on a respirator, there is a conflict in case of an unconscious person; that is, what is the criterion to judge a person to be dead. The World Medical Association (WMA) gives the definition of a dead person as: “determination of death can be made on the basis of the irreversible cessation of all functions of the entire brain, including the brain stem, or the irreversible cessation of circulatory and respiratory functions” (WMA, 2006a). Sawaeng Boonchalermviphas, the former legal counsel of the Medical Council of Thailand gave a clear explanation about this issue as: “Brain stem death is regarded as death and it is not an euthanasia problem, but if death of the cerebral cortex or the layer of the brain happens, the being becomes a persistent vegetative state person who can still live his life span” (Professor Jitti Tingsapat Fund & the Medical Council of Thailand, eds, 2000, pp.35-36). It can be specified that a persistent vegetative state person is not really dead but is a living person who has lost consciousness.

The International Association for Hospice and Palliative care provided guidance in their manual by considering the balance between the possible benefits and the potential risks of such treatment (see more details in Appendix B). They view the
withdrawal of the artificial medical machine as legally and morally appropriate in order to allow the patient to die naturally of the disease, not to deliberately terminate life.

There are two major perspectives regarding how to justify the issue of the withholding or withdrawal of artificial life-sustaining technology. The first perspective is the deontological principle. The proponents of this ethical perspective indicate that continuing the patient's life on life support is the morality correct action. Dona J. Reese described that:

"The deontological principle relies on duty, laws, rules, based on a priority agreement on essential facts. Proponents have a perspective about what is right to do, about the intrinsic morality of an act. This perspective is not concerned with consequences of the act. From this perspective; a terminally ill person would be resuscitated and placed on life support, because saving life is the right thing to do, regardless of the suffering of the patient or the financial impact on society." (Reese, 2013, p.11)

On the other hand, the proponents of the utilitarian principle focus on the consequences of continuing life-prolonging machines as futile care thus:

"An alternative perspective is the utilitarian principle. The focus of this perspective is the consequences of an action. Concern is for society as a whole rather than the individual; proponents aim toward the greatest good for the greatest number of people. From this perspective, it would be considered better not to resuscitate the patient, based on concern for quality of life and cost of a treatment that is considered futile." (Reese, 2013, p.11)

Therefore, if the patient and family decide to join hospice program early, the problem of using life-prolonging machines does not arise. The researcher sees that hospice programs can respond to both the intrinsic morality of the action on saving life,
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not prolonging it, and the ultimate end by lowering costs and by providing quality to the patient's life. However, the use of oxygen therapy is appropriate in some cases of terminally ill patients in order to keep them comfortable thus: "oxygen therapy is used as a comfort measure for patients who suffer from dyspnea (breathlessness) and some patients are suctioned to help them breathe more easily" (Munley, 1983, p.60).

Another conflicting issue in hospice care is that of providing or withholding or withdrawing food and fluids at the end of life. It is ethically necessary for medical practitioners to provide food and fluids to a conscious patient who requests them and can take them by mouth. If a patient who is conscious but for some reason cannot receive food and fluids by mouth, the medical practitioners have the duty to inform the patient and family of the medical facts regarding artificial nutrition and hydration, the associated discomforts and the burden of medical interventions. After receiving relevant information, the patient and family can make the decision to accept or refuse artificial nutrition. The researcher recommends that the use of artificial nutrition and hydration should be accepted if they can recover the patient's health and quality of life, but the use of them must be carefully controlled by medical practitioners.

The International Association for Hospice and Palliative care has suggested artificial nutrition and hydration should not be provided if they will not enhance the quality of life for a patient (see Appendix B). If a patient is unconscious and the medical practitioners decide that death is likely to occur within the next few hours or days, the use of artificial nutrition and/or artificial hydration are considered by some medical
practitioners to increase suffering and provide a negative effect on a dying patient’s physical symptoms such as diarrhea, intravenous site infections, swelling and difficulty of breathing. David Cundiff explained that:

“The artificially administered fluids accumulate in the upper respiratory tract, producing increased secretions, and in the lower respiratory tract, producing cough and shortness of breath. The fluids also may accumulate in the abdomen and legs, causing additional discomfort.” (Cundiff, 1992, p.47)

In contrast, Robin Fainsinger, a professor in the Division of Palliative Care Medicine, Department of Oncology, at the University of Alberta, Canada, provided argument for hydration that:

“Dehydration can lead to pre-renal azotemia, which in turn can lead to accumulation of drug metabolites (notably opioids), leading to delirium, myoclonus and seizures. Hydration can reverse these symptoms in some patients leading to improved comfort. There is no evidence that fluids prolong the dying process. Providing hydration can maintain the appearance of doing something, even though there may be no medical value, and thus ease family’s anxiety around the time of death.” (Fainsinger, 2006, p.206)

If it is necessary to provide hydration, the researcher recommends the method of hypodermoclysis or the subcutaneous infusion of fluids as a useful and easy hydration technique suitable for dehydrated patients, especially home care patients and the elderly, as follows:

“These problems include infiltration of abnormal substances, extravasation, where blood escapes into the cannula, bacteremia, septicemia, cannula positioning, and phlebitis. When using hypodermic cannulation with hypodermic cannulation, these problems are rarely found.” (Donnelly, 1998, p.44)
Menahem Sasson and Pesach Shvartzman explained advantages of hypodermoclysis thus:

"Advantages are low cost, more comfortable than IV administration, less likely than IV administration to cause pulmonary edema or fluid overload, simple insertion, less distressing than IV; easier reinsertion at new site, more suitable for home care than IV line, with less staff supervision and less need for hospitalization, can be set up and administered by nurses in almost any setting, does not cause thrombophlebitis, has not been shown to cause septicemia or systemic infection, can be started and stopped at any time by opening or closing the clamp on clivysis tubing; and there is no danger of clot formation."

(Sasson & Shvartzman, 2001, p.1576)

They also explained disadvantages of hypodermoclysis thus:

"Disadvantages are usual rate is only 1 ml per minute; only 3,000 ml (at two sites) can be given in 24 hours, a limitation on administration of electrolytes, nutrition additives and medications, edema at infusion site is common, and the possibility of local reactions."

(Sasson & Shvartzman, 2001, p.1576)

However, it is not proper for use in cases of severe dehydration and emergency fluid administration. For severely dehydrated patient, intravenous (IV) administration is better way.

The medical practitioners should regularly consider the use of artificial nutrition and hydration as easy to initiate but there can be difficulties when the time comes to consider withdrawal. If a terminally ill patient has been placed on feeding tubes, the researcher suggests treatments should be continued. However, the quantity of nutrition and hydration must be controlled on a daily basis in order to avoid symptom burden from delirium and fluid overload. Additionally, it should be realized that the
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withholding of nutrition and hydration is not stopping care; comfort measures such as using crushed ice and lip balms to ease the discomfort caused by a dry mouth should be provided.

There is no consensus on the single best approach to care. The medical practitioners must first obtain informed consent or living wills from the patient regarding what kind of medical treatments he or she wants or does not want. David Cundiff explained the formal medical practice that: “Before physicians can write orders to withdraw life-support technology, as well as not to resuscitate patients, they must first obtain informed consent from the patients or next of kin” (Cundiff, 1992, p.51).

The medical practitioner’s decision regarding informed consent or living wills; it should not conflict with the moral code and religious values regarding prohibition on taking life. Kaiser Mahmmood argued that:

“Most ethical systems have some sort of prohibition against killing ‘thou Shalt Not Kill’ i.e. the Sixth commandment, the sanctity of human life is a basic value as decreed by God even before the times of Moses. Therefore, if a medical practitioner has to end the life of his/her patient deliberately, then he/she would be guilty of homicide.” (Mahmmood, 2006, p. 38)

In Buddhist ethical perspective, David Cundiff pointed out that:

“However, according to the first of the ten precepts of Buddhism, a physician should relieve the suffering of the terminally ill, but not interfere with the working out of one’s karmic patterns. Buddhism advocates hospice care, not euthanasia.” (Cundiff, 1992, p.71)
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2.2 The case study of euthanasia as appeared in the Buddhist texts

2.2.1 The concept of death (marat̄ha) in the Buddhist texts

Before discussing the issue of euthanasia from a Buddhist moral perspective, we must first consider the concept of life and death. A person living from within the Buddhist perspective consists of; both ‘bodily processes’ (rupa) and ‘mental processes’ (nāma). Mental processes comprise; ‘sensation’ (vedanda), ‘perception’ (saññā), ‘mental formations’ (sañkhāra) and ‘consciousness’ (viññāna). A combination of the ‘bodily processes’ (rupa), and the ‘mental processes’ (nāma), are combined to be called the ‘five aggregates’ (pañca-khandha). A person in Buddhist perspectives is decentralized through these components:

“By the expression, just as the person is known objectively, as both real and ultimate, so also the material form is known and so forth, a classification of the 57 ultimate of our conscious experience consisting of (5) aggregates, (12) sense-organs and objects, (18) elements and (22) controlling powers, being shown.”(KvA I 1, Law, tr, 1989, p.10)\textsuperscript{13}

Therefore, whenever the ‘five aggregates’ (pañca-khandha) and these above components are exhausted then a man dies.

In ‘The Middle-Length Discourses’ (Majjhimanikāya), it gives a definition of one who is dead as follows:

\textsuperscript{13} Ubhayenāpi yo parato puggalo upalabbhati saccikaṭṭhaparamatthena rūpaṁ ca upalabbhati ādīna khandhāyatanaadātthu-indriyavasena sattapaṇṇāsavidho dhammappabhedo dassito. (KvA I 1)
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"Your reverence, the bodily activities of that dead thing, passed away, have been stopped, have subsided, the vocal activities have been stopped, have subsided, the mental activities have been stopped, have subsided, the vitality is entirely destroyed, the heat allayed, the sense-organs are entirely broken asunder." (M I 296, Horner, tr, 1995, p.356)

In "A Manual of Abhidhamma’ (Abhidhammatha Saṅghā of Bhadanta Anuruddhācariya), it also explains about these three qualities of death thus: “By death is meant the extinction of ‘psychic life’ (jīvītindriya), and ‘heat’ (tejodhātu), and ‘consciousness’ (viññāna) of one individual in a particular existence” (Nārada, tr, 1979, p.305).

Therefore ‘death’ (maraṇa) in Buddhist texts refers to the exhaustion of psychic life of living being, the perishing of aggregates. The criterion is when vitality, heat and consciousness separate from the physical body.

2.2.2 The concept and the case study of euthanasia as appeared in the Buddhist texts

Although there is no term synonymous with euthanasia in early Buddhist sources, the concept of ‘the destruction of life’ (paññātipāta) in Buddhism can be applied in comparison with the concept of this moral dilemma.

14 Yvāyām āvuso mato kālakato, tassa kāyasankhārā niruddhā paṭippassaddhā, vacīsaṅkhārā niruddhā paṭippassaddhā, cittasaṅkhārā niruddhā paṭippassaddhā, āyu parakkhino, usmā vūpasanta, indriyāni viparibhinnā. (M I 296)
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The word ‘life’ (pañā) means, in conventional discourse, a living being (satta); in the ultimate sense, it is the life faculty (jīvitindriya). In ‘Buddhagosa’s commentary of the Dīgha Nikāya’ (Sumanāgalavilāsini), it also explains about six means (payoga) of ‘the destruction of life’ (pañātipātā) thus: “one’s own person (i.e., by oneself), commanding (another to kill), mobile weapons (such as spears or arrows), stationary devices (traps), magical formulas, and psychic power (DA I 1, Bodhi Bhikkhu, tr, 2007, p.112).\(^\text{15}\)

However, the Buddha stated in the first precept for lay people to abstain from destroying living beings. The five factors of the first precept consist of:

1. **Object**: ‘there is a living being’ (pañö). It can be considered through the three qualities of death mentioned above. If a person still has one of three things, it means the body is still alive.

2. **Knowing**: ‘one knows that the being is a living being’ (pañasaññita).

3. **‘Intention’ (cetanā)**: the ‘Pāli Canon’ (Tipiṭaka) gives the specific explanation of ‘intention’ (cetanā) for proving the purity of the first precept that: Intention (cetanā) means: “a transgression committed knowingly, consciously, deliberately” (Vin III 72, Horner, tr, 1992, p.126).\(^\text{16}\)

\(^{15}\) Sāhatthiko ānattiko nissaggiko thāvaro vijjāmayo iddhimayo. (DA I 1)

\(^{16}\) sañcicca’ ti jānanto sañjānanto cecca abhivitaritvā vītikkamo. (Vin III 72)
4. Effort: 'The effort to kill' (upakkamo) means one kills the being with his own hand, kills with praise, helps to kill or orders someone to kill.

5. Result: 'the resulting death of a living being' (tena maraṇatā).

The most important thing regarding the consideration to kill or not to kill is 'intention' (cetiṇā). If a person has the intention to kill and the being dies from his or her action, of course, the person performs the full offense of destroying living being and commits a 'sin' (pāpa) by violating the first precept.

In 'Buddhagosa’s commentary of the Digha Nikāya' (Sumangalavilāsini), it also explains about the weight of 'sin' (pāpa) of ‘the destruction of life’ (pāṇātipātā) thus:

"In the case of beings devoid of moral qualities such as animals, the act of killing is less blameworthy when the being is small in size, more blameworthy when the being is big. Why? Because of the magnitude of the effort involved in killing a being with a big body. But even when the effort is the same, the act of killing a big-bodied being is still more blameworthy because of the magnitude of its physical substance. In the case of beings endowed with moral qualities such as humans, the act of killing is less blameworthy when the being has low moral qualities and more blameworthy when the being has high moral qualities. But when the physical body and moral qualities of the victims are equal, the act of killing is less blameworthy when the defilements and force of the effort are mild, more blameworthy when they are powerful.” (DA I 1, Bodhi Bhikkhu, tr, 2007, pp.112-113)17

Additionally, if the being does not die, the person still commits a ‘sin’ (pāpa) due to the intention to kill because the person violates some factors of the first precept. However, the weight of ‘sin’ (pāpa) is less because the first precept has not been violated completely, but only in some aspects. If a human being or an animal dies without ‘intention’ (cetanā), such as a person stepping on ants carelessly, the first precept of a person is not pure because death happens. The person has not violated the first precept but a person still receives: “a cumulative kamma or a causal act (kaṭṭakākamma)” (Vism 601, as quoted in Phra Brahmagunabhorn, 2008, p. 250).

The first precept in Buddhism can be applied as one of criterions for judging the problematic issue of euthanasia. A discussion and formulation of assisted suicide was reported on in the third ‘rule pertaining to the expulsion from monkhood’ (pārājika) against taking human life, which was recorded in ‘The Book of The Discipline’ (Vinaya) and its ‘commentary’ (aṭṭhakathā). These cases could provide a useful starting point and direction for reflection regarding this moral dilemma.

The beginning of many stories in the third ‘rule pertaining to the expulsion from monkhood’ (pārājika) noted that once the Buddha had been preaching to the monks at Vesāli he began developing the contemplation of the impure to counteract attachment to the body. The Buddha retired into solitary retreat for a half-month. During this time, the monks dwelt intently upon the practice of developing disgust toward sufferings of life and loathing their own bodies. This intent became so extreme that many felt death
would be preferable to such a disgusting existence. Some of the monks deprived themselves of life and also lent assistance to one another in ending their lives. Others sought out Migalaṇḍika, a sham recluse, who agreed to assist them in terminating their lives in return for their bowls and robes. Migalaṇḍika killed the monks with a large knife, but after his killing was completed, while he was washing his knife at the River Vaggamudā, he was seized with remorse. At this point ‘an evil spirit’ (mārakāyikadevata) appeared and assured him that he was doing a noble service by bringing across those who had not crossed. Reassured by this he killed many more monks, up to sixty on a single day. When the Buddha came out of his half-month’s solitary retreat he noticed the drop in numbers among the monks and asked the venerable Ānanda for the cause. When he was told what had taken place he proclaimed the third ‘rule pertaining to the expulsion from monkhood’ (pārājika) as the prohibition on intentionally taking human life or lending assistance to end another’s life.

The Buddha expanded the proclamation of this precept to include not only killing or assisting in it but also inciting a person to die after the incident of the group of six monks who were enamored with the wife of a layman. They said to the layman that death would be better for him than life by praising his virtuous life which would be rewarded in heaven. As a result of hearing this, the layman ate and drank the detrimental foods and eventually succumbed to death. His wife and some other people were angry and blamed these monks. When the Buddha heard about this matter he
rebuked the monks and extended the rules of the third 'rule pertaining to the expulsion from monkhood' (pārājika) as follows:

“Whatever monk should intentionally deprive a human being of life or should look about so as to be his knife-bringer, or should praise the beauty of death, or should incite (anyone) to death, saying, ‘Hello there, my man, of what use to you is this evil, difficult life? Death is better for you than life,’ or who should deliberately and purposefully in various ways praise the beauty of death or should incite (anyone) to death: he also is one who is defeated, he is not in communion.”

(Vin III 72, Horner, tr, 1992, pp.125-126) 18

In connection with euthanasia, the proclamation of this precept might relate to an act of voluntary active euthanasia. Therefore, it could be concluded that both a patient who requests an end to his/her life and a medical practitioner who assists or performs euthanasia violates the precept. Damien Keown, a prominent Buddhist ethics, explained that the scope of this precept is very significant in the context of euthanasia thus:

“We have already considered the circumstances and provisions of the third pārājika, and this 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 use the wording of the precept, life seems evil and difficult.” (Keown, 2005, p.110)

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18 yopana bhikkhu sañcicca manussavigghaṁ jīvitā voropeyya satthahārahaṁ vāssa pariyeseyya maraṇavaṁṇaṁ vā saṃvaṁṇeyya maraṇāya vā saṃādapeyya ambho purisa kim tuyh’ iminā pāpakena dujjīvitena matan te jīvitā seyyo’ti, itiṭittamano cittasaṁkappo anekapariyāyenā maraṇavaṁṇaṁ vā saṃvaṁṇeyya maraṇāya vā saṃādapeyya, ayaṁ pi pārājiko hoti asaṁvāso’ ti. (Vin III 72)
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Another instance of an incitement to death is the story of an invalid man whose hands and feet had been cut off and he was living in a relative’s home. A monk visited him and suggested his relatives cause his death by prescribing a buttermilk drink that would prove fatal for him thus: “A certain monk said to these people, ‘Reverend sirs, do you desire his death?’ ‘Indeed, honored sir, we do desire it,’ they said. ‘Then you should make him drink buttermilk,’ he said. They made him drink buttermilk, and he died’ (Vin III 85, Horner, tr, 1992, p.149)\(^{19}\). This monk was in breach of the precept. A similar case concerns a nun who suggested that the relatives of an invalid man make him drink salted sour gruel that would be fatal for him thus: “Then you should make him drink salted sour gruel, she said. They made him drink the salted sour gruel, and he died” (Vin II 85, Horner, tr, 1992, p.149)\(^{20}\). The same judgment was declared by the Buddha. Both men in these two cases had suffered amputation of the hands and feet and required constant attention and care, including assistance with feeding. It was difficult for them to take care of themselves. Damien Keown explained about these two cases as follows:

“We are not told if the patient agreed with the view of his family that he should die. It may be that the man’s view about his death is not

\(^{19}\) aññataro bhikkhu te manusse etad avoca: āvuso icchatha imassa maraṇan ti. āma bhante icchāma’ ti. Tena hi takkaṃ pāyethā’ ti. to taṃ takkaṃ pāyesūp, so kālam akāsi. (Vin III 85)

\(^{20}\) tena hi loṇasuvirakaṃ pāyethā’ ti. te taṃ loṇasuvirakaṃ pāyesūp, so kālam akāsi. (Vin III 85)
Chapter II: The study of problems of general euthanasia in connection with hospice care and euthanasia in Buddhism as appeared in the Buddhist texts including scholars' perspectives reported because it is not thought relevant, since intentional killing is judged wrong regardless of whether the victim consents or not.” (Keown, 1999, p.267)

These two cases shown above can be applied to the area of all forms of active euthanasia, in which the medical practitioner who assists in bringing about the death of a patient, including when a relative or a patient requests it, is judged wrong in Buddhist moral precept. However, the other motive of the relatives might be the compassionate desire to alleviate ‘suffering’ (dukkha) of a patient. Therefore, the context of ‘compassion’ (kuruṇā) should be discussed in the conflict between the prohibition against taking life and the taking of life because of compassionate desire to help the patient end his/her ‘suffering’ (dukkha). One case was reported in ‘The Book of The Discipline’ (Vinaya) and was stated in only a couple of lines that: “Now at that time a certain monk was ill. Out of compassion the monks praised the beauty of death to him and that monk died” (Vin III 78, Horner, tr, 1992, p.137)\(^{21}\). Damien Keown quoted the explanation of Buddhaghosācāriya on this case as follows:

> “Out of compassion means that those monks, seeing the great pain the monk was in from the illness, felt compassion and said to him: You are a virtuous man and have performed good deeds, why should you be afraid of dying? Indeed, heaven is assured for a virtuous man at the very instant of death. Thus, they made death their aim and...Spoke in favor of death. That monk, as a result of them speaking favorably of death, ceased to take food and shortly after died. It was because of this

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\(^{21}\) tena kho pana samayena aññataro bhikkhu gilāno hoti, tassa bhikkhū kāruṇīna maraṇavaṇṇaṃ saṃvaṇṇesuṃ, so bhikkhu kālam akāsi. (Vin III 78)
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that they committed an offence." (VinA II 464, as quoted in Keown, 1999, p. 265)

In Buddhaghosacariya's explanation, the wrongdoing of the breach of the precept of these monks was to make death their aim and to suggest death to the monk rather than great pain. It shows that to make death one's aim, to suggest death as better, to embark on any course with death as one's desired outcome, to incite anyone to suicide, to lend help in the context of assisted suicide, regardless of compassionate motive, appears immoral from a Buddhist perspective. Therefore, 'compassion' (kurvā) is a moral motive if the outcome belongs to the precept.

In another case a monk went to the execution place and appealed for the sudden execution of a prisoner that: "Reverend Sir, do not keep him in misery. By one blow deprive him of life. All right, honored sir, he said, and by one blow he deprived the man of life" (Vin III 85, Horner, tr. 1992, p.148). Although it may be assumed that the motive of this monk related to the compassionate desire to release the mental suffering of the prisoner in waiting for the execution time and even though the prisoner would have certainly been killed, the Buddha rejected this line of intervention.

The researcher sees that the character of each person in this case can be applied to the modern context of euthanasia. It may suppose that the monk was a

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22 āvuso mā yimaṃ kilamesi, ekena pahārena jīvitā voropēhi. suṭṭhu bhante 'ti ekena pahārena jīvitā voropesi. (Vin III 85)
family member or a surrogate, the executioner was a medical practitioner and the
prisoner was a terminal patient. A family member who calls for the swift action of any
kind of euthanasia, although the group of medical practitioners have already decided
to perform it at the appointed time, regardless of whether the patient consents or not,
seems to be intentionally causing the death of the patient and is judged wrong in
Buddhist moral perspective.

In addition, Damien Keown raised issues relative to two interesting scenarios
regarding the situation of terminally ill patients from Buddhaghosācāriya’s
explanation thus:

“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). However, 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. (VinA II 467, as quoted in Keown,
1999, p.267)

Damien Keown in his discussion of this issue commented on the wishes of two
patients in contrasting scenarios that: “The first person wishes to die; the second
person wishes to live. The second person, however, is resigned to the fact that he is
beyond medical help and, therefore, declines further medical intervention” (Keown,
1999, p. 268). The second example based on Buddhaghosācāriya’s explanation
suggests that Buddhism does not believe there is a moral obligation to preserve life at
all costs. Similar to the second example, the third example shows that a terminally ill
patient who has a religious motive to spend his last stage of life doing a spiritual leap forward by declining food, is judged as a moral obligation thus: "It is also legitimate in the case of one who is suffering from a painful illness from which he knows he will not recover to withdraw from food in the knowledge that he is on the brink of a spiritual breakthrough" (VinA II 467, as quoted in Keown, 1999, p. 268).

The researcher observes that it seems to be the morally acceptable right of a competent patient to refuse treatment, such as by the withholding of medical treatment and food, in Buddhism, but withdrawing respirator remains problematic for many Buddhists and medical practitioners. If the patient's death is caused by being taken off artificial respirator, there is risk of violating the precept of Buddhism. Therefore, consideration must be given on case-by-case basis using the best available and reliable medical testing and the best medical knowledge and wisdom of medical practitioners to ensure a patient does not die because of the withdrawing of life-prolonging means. Allowing the patient to die naturally in such case does not violate the Buddhist precept. Nevertheless, no one can guarantee the accuracy and correctness of overall prognosis; therefore the risk of violating moral precept will always exist. The researcher still questions whether or not the withholding or withdrawing of treatments of an incompetent patient, such as a persistent vegetative state person, in accordance with a surrogate's decision is morally acceptable. Damien Keown suggested that:

"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 let events take their course. It is also justifiable to refuse or withdraw treatment that is either futile or too burdensome in light of the overall condition.” (Keown, 2005, p.113)

The researcher is still uncertain. How can we be sure that the overall prognosis is correct? How can we know whether the patient wishes to die or wishes to live? The researcher ponders on the word of the Buddha that: “All men tremble at the rod; all men fear death. One should treat one’s neighbor as oneself, and therefore neither strike nor kill” (Dhp129, Burlingame, tr, 1995, p.294). If you were the one who is being considered to have treatment refused or stopped, how would you feel? Teachings in Buddhism encourage having a good death with ‘mindfulness’ (sati) and preparing a peaceful mind for the time of death. If you fear death, how can you have a peaceful mind to have a good death? If treatments are withdrawn and then a patient dies, does it violate the principle of prohibition against taking life? It provides a risk for those who decide to withhold or stop treatment to be in a breach of the precept.

Another example of Buddhaghosācāriya’s explanation raised that: “Again, this time in the context of meditation, it is legitimate for one who is not ill but who is inspired by religious feeding to conclude that the search for food is burdensome, withdraw from it and exert himself in his meditation subject” (VinA II 467, as quoted in Keown, 1999, p. 268).

23 sabbe tasanti daṇḍassa, sabbe bhāyanti maccuno, attānaṁ upamaṁ katvā, na haneyya ghātaye. (Dhp 129)
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The Buddha, before he became enlightened, once decided to undertake the strict ascetic practices, such as extreme fasting from food and water. He became so thin that he could put his hand on his stomach and close his fingers around his backbone. He became so weak that he could not meditate and realized he would die. He stopped fasting, began eating again, restored his strength by eating and renewed his meditation until he achieved enlightenment. The Buddha said that: “But, when I, Bhāradvāja, had taken some material nourishment, having picked up strength, aloof from pleasures of the senses” (M II 212, Homer, tr, 1995, p.401). According to the researcher’s opinion, in comparison with the story of the Buddha, the explanation of Buddhaghosācāriya on this issue may be considered as an extreme practice. Damien Keown argued that:

“Buddhaghosā does not make clear whether this is undertaken by way of a fast unto death, as in the Jain practice of sallekhanā, or is simply a temporary fast. If it is the former, and is undertaken by a young person in good health, some may feel that it is morally culpable in endangering life unnecessarily and is not in keeping with the principle of the middle way.” (Keown, 1999, p.268)

2.3 Euthanasia in scholars’ perspectives

In regards to the issue of euthanasia, the researcher decides to consider two states, that of consciousness and unconsciousness. A conscious patient can request voluntary euthanasia either through lethal injection or by refusing all medical

24 Tassa mayhaṁ bhāradvāja, etadahosi: kiṁ nukho ahaṁ tassa sukhassa bhāyāmi, yaṁ taṁ sukhaṁ aññatreva kāmehi aññatra akusalehi dhammehi ti. (M II 212)
Chapter II: The study of problems of general euthanasia in connection with hospice care and euthanasia in Buddhism as appeared in the Buddhist texts including scholars' perspectives treatments. The researcher shall discuss the context of active euthanasia firstly. Dan Brock, the Frances Glessner Lee Professor of Medical Ethics in the Department of Global Health and Social Medicine at Harvard Medical School, proposed two ethical supportive values in favor of voluntary active euthanasia in that: “These values are for individual self-determination or autonomy and individual well-being” (Brock, 1992, p.11). Fully conscious patients should have power to make decisions regarding treatments that affect their own lives, even if it means ending their lives, except in cases of treatable clinical depression and serious dementia, which he maintained classifies these patients as incompetent persons so their requests should not be granted. He claimed when competent patients in severely debilitated states find life no longer worth living, but now a burden and voluntary active euthanasia should be an available legal option that:

“The same judgment underlies a request for euthanasia: continued life is seen by the patient as no longer a benefit, but now a burden. Especially in the often severely compromised and debilitated states of many critically ill or dying patients, there is no objective standard, but only the competent patient's judgment of whether continued life is no longer a benefit.” (Brock, 1992, p.11)

However, he argued that if the request to perform active euthanasia conflicts with a particular medical practitioner's reasonable understanding of his or her moral or professional values, the patient should not force the medical practitioner to perform the active euthanasia and should instead transfer their care to another medical practitioner.
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On the contrary, there is an interesting argument by Neil Campbell, Senior Legal Counsel and Researcher at University of Calgary in Canada, that the decisions to die of terminally ill patients are compelled by intolerable pain and are hence not freely chosen. Therefore, the choices to die in such cases, that were thought to be voluntary, might actually be involuntary. It is very difficult to know whether a patient’s decision to die may be compelled by other factors, such as internal or external compulsion. Voluntary euthanasia, therefore, may be against the true wishes of the patient. Campbell argued that:

"Consider the analogy of the prisoner who is tortured for information. When he finally gives in we tend to think that the prisoner is not responsible for revealing state secrets. The assumption is that since the pain was so excruciating the decision to talk was not voluntary, but was compelled. Indeed, that is the whole point of torture. Under the conditions of unbearable pain and suffering, then, if the concern of the agent is to alleviate the pain it seems to be a mistake to speak of voluntary choices." (Campbell, 1999, p.243)

Another common argument against voluntary active euthanasia is religious argument. Three main Semitic religions, Christianity, Judaism and Islam, are related by the common belief that life is a gift from God. God has sovereign authority over life and death. One who requests active euthanasia and one who helps others to commit suicide or performs active euthanasia violates the power of God. Paul Ramsey, an American Christian ethicist, argued that: “to choose death as an end is to throw the gift back in the face of the giver, it would be to defeat his (God’s) gift-gifting” (Ramsey, 1978, p.146).
For voluntary passive euthanasia, this action is in accord with the right of a conscious patient to refuse treatment. Pinit Ratanakul claimed that this action is morally acceptable if the patient is fully competent to understand that the result of this decision will inevitably lead to probable death, and the decision is made without pressure from others or influence by others or inner coercion or emotional disorder. However, he argued that this desire should not inflict serious harm on family members or loved ones. If there is no infliction of harm, the wishes of a conscious patient should be accepted. However, if there is the possibility of inflicting serious harm on others, he pointed out that: “If that were a real possibility, then the moral principle of non-maleficence would override the obligation to respect person’s wishes and their autonomy, their desire to live only according to their own religious beliefs and values” (Ratanakul, 2007, p.144). regarding caring for the feelings of others, but the researcher insists on observing the right of patients to refuse medical intervention if they wish to live but resign themselves to the inevitability of death after receiving complete diagnosis information that they are beyond medical help.

For a conscious patient, for whom it is necessary to use artificial machines to prolong life 24 hours a day, the researcher affirms that the life of these patients still has benefits to others. Some of their stories will also inspire those who feel dejected in life and provide knowledge for further medical study and treatment. For example, the story of Paulo Henrique Machado, the infantile paralysis Brazilian who continues to be hooked up to an artificial respirator 24 hours a day and spends almost his entire life
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in hospital. He and his friend Zagui, who is sick with the same disease, created an online campaign to raise finances for a 3D animated film series called The Adventures of Leca and her Friends, based on a book that Zagui wrote about their lives and which he will direct (Zobel, 2013).

The researcher agrees with their doctors’ decision to save their life, and argues that if the medical practitioners remove the machines, the real possibility exists that the patient will die suddenly and their act may be judged as assisted suicide or directly killing the patient and in violation of the moral medical principle of non-maleficence and the moral precept of their religious beliefs. They should instead provide psychological and spiritual care in order to relieve suffering and inner compulsion. They also should make patients feel less isolated.

In case of an unconscious patient, such as persistent vegetative state or cortex brain death, non-voluntary euthanasia occurs when a third party, a relative or the doctor, assumes the rights of the patient by deciding to inject lethal drugs or to withdraw life-prolonging treatment.

Regarding medical treatments, a living will is designed while the patient has full consciousness to indicate his or her wishes in the event he or she becomes comatose and unable to make decisions. Judith Areen argued the effectiveness of a living will that:

"Physicians and other health care providers are likely to be uncomfortable at first with the responsibility of assessing whether family members are acting in good faith....A good way to avoid both
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the legal uncertainty surrounding family consent, and the burden that being a proxy decision maker places on family members, is to having a living will or a durable power of attorney with instructions governing health care.” (Bernards, ed, 1989, p.179)

In contrast, Pinit Ratanakul argued that a living will should not be considered with respect to possible future medical developments in treatments thus:

“It does not take into account possible future medical developments in treatments and cures or that people who, when they are actually facing dying, might change their minds and, if they could, express the desire that everything possible be done to sustain and prolong life.” (Ratanakul, 2007, p.145)

The researcher offers alternative guidelines to consider regarding the conflicting issues of a living will; if the desires of incompetent patients expressed through prepared living wills, while mentally competent, call for ceasing extraordinary treatments to prolong life, their medical practitioners and families, including surrogates, should honor their wishes, but they ought to provide curative care to relieve pain and psychological depression of their patients or their loved ones.

If the request on a living will is the desire to sustain life, the medical practitioners ought to confer with patients’ families or surrogates firstly. They should not decide to use extraordinary means, therefore, hospice care is a proper alternative to help the patients die with dignity and ease suffering caused by incurable pain.

If extraordinary means or feeding tubes are provided before knowing the desire of the patients as indicated in a living will, as an example in the case of urgent emergency case, the use of these medical interventions should be continued until the
patients die under the control of skilled medical practitioners with consideration for beneficence and non-malfeasance regarding patients’ life. The medical practitioners ought to avoid withdrawing life-support means or lethal injection to an unconscious person because they risk breaching religious moral precepts. In addition, they may face legal prosecution if their acts conflict with social moral norms or without informed consent of families or surrogates. However, the continuation of extraordinary medical care probably causes a problem regarding medical expenses for poor families. Hospice program uses lower costs which can help alleviate this financial problem, but will not eliminate all of it. Government should come forward to support this program in order to provide the best quality for their citizens' lives.

In Buddhist scholar perspective, Somparn Promta proposed that:

“Killing in Buddhism always is a mistake regardless of whatever reason. In performing euthanasia, a person who takes the action is to be regarded as violating the first precept of Buddhism, but a person who requests it is to be regarded as not to violate the precept. Buddhist monk has absolutely prohibition against performing euthanasia on others.” (Promta, 1992, p. 196)

The researcher does not agree with him when he says that it is not morally inappropriate for a patient to request that a medical practitioner perform voluntary active euthanasia. We see in the first precept of Buddhism, to avoid killing, cutting off the faculty of life does not mean only killing others but also killing one’s own self. Therefore, both one who performs active euthanasia and a patient who requests it are judged as to violate the Buddhist precept and to commit sin. Although the patient has
autonomy for calling medical practitioners or someone else to kill them, they should refuse.

However, Somparn Promta rejected involuntary euthanasia, both in terms of active and passive opinion that:

“In the case of dying persons who are fully competent for making decisions regarding their life and who decide that they do not want to die but one performs euthanasia on them by judging that they should die because their life is full of ‘suffering’ (dukkha), it is unnecessary to discuss the suitability of this because their action is obviously murder.” (Promta, 1992, p.145)

In case of unconscious patients, Somparn Promta pointed out that Buddhism should allow performing euthanasia for immedicable infants and patients who are in persistent vegetative state and require life-support machine to prolong their life because Buddhism sees long life of the physical body as not necessary, but rather the value of life is the ethical essence. He quoted a text from The ‘Pāli Canon’ (Tipiṭaka) to support his idea that: “Though one should live a hundred years, corrupt, not meditating, yet were it not better to live a single day in the practice of virtue, in meditation” (Dhp 110, Burlingame, tr, 1995, p. 246)\(^\text{25}\). He argued that:

“Buddhist ethics are absolutely fixed ethics. Killing is killing. It is to be regarded as violating the first precept of Buddhism. Killing with good ‘intention’ (cetanā) may alleviate a heavy sin to become a lesser sin, but it cannot confute the fact that euthanasia is a wrongdoing in Buddhism. If the society can show some necessary conditions, which present a choice between immortality and the greater benefits,

\(^{25}\) Yo ca vassasatam jīve, dussīlo asamāhito, ekāham jīvitaṁ seyyo, sīlavantassa jhāyino. (Dhp 110)
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Buddhism allows having a necessary sin, but it does not mean that sin is not a mistake. Sin always has a result, according to the law of *kamma*. (Promta, 1992, p. 161)

The researcher argues against this opinion that a ‘sin’ (*pāpa*) should be avoided. A person who performs non-voluntary euthanasia has ability and ‘mindfulness’ (*sati*) to know and understand what is good or bad, to consider the result of action, which is death. Killing is always prohibited in Buddhism. No one has the right to judge another’s life. Even though the patients had signed a living will to allow the third party to perform euthanasia on them legally, they cannot know whether the patients still have the same desire or not.

However, Somparn Promta affirmed that there is no reason to perform euthanasia on disable infants thus: “They still have consciousness and can live as a normal person...Buddhism believes that they have chance to do good things and to attain the highest goal” (Promta, 1992, p. 183). That is to say, they also have probability to achieve the highest goal of their religious beliefs.

There is a different view regarding euthanasia based on the idea of ‘compassion’ (*kuruṇā*) in order to help the patient become free from suffering and to reflect the meaning of death as a door to liberation. Courtney S. Campbell, Professor of Ethics, Science, and the Environment in the Department of Philosophy at Oregon State University pointed to this issue thus:

“Hindu and Buddhist scholars have found support for this so-called ‘active’ euthanasia in their traditions by reflecting on the meaning of death as a door to liberation, the culmination of life in detachment from
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the material world. They then go a step further by linking compassion to the norm of self-similitude: 'one should act towards others as one would have them act toward oneself'. So euthanasia can be seen as a compassionate act or a 'mercy killing' for a dying person striving to the highest purpose of human destiny, liberation.” (Campell, 2000, pp.38)

In contrast, Pinit Ratanakul affirmed that the medical practitioners cannot perform euthanasia without a feeling of 'hatred' (dosa) toward the patient's pain and suffering which disturbs their minds; even though they may believe their actions are motivated by generosity. Their intentions and those of the surrogates may have complicating factors involved such as the desire to save medical costs. He insisted that:

"Therefore, from the viewpoint of Buddhist psychology, mercy-killing is not really a benevolent act. It is done from ill will and thus has bad kammic effects both for the doctor and the patient. In case of terminal patients, compassion is limited to giving drugs in sufficient quantities to relieve intense pain. This is the farthest that compassion can go. Beyond this point the precept against the taking of life is violated.” (Ratanakul, 2000, p.176)

The researcher argues that the performance of euthanasia, perhaps, is not goodwill to relieve the patients 'suffering, but instead the preference of medical practitioners or families' to save themselves from further suffering and burdens. It has a good explanation in 'A Manual of Abhidhamma' (Abhidhammattha Sangaha of Bhadanta Anuruddhacariya) thus:

"Does one experience ill will when one kills a wounded animal with the object of putting an end to its suffering? Moved by compassion, one may do so; yet there is ill will at the moment of killing, because there is a certain kind of aversion towards the object. If such an action is morally justifiable, could one object to the wholesale destruction of patients suffering from acute chronic incurable diseases? It was stated above that there is ill will where there is displeasure.” (Nārada, tr, 1979, pp.39-40)
If you were the one who would be killed, how would you feel? The researcher believes that all human beings love their life and fear death. Even if a person may not suffer pain from illness, a person may suffer from the fear of death or the leave-taking of a loved one. If you fear death, how can you have a peaceful mind to have a good death? In ‘A Manual of Abhidhamma’ (*Abhidhammattha Saṅgaha of Bhadanta Anuruddhācariya*), it raises a good example that: “When, for instance, one feels sorry for having failed in an examination, does one harbor ill will at that time? If one reflects on the meaning of the term *paṭigha* (ill will), the answer will become clear. There is no doubt a subtle kind of aversion over the unpleasant news” (Nārada, tr, 1979, p.40).

Based on the idea of liberation in Buddhism, Nirvana (*nibbāna*) means to be free from all attachments, defilement (*kilesa*) and suffering (*dukkha*). Euthanasia may help to relieve the physical suffering, but not mental suffering. If you have eradicated ill will (*paṭigha*) or hatred (*dosa*), how can you free from mental defilements or mental suffering? Therefore euthanasia is not the proper way to help people attain Buddhist liberation. However, Buddhism allows human beings to refuse treatment in order to die naturally if their acts do not violate the precept. Therefore, the medical practitioners and families should accept the right of the patient to refuse treatment if he or she does not harm social moral norms or the moral principle of their religions.
CHAPTER III

COMPARATIVE DISCUSSION CONCERNING EUTHANASIA IN BUDDHISM

IN THE CASE OF BUDDHADĀSA BHİKKHU’S DEATH

3.1 Buddhadāsa Bhikkhu and Buddhism in Thailand

3.1.1 The life and works of Buddhadāsa Bhikkhu

Buddhadāsa Bhikkhu was born into a Chinese merchant family, on May 27th 1906, in the Phumriang sub-district of Chaiya located in Suratthani province, Southern Thailand. He was given the name Nguam Phanit, and was the eldest son of three children. In his early childhood he helped his father, Sieng Phanit, and his mother, Kluan Phanit, in their family shop. At a later age, he was sent to receive a basic education at Wat Mai, where he spent three years as a temple boy, from 1914 to 1916. In 1918, he went back home and attended Phothiphitthayakon School in Wat Photharam, and soon transferred to study at Saraphiuthit School, in Chaiya. During that time, he left his home and stayed with his father in another family shop in Chaiya. In 1923, his father died whilst he was studying in high school. As a result, after he completed his high school grade of Mathayom III, he had to leave school and close the shop in Chaiya, and move back to his home town of Phumriang, to take over the responsibility of his family business. On July 29th 1926, at the age of twenty, he was ordained to be a Buddhist monk of the Mahānikāya order, at Wat Nok. His religious name, ‘Indapaño’ (Wisdom of Indra) was given by his preceptor, Phrakhrū Sophon Cetasikāram. He then went to stay at Wat Mai. He decided to learn the Dhamma study
program (Naktham), and he passed the intermediate level of Dhamma studies (Naktham tho) in his second year of monkhood. In 1928, he went to Bangkok for Pāli studies. In 1930, he achieved three of the nine levels in Pāli studies, but he failed his fourth level Pāli examination. During his studies in Bangkok, he independently read and studied the ‘Pāli Canon’ (Tipiṭaka), and found that: “In studying the pariyattidhamma during this period we don’t truly study the Tipiṭaka itself. We study only the commentaries” (Jackson, 2003, p.11). Therefore, he changed his intentions to deviate from the Pāli formal education, because he realized that even though he wrote answers from original doctrine, which he considered as being correct, he would fail the examination. In addition, he was disappointed with the lax practice of many monks in Bangkok. Most of them attempted to have more power and more wealth.

He decided to interrupt his studies and move back to his home town, in 1932. At that time, he stayed in an abandoned temple called Wat Trapangjid, and intended to live with purity in a forest, in order to be close to nature, similar to the ways of the Buddhist monks in the Buddha’s period. In May 1932, he established ‘The Grove of the Power of Liberation’ (Suan Mokkhabalārama) near his home town, Phumriang, and then he moved to Chaiya district.

In the early times of the founding of Suan Mokkh, he took the practice of meditation very seriously, especially the ‘mindfulness of in and out-breathing’ (ānāpānasati). He also studied ‘the teachings of the Buddha’ (dhamma) in Buddhist scriptures, by himself. He decided to use the name Buddhadasa, or the slave of the
Buddha, in August 1932: “I commit this life and body as a dedication to the Lord Buddha. I am a servant of the Buddha. The Buddha is my lord. For this reason I am named Buddhadasa” (Quoted by Jackson, 2003, p.13 in Buddhadasa Bhikkhu, 1933, p.2).

In 1933, he published his first article ‘Following the Arahants’ Footprints’ in the journal of Buddhadasana. He studied the teachings of all schools of Buddhism and other religious doctrines. He worked with other Buddhist sects, and other religious people from around the world, with broadmindedness. He set three main wishes in his life. His first wish was that people should try to understand the core of their own religion honestly. His second wish was to build mutual understanding between religions. He even abridges the gap between each religion, by creating the interfaith dialogue. We could share the ideal goals which propose the intellectual and spiritual approaches to wiping out suffering. He identified the relationships between each religion, as follows:

“Principally, we should recognize here that all religions in the world have something in common, which is the very backbone and essence in terms of Karma, or action for practice. Karma, or action, is indeed the very religion itself. By action, it is meant the very practice which brings man into a relationship with God. It does not matter whether that which is called God is conceived of as a person or a power or a condition. The only characteristic required of what is called a God is that it signifies the extinction of suffering. That much is quite enough.” (Buddhadāsa Bhikkhu, 1999, p.89)

His third wish was to lead people in this world away from materialism. He aimed to religiously offer people significant lessons, in order to help them get away from the influence of materialism and thus the world would remain peaceful.
Chapter III: Comparative discussion concerning euthanasia in Buddhism in the case of Buddhadasa Bhikkhu’s death

During his life time, he wrote more than one hundred and forty works. Many of his works were translated and published in many languages, such as English and Chinese. Some of the well-known books by him are; the ‘Handbook for Mankind’, ‘Heart-Wood from the Bo Tree’, ‘Mindfulness of in and out-Breathing’ (Anāpānasati) and ‘No Religion’. In addition, he compared the main ideas between Christianity and Buddhism, and translated the English doctrinal book of ‘Zen’ into the Thai Language. He insisted that the supreme goal of each religion can be achieved in the current life, ‘here and now’:

“Thus, the ultimate consummation of religion sought by man is what is called the loftiest Dhamma, the Highest Good or Summum Bonum, or what man can attain in his life time and not after his death. In Christian terms this is called ‘entry into the Kingdom of God’, and in Buddhist Dharmic terms ‘the attainment of Deathless’, or to use layman’s terms, ‘entry into the land of Nirvana.” (Buddhadasa Bhikkhu, 1999, p.305)

He received eight honorary doctorates from Thai universities. In 1987, he received the honorary clerical senior posting title of ‘Phra Dhammakosacarya’. He died on July 8th 1993, at the age of eighty seven, after a series of heart attacks and strokes. Nevertheless, his works still have influences up on all the practices and the studies of Buddhism in Thailand, and worldwide. In 2006, at the 100th anniversary of Buddhadasa Bhikkhu’s birth, his name was included in the United Nations ‘Educational, Scientific and Cultural Organization (UNESCO) List’ of the greatest personalities, and it appreciated him as a pioneer in the promotion of inter-religious dialogue that created mutual understanding and peace among different faiths.
3.1.2 Buddhadāsa Bhikkhu and Buddhism in Thailand

Buddhadāsa Bhikkhu is one of the most well-known reformist Buddhist scholars in Thailand. He attempted to interpret the relevance of Buddhism for the mutual benefit of people in contemporary society. Buddhadāsa's movement focused on reverting back to the original meaning of the 'Buddha's teachings' (dhamma), as well as the strategy of applying Buddhism in response to the needs of the modern world, and to access the lay people with special regard to the growth of the Thai intellectual middle class. One of Buddhadāsa Bhikkhu’s disciples, Santikaro Buddhist, explained as follows:

“Progressive elements in Thai society, especially the young, were inspired by his teachings and selfless example. Since the 1960s, activists and thinkers in areas such as education, ecology, social welfare, and rural development have all drawn up on Buddhadāsa Bhikkhu’s teachings and advice. He provided the link between the scriptural tradition, and he engaged Buddhist practices of today.” (Santikaro Bhikkhu, 1993, p.39)

However, he emphasized the real purpose of Buddhism as ‘the practice for salvation from ‘suffering’ (dukkha). Buddhadāsa argued against these metaphysical aspects. He claimed that heaven and hell can be identified through mental cognition, which comprises happiness and ‘suffering’ (dukkha) in which a person partakes in the present life. Thus, it is theoretically believed that making merit will purify the mind and give direction to ‘liberation’ (nibbāna). He advised thus: “The meaning of ‘giving’ (dāna) and donating is to relinquish, to end all grasping at and clinging to things as being the ‘I or mine’” (Buddhadāsa Bhikkhu, 1984, p. 41). He opposed the traditional practice of rituals and ceremonies taught in Buddhism. He also mentioned that many different
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sides, from the points; of morality, of truth, of religion, of psychology, of science, of the art of living, of philosophy and so on, might all lead to a false grasp of the real meaning of Buddhism. He pointed out that a person who always performs a detailed investigation of his or her mind, whenever 'suffering' (dukkha) happens and scorches the mind, is a person learning the ‘Pāli Canon’ (Tipiṭaka) through true practical experience; a person who can even go beyond the points of those who just simply read it, even if never having seen or heard of the ‘Pāli Canon’ (Tipiṭaka) before. He concluded, in the real meaning, as follows:

"Real Buddhism is not books, not manuals, not words for word repetition from the Tipiṭika, nor is it rites and rituals. These are not real Buddhism. Real Buddhism is the practice by way of body, speech and mind that will destroy defilements, in part or completely." (Buddhadasa Bhikkhu, 2005, p.25)

He suggested that people study Buddhist doctrines through the application of ‘the instruction to the kalamas’ (Kālama Sutta); the logical judgment criteria and scientific method, in order to help people achieve the ‘right view’ (sammādiṭṭhi) and with an aim to clarify the pure doctrine that can be best used to develop quality of mind. He focused upon ‘The Basket of Discourses’ (Suttaniputta) which contains the reputed words of the Buddha, but which are repudiated in ‘The Basket of Sublime’ (Abhidhammapiṭaka); ‘they do not exist in the form of the Buddha’s words and are not necessary for those who desire to cease ‘suffering’ (dukkha).’ Although Jackson mentioned a Thai scholar, the former director of the Tipiṭika Studies Center, Winay Siwakun, who argued against Buddhadasa Bhikkhu that: “the science for the
transcendence of the suffering of life, which is found in the *Abhidhammapitaka*, is a result of the realization of the Lord Buddha” (Jackson, 2003, p.131). Buddhadasa Bhikkhu continued, insisting that:

“On some occasion the Lord Buddha mentioned (in the *Suttapiṭaka*) the words *abhidhamma* and *abhivinaya*. These denote the parts of the *dhamma* which are excessive. The parts which provide too deep an explanation beyond what is necessary for a person to know, or to have, in order to attain *nibbāna*” (Quoted by Jackson, 2003, p.126 in Buddhadasa Bhikkhu, 1982, p.82).

The initial point of misunderstanding in Buddhist doctrines, for him, is an erroneous interpretation. He insisted that Buddhist scholars should realize the existence of the other meanings of the words of Buddhist doctrines which are hidden from a definitive dictionary. He has proposed the innovation ‘the hermeneutic method’, which has been separated into two kinds of languages; the everyday language (phasisakhon) and the *dhamma* language (phasatham). The hermeneutic method leads contemporary people to have a more accurate understanding of the Buddha’s teachings. His re-interpretation identifies a reduction of the metaphysical aspects under psychological conditions. He quoted the words of the Buddha to support his idea, as follows:

“The wise and heedful person is familiar with both modes of speaking; the meaning seen by ordinary people, and the meaning which they can’t understand. One who is fluent in the various modes of speaking is a wise person.” (Buddhadāsa Bhikkhu, 2007b, p.38)

His interpretation of Buddhism focused not only on an individual’s practice, but also on the social sectors, when applying the teachings of Buddhism to their daily lives and activities. He mentioned that social, political and economic problems occur from
Chapter III: Comparative discussion concerning euthanasia in Buddhism in the case of Buddhāsā Bhikkhu’s death

the results of self-centered delusion of ‘I and mine’. He suggested to do work with an empty mind (cit-wang) is to do so without clinging to anything as ‘ourselves’. He explained the word emptiness as thus: “A mind is empty (unencumbered, disengaged, or free) when it is free of greed, hatred, and delusion” (Buddhāsā Bhikkhu, 2007a, p.97).

As a result, Buddhāsā Bhikkhu proposed his theory of dhammic socialism, in pointing out that:

“This dhammic socialism is not a system which should be abandoned, and it is not the absolute monarchy which is so hated. Perhaps this system will be able to remedy the world’s problems better than any other system.” (Quoted by Jackson, 2003, p.241 in Buddhāsā Bhikkhu, 1974, p.53)

Buddhāsā Bhikkhu saw the Buddhist community in the Buddha’s period as the state of nature, or the state of a balanced socialist system for whole living beings and the ecology of the world, as follows:

“All members of the Buddhist community-monks and lay people are not only taught, but are also required to consume no more than their share of material goods. Excessive consumption is wrong and de-meritorious. Therefore, Buddhism is a truly socialist religion, both in its principles and its spirit.” (Swearer, eds., 1991, p.174)

For him, this ethical society is controlled by ‘morality’ (sīla) in relation to the natural state of things which equalize moderation as well as limit ‘defilement’ (kilesa).

An American contemporary and Asian religious scholar, Donald K. Swearer, explained the characteristics of Dhammic socialism, with:

“Buddhāsā’s Dhammic socialism can be interpreted in terms of three fundamental principles; the good of the whole, restraint and generosity, respect and loving-kindness. Democratic Socialism is a unique social-ethical rendering of interdependent co-arising. Being a peace-maker
becomes a way of following the Noble Eightfold Path.” (Swearer, ed, 1991, p.1)

According to the Buddhist viewpoint, nothing exists in independence. Everything co-exists interdependently. The arising of The Twelve Factors of ‘Dependent Origination’ (paticcasamuppāda) is the arising of the idea of I and mine, which is the main cause of ‘suffering’ (dukkha). Buddhadasa Bhikkhu stated that:

“Dependent Origination refers to the arising and passing away of attachment to the ‘I’ concept at any one time. Moreover, it means understanding the arising and passing away in terms of paticca-samupana-dhamma: merely interdependent natural phenomenon arising and passing away. Dependent on something, something arises. Dependent of something, something passes away.” (Buddhadasa Bhikkhu, 2002, p.74)

Buddhadasa Bhikkhu also emphasized on applying this principle and the theory of ‘emptiness’ (suññatā) to daily life, through the practice of releasing the idea of I and mine, or ‘selfness’ (attā) to ‘selflessness’ (anattā), or non-attachment to I and mine. Buddhadasa Bhikkhu pointed out that the Buddha gave a practical lesson of ‘emptiness’ (suññatā) as an eternal benefit and for the welfare of all human beings in a secular society, as follows:

“That being so, who most needs something to extinguish that fire, to completely be of absolute coolness right there in the midst of the fire? That point is emptiness, the absence of self and belonging to self, suññatā. This group of people asked what would be of eternal benefit to them, and the Buddha answered: suññatā-ppatisamyutta lokuttarā dhamma- dhamma endowed with suññatā, transcending to be endowed with suññatā, is to be empty of clinging to things as self or as belonging to self.” (Buddhadasa Bhikkhu, 1984, pp. 54-55)
Moreover, it can be observed that he explained the practical way to be free from ‘defilement’ (kilesa) and ‘suffering’ (dukkha) through the concept of ‘emptiness’ (suññatā), which is the core teaching of Zen and Mahāyāna for mutual understanding of the fundamental essence of the ‘Buddha’s teachings’ (dhamma): “The conditions of emptiness resulting from the complete and thorough elimination of the ‘self-idea’ is nibbāna. This can be summarized by saying Nibbāna is supreme emptiness, or supreme emptiness is nibbāna” (Buddhadasa Bhikkhu, 2007a, p.99). He encouraged people to take interest in the heart of ‘Buddhist teachings’ (dhamma) rather than different sects of Buddhism: “True Buddhism is neither Theravāda nor Mahāyāna.” (Quoted by Jackson, 2003, p.181 in Buddhadasa Bhikkhu, 1977, p.1) Therefore, if people can envisage the world as emptiness then people can fulfill their daily lives with happiness and ‘mindfulness’ (sati), whilst sharing ‘loving-kindness’ (mettā) and ‘compassion’ (karuṇā) with others, as well as respecting each other.

3.1.3 Buddhadasa Bhikkhu and Socio-Political Patronage over the Thai Buddhist monk community (Saṅgha)

The Thai traditional view of the three pillar institutions are; the nation (chart), religion (satsana), and the king (phra mahakasat). Nearly 95% of Thailand's population is Buddhist. The ‘Buddha’s teachings’ (Dhamma) have been applied to the form of the way of life in Thai national society, so it can be said that Buddhism and Thai national stability cannot be separated. Additionally, the morality of the Ruler of Thai citizens has
an effect upon the tranquility, well-being and prosperity of the nation. Conversely, the
prosperity of the nation has an effect upon the religion, Buddhism and the ‘Buddhist
monk community’ (Saṅgha). Somboon Suksamran described that:

“It is thus a vital traditional function of the Political Ruler to promote,
support, and protect Buddhism and the Saṅgha. It has always been
maintained that if this function is not successfully performed then Thais
would lose faith in the Saṅgha, in Buddhism, and ultimately in society’s
moral foundation.” (Suksamran, 1982, p.12)

Since the Sukothai period to the period of Thai political change in 1932, the
King played an important role both as, the absolute protector and promoter of Buddhism
and the ‘Buddhist monk community’ (Saṅgha), and the commander of the government.
After the change of the Thai political system from absolute monarchy to a monarchical
democracy, the main duty of the protection and promotion of Buddhism and the
‘Buddhist monk community’ (Saṅgha) was turned over to the Thai government. The
Department of Religious Affairs, Ministry of Culture, is the central organization which
works with regard to Thai religious affairs. This department and ‘the Saṅgha Supreme
Council of Thailand, or the Council of Elders’ (Mahatherasamākhom) which had been
set up in period of King Rama V, play a key role in controlling Thai Buddhist monks,
and protect the monks against themselves. The power of designation of the
ecclesiastical honorific tile award of the king was turned to the hand of the Supreme
Patriarch (Somdēt Phra Sangkharāt). Somboon Suksamran pointed out that:

“At present the King appoints the Supreme Patriarch as previous Kings
did, and confers certain prestigious honorary titles, such as Somdēt Phra
Rajakana and Phra Rajakana, which are essential for holding high office
within the Saṅgha administration. These monks are normally nominated
by the Council of Elders. The award of honorific titles to the monks, and their appointment to the ecclesiastical office, are based ideally on merit. The criteria are competence in terms of ecclesiastical education or of the religious and secular work they have performed, especially work which contributes to the prosperity of religion and society. However, in some cases patronage plays a conspicuous part. A learned monk asserts that some monks flatter authorities who can bestow favors.” (Suksamran, 1977, p.31)

After the establishment of Suan Mokkh in 1932, Buddhādāsa Bhikkhu tried to reform the propagation of the ‘Buddha’s teachings’ (dhamma) by returning to the original meanings, as well as adjusting the doctrine to the needs of the people in the contemporary era. He saw that most of the monks in Bangkok had the behavior of excessively luxurious life styles. This is different from Buddhist orthodoxy, in which monks should not accumulate wealth. In 1948, he was invited to give a lecture at the Buddhist Association of Thailand (Buddhāsamākhom) - ‘The Mountainous Methods of Buddhist Dhamma - Things Which Obstruct People from Obtaining Buddhist Dhamma’. He lectured this topic by interpreting the Buddhist doctrine principle in comparison to its scientific counterparts. He criticized the practice of both Thai lay Buddhists and monks, including the Thai Buddhist monk hierarchy, in that he was accused by some lay-persons and monks of being communist.

Although he severely criticized the practice of the traditional Thai ‘Buddhist monk community’ (Sāṅgha), he never refused the authority of the ‘Buddhist monk community’ (Sāṅgha). In 1949, he was appointed to be the fifth regional leader for the propagation of ‘Buddhist doctrine’ (dhamma) throughout fourteen provinces of the South. Later, in 1967, he was chosen to be the leader of the firstling training of dhamma
'ambassador monks' (*dhammaduta*), in their going abroad to propagate Buddhism (Pasannadhhammo Bhikkhu, 1985, p.471).

However, he spoke out through his works *Dhamma and Politics* and *Dhammic Socialism*, regarding the ideal state, as being like the historical Buddhist society in which the King, the cabinet and the people kept steadfast for good morality. Professor Somboon Suksamran gave his opinions regarding the theory of *Dhammic Socialism* as thus:

"It was intended to provide a Buddhist compromise between secular left and right-wing ideologies. Though his ideas were exploited by both left and right wing political monks to suit their goals, essentially he has a conservative viewpoint which emphasized the duties and responsibilities of individuals to their religion, government, nation and their fellow men." (Suksamran, 1982, pp.91-92)

Taweewat Poondarikviwat argued that:

"Latter political works of Buddhadasa got along well with the Buddhism of Thai governing classes, which tried to build righteousness into an absolute centralized administration, and they stressed to have a strong leader who has morality and responsibilities in providing national welfare." (Poondarikviwat, 1997, p.96)

A reputation in knowledge of Buddhist doctrine and Buddhist scriptures, and the ability to propagate Buddhism and good behavior, were brought into consideration, and the bestowing of the honorific title of Phra Dharmakosacarya to him. This honorific position can bear comparison with the regional inspectors of the Thai government. According to those aforementioned reasons, the government sent doctors to treat him when he was ill, because he was a highly valued person within the Thai nation.
3.1.4 The problematic issues of the death of Buddhadasa Bhikkhu

In the case of Buddhadasa Bhikkhu's death, it takes the floor of dissemination in issues of euthanasia, and the rights of a patient to refuse treatment. To return to the case of Buddhadasa Bhikkhu, a famous, innovative re-interpreter of Buddhist doctrine in the 20th century; he often disclosed his wishes to his disciples, and wrote a living will indicating that in case of an incurable coma he did not want to prolong his life by using life-sustaining measures, such as feeding tubes and respirators, to maintain his bodily functions. He preferred a peaceful death by natural ways. San Hatteerat claimed that Buddhadasa Bhikkhu often showed his steady intentions, as thus: "wished to die naturally, no use of respirators, no use of tubes, no tracheostomy, and a wish to die at his monastery" (Hatteerat, 1993b, p.8). Buddhadasa Bhikkhu saw that the use of chemical and mechanical devices to control the body as unnatural, and he strongly emphasized and believed in the power of self-healing through natural means, in accordance with the 'teachings of the Buddha' (dhamma). When he was diagnosed with heart disease in October 1991, doctors wanted to treat him at a hospital but he refused, preferring instead to treat himself at his own monastery, Suanmok, without any high-tech medical assistance. Nitipat Jearakul, one of his attending doctors, took notes about Buddhadasa Bhikkhu's steadfast intention, as follows:

"I would like my illness and my medical treatment to be in accordance with a natural way, in similarity to the illness of Buddhist monks in the Buddha's period which made this land (Suan Mokkh) a hospital." (Jearakul, 2012, p.33)
Buddhadāsa Bhikkhu was not hostile towards modern science, but he viewed medical science as only one component of the treatment of illness. He did not reject all medical treatment, but he rejected the use of modern high-tech medical devices to prolong the dying process. He believed that even if in the last conscious moments of one's life one still has the opportunity to expunge all defilements and attachments, allowing one to attain nibbāna.

After suffering a stroke, he went into a coma in the early morning of May 25th 1993. Anothai, the author of a study about the death of Buddhadasa Bhikkhu, wrote down that:

"In the early morning, 25th May 1993, his disciples and doctors sent Buddhadasa Bhikkhu, who was unconscious at the time, to Sutthani hospital at 3p.m. and scanned his brain using an electronic computer. It found a cerebral haemorrhage in his brain. Then he was sent to Siriraj hospital on 29th May 1993." (Anothai, 2002, p.34)

However, there was a debate among his attending doctors and his disciples, about sending him to Siriraj hospital, in Bangkok, or keeping him at his monastery. Nitipat Jearakul explained, in his verbal notes about Buddhadasa Bhikkhu's symptoms, that Nipon Pongvarin, a specialty neurologist at Siriraj hospital, told him to bring this Buddhist monk to Bangkok. Buddhadasa Bhikkhu was admitted to Siriraj hospital after 1:00 a.m., on 29th May 1993. The attending doctors decided to use life-prolonging medical devices to save his life. One of his close disciples, Phrakru Bhavana Chaikhun (Bodhi Jantasaro), said that, "Nipon said if the correct medical treatment was used then Buddhadasa Bhikkhu could recover, so we took him to Bangkok" (Professor Jitti
Tingsapat, Fund & the Medical Council of Thailand, 2000, p.78). Nevertheless, Buddhadasa Bhikkhu still remained in a coma for one month. After some of his disciples saw no improvement in their master’s illness they protested strongly, because the treatment administered was against the wishes of their master. They wanted the attending doctors to stop life-prolonging treatment and send him back to his monastery, to die naturally. However, the attending doctors still believed in the power of modern medical science and continued treatment. Anothai noted that:

“A declaration by doctors on 7th July 1993 declared the symptoms, whereby; there was subsidence of cerebral tissue rim, an inoperative excretory system, kidney failure, an intumesced body, and many concurrent diseases. The doctors were very serious, because there was only a one percent chance of recovering him (Buddhadasa Bhikkhu). However, they still confidently declared that the use of medical technologies could prolong his life, even though they stopped prolonging his dying process a few hours later because they did not entirely have the ability to save his life.” (Anothai, 2002, p.67)

At about 2:00 a.m. on 8th July 1993, his blood pressure continuously lowered and so the attending doctors decided to take him back to his monastery by plane, but still with an automatic respirator and feeding tubes in place. He arrived home to his monastery, Suan Mokkh, at about 10.30 a.m. that morning, after he had spent forty-one days in Siriraj hospital. Anothai noted that: “At 11.20 a.m. Master Buddhadasa Bhikkhu died peacefully in his temple. His heart stopped beating naturally. Previously, doctors had tried to sustain his life by using a respirator and other devices, until the last minute” (Anothai, 2002, p.36).
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Buddhadāsa Bhikkhu’s death

Two main discordances immediately became apparent. First, some of his
disciples had requested that the doctors cease all medical treatment, but the doctors had
refused. This conflict is judged to be in the scope of non-voluntary passive euthanasia,
which means ceasing medical devices which are used to prolong an incompetent
patient’s life. Should the attending doctors have permitted passive euthanasia, or should
they have continued treatment? Second, the case of Buddhadasa Bhikkhu also raises the
question; should his disciples and the attending doctors have respected his right to
refuse treatment, or not?

3.2 Euthanasia in the case of Buddhadasa Bhikkhu’s death

3.2.1 Euthanasia in the case of Buddhadasa Bhikkhu’s death in comparison
to the case study of euthanasia in the Buddhist texts

Even though there have been many cases in the category of the third ‘rule
pertaining to the expulsion from monkhood’ (pārājika), which was noted in ‘The Book
of Discipline’ (Vinaya) and which differs from modern ethical problems in the present
world, the researcher observes that some of them can be applied, in order to be used as a
guideline for solving moral and ethical dilemmas in medical care. In the case of
Buddhadāsa Bhikkhu who was in a coma, the debate of morally conflicting problems
within the context of non-voluntary passive euthanasia, had been started from the
differing viewpoints of his disciples and his attending doctors. That is to say, between
letting him die in a natural way and on the contrary, saving his life at all costs, although
his attending doctors still continued to use extraordinary means to prolong his life until
he died. However, the raised moral question is what should the attending doctors do in such cases?

In ‘The Book of Discipline’ (*Vinaya*), there is one case about a monk who went to a place of execution and asked the executioner for a sudden death of the prisoner. The monk said to the executioner, “Reverend Sir, do not keep him in misery. By one blow, deprive him of life. ‘I will not do your bidding’, he (the executioner) said, (but) deprived him of life” (*Vin III 85*) 26. The motive of this monk was to spare the mental suffering of the prisoner, who was waiting for his execution time. Although his request was rejected by the executioner, the prisoner was to have been killed anyway. The Buddha judged this case that: “Monk, there is no offence involving defeat. However, there is an offence in wrong-doing” (*Vin III 85*) 27. Even though this monk was not judged as to violating the prohibition of taking a life, he was judged as to having committed an offence of wrong-doing.

To compare with the modern context of euthanasia in the case of Buddhadāsa Bhikkhu’s death. The researcher supposes that the monk was his own disciple, the executioner was his attending doctor, and the prisoner was a terminally ill patient, Buddhadāsa Bhikkhu. Some of his disciples, who called for the withdrawal of the

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26 āvuso mā yimaṁ kilamesi, ekena pahārena jīvitā voropehīti. so nāhaṁ tuyhaṁ vacanaṁ karissāmīti taṁ jīvitā voropesi. (*Vin III 85*)

27 anāpatti bhikkhu pārājikassa, āpatti dukkaṭassā’ ti. (*Vin III 85*)
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respirator and the feeding tubes, were judged as to having committed an offence of wrong-doing, although the attending doctors did not respond to their requests.

Another case was that of a monk who told an executioner to end a death row prisoner’s life with a single blow, in order to release him from the misery of having to wait for the execution time, and the executioner did so according to the monk’s request. The Buddha judged that in this case the monk was in breach of the precept, thus: “You, monk, have fallen into an offence involving defeat” (Vin III 85)\(^{28}\). Therefore, if Buddhadāsa Bhikkhu’s attending doctors had accepted his disciples’ requests, and stopped the artificial medical means, both of them would be judged as violating the prohibition of taking a life, in Buddhism.

3.2.2 Scholar’s perspectives on euthanasia in the case of Buddhadāsa Bhikkhu’s death

The contradictory issues between Buddhadāsa Bhikkhu’s disciples and his attending doctors were the different opinions about the continuous treatment, or the stopping of his artificial respirator, and to simply permit him to die naturally. Phra Maha Wanchai Dhammajayo analyzed the euthanasia issue of Buddhadāsa Bhikkhu by applying the five factors of the first precept of Buddhism, that being the prohibition of taking life. He explained that the attending doctors stopped life-support machines and

\(^{28}\) āpattip tvām bhikkhu āpanno pārājikam ti. (Vin III 85)
their intentions were not to kill Buddhadasa Bhikkhu, but they lost hope in saving his life, so they allowed him to die in a natural way - according to his wishes:

"The detachment of medical machines by doctors was a procedure based upon Buddhadasa Bhikkhu's wishes, in that he wanted to die at his monastery, Suan Mokkh, without medical equipment being used. That does not pertain to a killing 'intention'. On the way, the doctors lost all hope in recovering him so they decided to stop treatment. Such cessation of medical treatment is judged that it has no intention to kill, in Buddhist principles, so their actions did not violate the precept of prohibition in killing." (Wanchai Dhammajayo, 2005, p.48)

The researcher disagrees with Phra Maha Wanchai Dhammajayo's opinion. First, he may have received wrong information regarding the cessation of Buddhadasa Bhikkhu's treatment from the attending doctors. In fact, the attending doctors neither stopped nor switched medical means off. Anothai noted this past occurrence: "At the end, the doctors did not turn the respirator off and so he (Buddhadasa Bhikkhu) died, even if the respirator was being used" (Anothai, 2002, p.74). One of his attending doctors, Nitipat Jearakul, wrote down in his memo that:

"After 29th May 1993, we had still provided intravenous injections accompanied by the use of a respirator which had both been prepared at Sutthani hospital. Ultimately, we found that his pulse had stopped and that Master Buddhadasa Bhikkhu had died peacefully, at 11.20 a.m. on Thursday 8th July 1993." (Jerakul, 2012, pp.117-118)

Secondly, the researcher supposes if the attending doctors stopped Buddhadasa Bhikkhu's life-support machines, they consciously realized that their actions would result in the death of this monk, and thus their actions would have taken a risk in direct breach of the first precept.
However, in fact, no one stopped his medical treatment. The researcher agrees with Pinit Ratanakul's opinion that, "none of them wanted to be blamed for causing the death of such a saintly monk, as that would have very grave kammic consequences for them all" (Ratanakul, 2000, p.174). The researcher shall discuss in more detail about euthanasia in the case of this well-known scholarly monk later.

### 3.3 The right to refuse treatment in the case of Buddhadasa Bhikkhu's death

Buddhadasa Bhikkhu preferred to encounter death with a peaceful mind, and so he always intended to reject the use of extraordinary means to prolong his life. However, his right to a natural death was over-ruled by his attending doctors. His case began a debate about the issue of the rights to refuse treatment.

#### 3.3.1 The rights of a patient to refuse treatment, in general

The World Medical Association (WMA) realized the significance of the rights of a patient, and so in October 2006 it declared the 'Declaration of Venice on Terminal Illness', ratified by the 35th World Medical Assembly in Venice, Italy. That was reaffirmed by the 57th WMA General Assembly in Pilanesberg, South Africa, with the third topic of this declaration highlighting that:

"A patient's right to autonomy in decision-making must be respected with regard to decisions made in the terminal phase of life. This includes the right to refuse treatment and to request palliative measures, in order to relieve suffering; but which may have the additional effect of accelerating the dying process. However, physicians are ethically prohibited from actively assisting patients in suicide. This includes administering any treatment for which the palliative benefits, in the opinion of the physician, do not justify the additional effects." (WMA, 2006b)
This declaration relates to the right of self-determination, based upon the 'Declaration of Lisbon and the Rights of the Patient', adopted by the 34th World Medical Assembly in Lisbon, Portugal, in September-October 1981. It was editorially revised in the 171st WMA Council Session in Santiago, Chile, in October 2005; with the third topic of this declaration stating:

"The patient has the right to self-determination and to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his/her decisions. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. A patient has the right to necessary information, in order to make clear decisions. A patient should clearly understand what the purpose of any test or treatment is, what the results would imply and what the implications would be in withholding consent. A patient has the right to refuse to participate in research or the teaching of medicine. (WMA, 2005)

In addition, the WMA affirmed the rights of unconscious patients in the fourth topic of this declaration, as follows:

"If a patient is unconscious or otherwise unable to express his/her will then informed consent must be obtained whenever possible, and from a legally entitled representative. If a legally entitled representative is not available, but medical intervention is urgently needed, then consent of the patient may be "presumed" unless it is obvious and beyond any doubt, on the basis of the patient's previous firm expression or conviction, that he/she would refuse consent to any intervention in that situation. However, physicians should always try to save the life of a patient who is unconscious due to a suicide attempt." (WMA, 2005)

The WMA also gave guidelines to medical practitioners, in order to manage the problem of unconscious patients' treatment. So herein lies the fifth topic of the 'Declaration of Venice on Terminal Illness', as thus:
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"Physicians should recognize the right of patients to develop written advance directives that describe their wishes regarding care, in the event that they are unable to communicate, and that can designate a substitute decision-maker to make decisions that are not expressed in the advance directive. In particular, physicians should discuss a patient's wishes regarding the approaches to life-sustaining intervention, as well as palliative measures that might have an additional effect of accelerating death. Whenever possible, the patient's substitute decision-maker should be included in these conversations." (WMA, 2006b)

The researcher sees that the WMA seemingly respected the right to refuse treatment of patients, if they showed their informed consent or had prepared a living will. If unconscious patients do not express their wishes, or prepare living wills, the WMA affirmed that the medical practitioners should discuss with patients' surrogates first, before they perform further treatment. However, the WMA clearly rejected assisted suicide, and allowed medical practitioners to provide medical treatment, in cases of urgent needs, if patients did not show any expression.

Moreover, the WMA opened up the gap to perform medical intervention against a patient's will as: "diagnostic procedures or treatment against a patient's will can only be carried out in exceptional cases, when specifically permitted by law and conforming to the principles of medical ethics" (WMA, 2005). The researcher has doubts about what the real reasons are for medical practitioners to want to refuse the needs of fully conscious patients, and who are in receipt of current medical information and fully understand their situation clearly. The researcher do not have confidence as to whether medical intervention is in line with the biomedical ethical principles of beneficence and maleficence of a patient, or if they are not. Their relatives or surrogates may use the
powers of law to merely relieve their own suffering from the loss of their loved ones, or they may receive some advantages if the patient still be alive. However, the researcher agrees to that if medical practitioners try to save their patient’s life in an emergency case. In the case of much younger patients or a patient who has not reached legal age then, if medical practitioners and their surrogates decide to provide medical treatment, the researcher must suggest that they provide hospice and palliative care in order to relieve suffering and support their psychological and spiritual needs, instead of implementing extraordinary treatment that may increase suffering and uncomfortability. According to the declaration of the WMA, which has allowed medical practitioners to stop palliative care if they decide that the benefits are not worthwhile, in comparison to the additional effects, the researcher still has simple questions to ask as to what the additional effects of the opinion of the WMA are, and how we can be confident in the opinion of medical practitioners? The researcher always sees the giving of palliative care at the end of a life as being an ethical practice, and a benefit for patients’ body and mind.

3.3.2 The rights of the patient to refuse treatment in Thailand

On April 16th 1998, based upon the third issue of the declaration of a patient’s right in Thailand, the Medical Council of Thailand made the following statement for clarification:

“Patients who seek medical services have the right to receive their complete and current medical information from their doctor, in order to thoroughly understand their illness. Furthermore, patients can either
voluntarily consent to, or refuse, treatment from the medical practitioner treating them; 'except in emergencies or in life threatening situations'."

(The Medical Council of Thailand, 2000, p.2)

This declaration is related to the third topic of the WMA ‘Declaration of Venice on Terminal Illness’. In theory, the patient has the true right to receive or refuse treatment. It is not a problem in the case of a competent patient who has voluntary understanding of the decisions, and who can also communicate with others, and can comprehend and appreciate the consequences of refusing medical treatment. In fact, most dying patients who are in a coma and unable to speak cannot make decisions for themselves, and so the burden of making a decision about their receipt or refusal of medical treatment is the duty of their doctors and their relatives, or their surrogates. Sometimes the conflicts of problems occur amongst differences of opinions. These problems bring forth the idea of advance directives, or a ‘living will’. Section 12 of the Thai National Health Act of 2007 asserts a patient’s rights to prepare a written living will and to refuse futile medical treatment that would prolong terminal stages of life, and which would only relieve symptoms that would otherwise not end severe suffering.

The President of Dhurakij Pundit University, Varakon Samakoses describes the brief details of preparing a living will through received information from Amphon Jindawatthana, one who supports the use of section 12, as thus:

"Any person who is fully competent, which means a healthy person, elder or a patient who has decision-making capacity, and is above the age of eighteen, can make a living will. The process of making a living will can be done by both typing and writing, and by them or at the request of another person to do it for them. A list of information should contain; the patient’s name, surname, age, ID card number, signature or fingerprint,
current address and contact number, the date that the living will is made, including a witness’s name and surname, ID card number, signature or fingerprint and how he or she is relevant to the patient. In a living will the patient must write undesirable medical treatment, or request to cease undesirable health services in the case of the doctors and nurses performing it without knowing his or her living will beforehand. A living will should be made in copy form, to submit to the attending doctors and the relatives, in order to help the attending doctors and nurses to do everything that respects the rights and wishes of their patient, and to help the relatives understand the current illness situation and the real purpose of the patient.” (Samakoses, 2011, p.6)

A person who is below the age of eighteen is required to obtain the informed consent of his or her parent/s, or legal surrogate/s. This section is related to the fifth topic of the WMA ‘Declaration of Venice on Terminal Illness’, which requires that medical practitioners should respect the living wills of their patients, and should discuss with the patient’s surrogate/s before providing or refusing life-prolonging treatment. Dusit Staworn explained the practical way for a medical practitioner after receiving the patient’s living will:

“A patient who can display obvious or clearly informed consent, in that they want to die with dignity and want to refuse complicated technological treatment that cannot save their life, and may well replace pain and suffering including cardiopulmonary resuscitation, the use of endotracheal tubes and artificial respirators; then in such cases, if doctors consider the accuracy and suitability of a life being based upon the four standard principles of biomedical ethics, which are; beneficence, maleficence, autonomy and complete justice, it is therefore necessary for them to explain the consequences and the ill effects to their patients’ families and relatives.” (Staworn, 2007, pp.412-415)

However, the former president of The Medical Council of Thailand, Amnaj Kussalanan, and the assistant secretary of The Medical Council of Thailand, Wisut Lajchasawee, both argued in reference to section 12, on June 30th 201, as follows:
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"This Ministerial regulation has many covenants which violate and limit the rights of a patient and the doctor. It forces the doctor to stop treatment or clearly hasten the patient’s death or, for example, to make an exception in saving life by the withdrawal of an artificial respirator; and this is contrary to medical ethics." (Editorial team, 2011, p.31)

Sawaeng Boonchalermviphas argued against that opinion, as follows:

"The right to develop a written living will is not a provision of the right to suicide for any person, but it is the right to refuse public health services in the terminal stages of life when the patient’s condition is inevitable and the patient prefers to die in a natural way, and requests to neither restrain or go against death with any method. The preparation of a living will is not euthanasia, nor is it the acceleration of death, but is simply the patient’s request to die naturally.” (Editorial team, 2011, pp.33-35)

Nevertheless, the right to refuse treatment is the withholding or the withdrawal of futile medical treatment, which is simply used to temporarily prolong their lives. It does not mean that medical practitioners stop all treatment, but that they still provide palliative care, in order to alleviate pain and suffering. Sawaeng Boonchalermviphas insisted that:

“An act done, in compliance with a patient’s request to not perform a tracheostomy, or not to attempt resuscitation (DNAR), does not mean that doctors will neglect their duties. Palliative care is still being provided, so no issues can be used to blame any dereliction by doctors.” (Editorial team, 2011, pp.34)

Varakon Samakoses explained this point as follows:

“Although a patient makes a living will, it does not mean the doctor and health care providers ignore the patient when they see a prepared living will. The doctors and health care providers still have a duty to help and take care of the patient, until the terminal stage of life, by providing palliative care.” (Samakoses, 2011, p.6)
Finally, The Medical Council of Thailand accepted section 12 of the National Health Act of 2007, on July 14th 2011, and proposed certain definitions of the terminal stage patient as thus: “the patient whose doctor knows with certainty that the current received medical treatment, or further treatment, cannot prolong life, in being enough to maintain and sustain human dignity” (Boonchalermviphas, 2007, p.403):

The researcher agrees to the use of both living and palliative care. However, in the case of patients who have the option of extraordinary medical means to be applied to them then the researcher requests the continuation of treatment, because no one can guarantee the correctness of prognosis wherein doctors’ opinions are required on a case-by-case basis, in order to determine whether or not a patient is considered terminally ill.

From my traditional religious perspective, the medical practitioner should avoid any risk of breaching the moral precept of taking life. In my considered legally correct perspective, everyone should be receiving proper health services, such as hospice or palliative care, until their last moments of life, according to the right to receive public health services and welfare from the State; set out in Article 51 of the Thai Constitution, as follows:

“A person shall enjoy an equal right to receive public health services which are appropriate and measure up to the best quality, and the indigent shall have the right to receive free medical treatment from public health centers of the State. A person has the right to receive public health services from the State, which shall be provided thoroughly and efficiently. A person has the right to be appropriately protected by the State against harmful contagious diseases, and to have such diseases eradicated, without charge and in a timely manner.” (Nanakorn, tr, 2007, p.22)
3.3.3 The right to refuse treatment in the case of Buddhadasa Bhikkhu’s death

In particular, the death of Buddhadasa Bhikkhu needs to be examined regarding the right of a patient to refuse treatment. As previously mentioned, Buddhadasa Bhikkhu was a well-known 20th century innovative re-interpreter of Buddhist doctrine, who had no desire to have his life prolonged by extraordinary means. Whilst fully conscious, he made his wishes known to his disciples and had also written a living will stating such. Phrakru Bhavana Chaikhun (Bodhi Jantasaro) said about Buddhadasa Bhikkhu’s steadfast intentions, thus: “do not treat more than is necessary. If seeing it has reached its end then it is better to let go of life naturally. Do not make distress in mind. If it has something disheveled in body, mind cannot be peaceful inside” (Anothai, 2002, p.76). His objective was to consider ‘painful feelings’ (dukkha-vedanā) in a natural way. He preferred to die peacefully and naturally, but his wishes were corrupted by his attending doctors in their sending him to be admitted to hospital, and in their decision to use artificial medical means to save his life.

Prayanee wrote in her article ‘Prolong Life - Prolong Death’; a remembrance of death, in the case of Buddhadasa. She gave her opinions that the main causes of the conflict in the case of Buddhadasa Bhikkhu’s illness came from two diverse opinions of idealist and capitalist supporters:

“The idealists see that Buddhadasa Bhikkhu’s medical treatment was to arrest his objective, which was that he preferred to desert his life by following the way of Buddha’s teachings. He often expressed his wish
that he did not want to age older than the Buddha, and so he refused to be treated at hospital. However, the capitalists claim that the medical practitioners had a duty, based upon biomedical ethics, because they were trained to save lives.” (Prayanee, 1993, p.7)

The Thai Buddhist scholar, Phra Paisal Visalo remonstrated in an article to show the true wishes of Buddhadasa Bhikkhu, who preferred to die with a peaceful mind, and by natural causes. He affirmed that the refusal to be treated at hospital by Buddhadasa Bhikkhu was not a thought of suicide and, although some actions may have had a bad effect upon his physical body and life, the objectives of his intentions do not emphasize a breakdown of life. The things Buddhadasa Bhikkhu acted upon did not follow the present social values of most people, who want to escape death. When he still had consciousness he refused to be sent to hospital, even though the attending doctors or intimates tried to explain the processes, with goodwill. However, he could not choose the way to die. Many people came to take away the right to self-determination, and chose the way for him because he was a public man. Everyone wanted to have a right, in terms of his death. Moreover, Phra Paisal Visalo affirmed that many cases of terminally ill patients in a hospital are simply the prolonging of life, in terms of quantity of respiration. Here is a life without quality and meaning. Even if there are many diseases that doctors can, indeed, heal; we may not escape death. If people do not see and understand the limits of medical practitioners then they lose both their possessions and their chance to consider death with a calm mind:

"That should neither let the doctor become an arbiter, to specify what I should die of, nor to choose my way of death. The attachment in the abilities of physicians, by not seeing the limits of their abilities, not only
Chapter III: Comparative discussion concerning euthanasia in Buddhism in the case of
Buddhadāsa Bhikkhu’s death

loses money but also loses an opportunity to consider death with a
peaceful mind, and without searching for ‘the escape route’. If we relieve
the attachment in physicians, see the limits of them, stop thinking about
escaping death, and practice our own self to be ready to confront death at
every moment, then we will understand the Venerable Buddhadasa’s
intention, which he explained before he became ill.” (Paisal Visalo,
1993, p.10)

However, according to the designation in taking the highly ecclesiastical title of
Phra Dharmakosacarya from King Rama IX, when he lost his consciousness from his
long suffering stroke, there was news that King Rama IX had ordered for him to be
taken for treatment at Siriraj hospital, in Bangkok. Thai lawyer, Narong Nitichamd
wrote, “King Rama IX had royal grace to bestow upon a plane to receive Buddhadasa
Bhikkhu for treatment at Siriraj hospital” (Nitichamd, 2000, p.42). Furthermore, Narong
expressed his opinion that the attending doctors had the right to treat Buddhadasa
Bhikkhu:

“When talking about the duty to judge if the treatment should have been
continued for Buddhadasa Bhikkhu, or not, then there was no hesitation
in immediately answering that the doctor was the decision-maker,
because at that moment Buddhadasa Bhikkhu was in the status of being a
patient, and in a coma.” (Nitichamd, 2000, p.43)

Additionally, Pinit Ratanakul explained the decision to save Buddhadasa
Bhikkhu’s life from a doctors’ perspective:

“Their underlying belief was that it was a doctor’s duty to save lives
when there was some spark of hope, and that prolonging life, even if
only for hours, was worthwhile. Saving the life of this particular monk
was of great importance, because of his reputation as a prominent scholar
and teacher, and his inspiration as a modern saint of Buddhism.”
(Ratanakul, 2000, p.172)
Nevertheless, Anothai mentioned Buddhadasa Bhikkhu’s words that a patient has the right to receive or refuse treatment: “it is truly a patient’s right to receive or refuse treatment” (Anothai, 2000, p.84).

Anothai also mentioned Buddhadasa Bhikkhu’s answers to the question of some medical practitioners of whether the refusal of extraordinary medical treatment is different from suicide, such as hanging or taking an overdose of drugs: “suicide and taking an overdose of drugs consist of delusion (moha) and hatred (dosa)” (Anothai, 2000, p.85).

The researcher wants to express two opinions about his case. First, his disciples and his doctors knew of his wishes to not use extraordinary means to prolong his life. His disciples and his doctors should have complied with his wishes, by not using artificial means and allowing him to die naturally, because his wishes did not violate Buddhist morals. He had no desire to cause himself more suffering. He simply wanted to confront death with a peaceful mind. Second, if he had not expressed his intentions, nor had he not prepared a living will and rejected life-prolonging treatment, his doctors would have had a moral duty to treat him. However, they should have avoided using extraordinary means. This is an expression of ‘compassion’ (karunā) wherein people desire to relieve others of ‘suffering’ (dukkha). Again, however, because he had a living will his doctors should not have put him on life support in the first place, as that could increase his needless suffering and interfere with his wishes.
The actions of Buddhadasa Bhikkhu’s doctors, in deciding to send him to Siriraj Hospital in order to save him by extraordinary means, were in conflict with the rights of unconscious patients in the WMA ‘Declaration of Lisbon on the Rights of the Patient’, the third topic of a patient’s declaration rights, and section 12 of the National Health Act of 2007 of Thailand, because they knew of his expressed wishes to refuse extraordinary treatment beforehand. Therefore, I propose that medical practitioners must legally comply with a patient’s right to refuse medical treatment.

Buddhadāsa Bhikkhu’s living will made clear the wishes of this revered monk, who had devoted over sixty years of his life to understanding the heart of the Buddhist teachings. He had practiced Buddhism daily, and had prepared his mind to confront death peacefully. He was ready to face death without fear, and often insisted that people have the opportunity to attain ‘liberation’ (nibbāna) until the last conscious moment of life. According to Buddhist teachings, the thought process that arises near the time of death (maraññasanā-viññī) is very important. If a dying person has an untainted mind at the moment of death then they will be reborn into ‘a happier existence’ (sugatibhūmi).

In the book ‘The Living Will Declaration of the Geriatrics Institution’ Theravada scholar Phra Brahmagunabhorn (P. A. Payutto) explains that: ‘Buddhism affirms that human beings have the opportunity to become enlightened, even in their last consciousness moments of life’ (Geriatrics Institution, 1998, pp.12-13). Therefore, the actions of Buddhadasa Bhikkhu’s doctors and his disciples can be regarded as not only
interrupting 'the thought process of dying' (*cuticittavīthi*), but also his opportunity for enlightenment.

### 3.4 Discussion of euthanasia in the case of Buddhadasa Bhikkhu’s death and Buddhadasa Bhikkhu’s views on death

To respect Buddhadasa Bhikkhu’s wish to die in a natural way and without the use of chemical and extraordinary medical machines, some of his disciples requested his attending doctors to remove the respirator, the feeding tubes and all life-prolonging machines. They further requested that he be sent back to die in his monastery, when they saw the treatment was useless in saving their master’s life. If their request had been granted it would have been non-voluntary passive euthanasia, which means the cessation of life-support systems of an incompetent person. However, his attending doctors insisted on the power of modern medical science, so they continued to ‘save his life’, even when they knew very well that their actions were against Buddhadasa Bhikkhu’s expressed wishes contained in his living will. Buddhadasa Bhikkhu’s case is regarded as an issue of the incompetent patient who prepares his or her living will while still fully, reasonably competent. In many raised cases by Dusit Staworn, there is one other interesting case which should be used to consider such an issue. He mentioned the case of an incompetent seventy-two year old lady who had suffered severe brain damage, and had remained in an intensive care unit (ICU), with a respirator in place, for more than two months. Her son informed the doctors that she and her husband had made a living will together, some years earlier. The message on her living will insisted...
that she did not want to prolong her life by using a respirator and modern medical technology, her meaning being if she became a case of being in a terminal condition or of being in a permanent vegetative state then she wanted no medical intervention or support. However, her husband rejected her wishes and he begged the medical practitioners to prolong her life. On the contrary, her son wanted to respect her wishes (Staworn, 2007, p.416).

Dusit Staworn concluded that the two main legislative and biomedical ethical points for judgment in this case were patient autonomy and informed consent. In this case, the patient was in a coma and unable to speak for herself. He explained thus:

"This patient was not within the scope of showing her informed consent after receiving information from doctors, because of her lack of decision capacity. The practical way to consider such a case had two ways; the consideration from advance directives or, alternatively, her surrogate decision maker." (Staworn, 2007, p.417)

Dusit Staworn described that an advance directive can be separated into different forms, such as; a living will or a written book which shows the desire to receive or reject any kind of treatment, durable power of attorney, and or a written directive. Even though there is an argument that patients may change their minds when they are facing death, he also insisted upon medical principles of conduct, as follows:

"If the contents of an advance directive show the strong standpoint of a patient's belief, which his or her intimate persons know very well, then it should deserve the respect and the delivery of properly ordered action. In the case of not having an advance directive in practice then all family members should participate in a discussion meeting, in order to find a consensus of agreement." (Staworn, 2007, pp.417-418)
In the case of this old, incompetent lady he argued that we should respect her desire to refuse life-prolonging treatment, as expressed in her living will.

However, the case of Buddhadasa Bhikkhu was different from the example of the old lady, because Buddhadasa Bhikkhu was a well-known person, a leading Buddhist scholar, and was considered as a saintly monk of this century. Many people realized that his life was worthy for the continued protection and propagation of Buddhism. Jermsak Pinthong said in an academic seminar, on the topic of euthanasia:

“But you are a human resource of society, and are considered to be a common interest-maker, so society wants to lay down a rule to manage and control your rights, in that you should have to die or should be kept alive.” (Professor Jitti Tingsapat, Fund & the Medical Council of Thailand, 2000, p.46)

The main conflicting problems in the case of Buddhadasa Bhikkhu are; the different opinions between his disciples, who cried out for respecting the rights of self-determination and to refuse life-prolonging treatment of their master, based upon his wishes and his Buddhist beliefs; and the doctors who had strong beliefs in the power of modern medical technology to save his life, because of his life as a common interest making leader of Buddhism in Thai society. If Buddhadasa Bhikkhu could have determined the end of his life alone then the problematic issue of euthanasia would not have arisen.

Therefore, the researcher would like to apply five factors of the first precept, in order to judge whether or not the doctors should have permitted passive euthanasia, according to the request of his disciples. Let us analyze each factor:
Chapter III: Comparative discussion concerning euthanasia in Buddhism in the case of Buddhadasa Bhikkhu’s death

A. In Buddhism’s Middle-Length Discourses (Majjhimanikāya) there are explained the three qualities which determine the presence of life in the physical body. Those are vitality, heat and consciousness. (M I 296) We cannot determine whether or not Buddhadasa Bhikkhu had consciousness because he was in a coma, but he certainly did have vitality and body heat. Therefore, he was alive.

B. His doctors knew he had vitality and body heat proving that he was still alive.

C. Intention: the Pāli Canon explains that intention is the major factor in determining whether or not the first precept has been violated. It can be said that his disciples had not intent to kill but the intent not to prolong life artificially. However, we know that his disciples thought it over, and had intent to act. They knew the result of their actions would be the death of their master, but yet they made the request.

D. The doctors did not take him off the respirator, and did not cease life-prolonging treatment.

E. He died, naturally, after the doctors sent him back to his monastery, but it can be said that he did not die as a result of their actions.

The researcher proposes that his lay disciples’ request to stop the pointless treatment, and allow their master to die, would have violated the first precept, because
they fully realized what the results of their actions would be. The researcher must side with the doctors in their decision to continue treatment. The researcher accepts the Buddhist moral reasons. The doctors’ decisions did not violate Buddhism’s first precept, and they avoided any bad *kammic* consequences for themselves.

Nevertheless, Pinit Ratanakul commented that ‘only reason cannot solve moral conflicts in such cases’. He wrote, as follows:

> “Given the fact that sufficient ethical thinking had not considered this new issue of Buddhist ethics or medical ethics, and given their different values, the conflicting claims of the doctors and the disciples could not be mediated through arguments alone. At this juncture, both sides practiced compassion, patience and tolerance as Buddhists, both and accepted a compromise.” (Ratanakul, 2000, p.174)

The researcher agrees with his opinion about the use of tolerance and compassion to solve the conflict of the euthanasia problem. Even so, the researcher insists that a living will should be used for patients who do not want to prolong their life by the use of extraordinary life-prolonging medical devices, especially in the case of irreversible coma. They should submit a copied form of their living will, or should show their informed consent to their medical practitioners and their family members. On the other hand, the medical practitioners and family members should respect a patient’s rights and wishes, if their wishes do not violate the biomedical principles and moral principles.

However, they should avoid permitting euthanasia for an incompetent patient, and should turn their concentration to providing hospice care. Pinit Ratanakul suggested the medical practitioners to provide hospice care that:
Chapter III: Comparative discussion concerning euthanasia in Buddhism in the case of Buddhāsā Bhikkhu’s death

“They should instead turn their full attention now to the compassionate care of the dying. Their main concern, of course, is to relieve the suffering of patients and families and ensure a good death.” (Ratanakul, 2000, p.179)

This kind of care is to help a patient to accept death as a natural part of life, through the provision of psychological and spiritual support, and the relief of the patient’s suffering; both in body and mind. If we can confront death with a conscious mind, then we can ensure a good death.

In Buddhāsā Bhikkhu’s teachings about ‘death’ (maranā), he focused on the life before death, by making practical use of contemplation of death in daily life, in order to understand ‘death’ (maranā) correctly. He used his own hermeneutic method; the two kinds of language to explain Buddhist doctrine. One is called everyday language (phasa khon), which is spoken by ordinary people and refers to physical things. The other is called the language of dhamma (pha satham), which is spoken by the people who know dhamma or understand the truth of nature, and it refers to mental things. The word ‘death’ (maranā) by his explanation is:

“Now let’s consider the word death. Death in everyday language describes the event which necessitates putting something into a coffin and cremating or burying it. But in Dhamma language the word death refers to the termination of the ideas mentioned previously; the cessation of the idea of ‘I or mine’. The closure of this idea is what is meant by death in Dhamma language.” (Buddhāsā Bhikkhu, 2007b, p56)

Buddhāsā Bhikkhu suggested the principle of remainder-less extinction of self to be practiced in daily life, until the absolute remainder-less of self is achieved:

“The extinguishing of ‘self’ or ‘atta’ does neither mean the extinction of the body, nor that of life. Instead, it is the extinguishing of the feeling
that perceives the sense of being ‘I’ or ‘mine’; which in short we call the extinguishing of ‘atta’. The word ‘extinguishing’ here means ‘to prevent it from arising’, including to put to extinction the ‘self’ that has already arisen.” (Buddhadāsa Bhikkhu, 2010, p.167)

The concept of death before death (tai kawn tai) can be applied to psychological and spiritual support in Buddhist hospice care. Buddhist hospice care is to help a patient to accept death as a spiritual event and to ease with the dying experience parallels the hospice notion of the normalization of death in which death is seen as a natural part of life, as thus: “In hospice care, as with Buddhist philosophy, the final days and hours of death are given particular attention, with opportunities provided for patients to experience their final moments in a way meaningful to them” (Mor, Greer & Kastenbaum, eds, 1988, p. 10).

Death before death (Tai Kawn Tai) focuses on the mental awareness of ‘suffering’ (dukkha), ‘ignorance’ (avijjā) and ‘defilement’ (kilesa) before the person experiences the end of their lifespan. A mind without ‘defilement’ (kilesa) is extricated from ‘suffering’ (dukkha). Therefore, at the moment of life’s end a person who practices and understands the concept of death before death (tai kawn tai) has a good chance to attain a good death.
CHAPTER IV
CRITICAL APPLICATION OF THE LESSONS FROM BUDDHADĀSA
BHIKKHU’S DEATH TO HELP THAI MEDICAL PRACTICE ON THE ISSUE OF EUTHANASIA

4.1 Buddhāsa Bhikkhu’s application of Buddhist teachings during his illness

Buddhāsa Bhikkhu mentioned that illness is a common occurrence, and a resultant of ‘compounded things’ (saṅkhāra). He explained the words ‘compounded things’ (saṅkhāra) as, “they are just one of the aggregates of assorted components that make up the individual, and where no ‘I or self-entity’ is involved” (Buddhāsa Bhikkhu, 2005, pp.86-87). If we cling to ‘compounded things’ (saṅkhāra) as mine, illness becomes a belonging of mine, too. He considered illness through ‘the principles of three Characteristics’ (Tilakkhaṇa), as follows:

“Compounded things (saṅkhāra) contain illness as a normal thing. The subject matter of ‘compounded things’ (saṅkhāra) is the subject matter of ‘compounded things’ (saṅkhāra). Do not bring it as belonging to me. ‘Compounded things’ (saṅkhāra) are ‘impermanence’ (anicca), ‘suffering’ (dukkha) and ‘non-self’ (anatta).” (Buddhāsa Bhikkhu, 1990, p.3)

When we understand that ‘compounded things’ (saṅkhāra) always change according to the causation of self in ‘suchness’ (tathatā), Buddhāsa Bhikkhu insisted that we will see and understand the law of ‘dependent origination’ (paṭiccasamuppāda) or ‘specific conditionality’ (idappaccayatā). This law, in effect, means this happens so
that happen, and this ends therefore that end. Hence, if illness ends then it ends because of the cessation of its causation.

The book ‘Dhammānussati Jāk Jēttanārom Yām Āphāt KhongThan Buddhadāsa Bhikkhu’ (A Recollection of the Dhamma, about Buddhadāsa Bhikkhu's intentions during his illness) has recorded the significant events of Buddhadāsa Bhikkhu's illness and a dialogue of Buddhadāsa Bhikkhu with his doctors and disciples. On 27th October 1991, Buddhadāsa Bhikkhu was severely ill with heart failure, and a group of doctors came to treat him at his monastery, Suan Mokkh. On the afternoon of 29th October 1991, a Thai senior professor, Prawase Wasi, came to consult him regarding the proper medical treatment required, or about to be advised. Some issues arose in that consultation, whereby Buddhadāsa Bhikkhu discussed the ‘Buddhist doctrines’ (dhamma) which he had so far applied during his illness, as follows:

“By means of the principles of nature, nature is our caregiver. Various medicines simply help not to permit our natural death. Let us be cured by nature, or by dhamma. One point I would like to ask is; why is it that a patient, who brought some discourses of the Buddha, such as ‘the ten contemplations’ (sañña) and ‘the seven enlightenment factors’ (bojjhanga) to pray, get well? This patient is not a general patient, but a patient who knows dhamma. I hope this method will return to be used again.” (Komol Kimthong Foundation, eds, 1993, pp.12-14)

From his dialogue, I can clearly see the relationship between the two discourses of the Buddha which were mentioned. I will discuss those, respectively. The first discourse is the ‘Ten Contemplations’, or ‘ideas as objects of meditation’ (sañña), which comprise that:
Chapter IV: Critical application of the lessons from Buddhadāsa Bhikkhu’s death to help Thai medical practice on the issue of euthanasia

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“1. Contemplation of impermanency (Anicca-saṁññā)
2. Contemplation of impersonality (Anatta-saṁññā)
3. Contemplation of foulness or loathsomeness (Asubha-saṁññā)
4. Contemplation of the disadvantages of the body (Ādīnava-saṁññā)
5. Contemplation of abandonment or overcoming (Pahāna-saṁññā)
6. Contemplation of detachment (Virāga-saṁññā)
7. Contemplation of cessation (Nirodha-saṁññā)
8. Contemplation of the non-delightfulness of the whole world (Sabbaloke anabhīrata-saṁññā)
9. Contemplation of the non-pleasantness of the whole world (Sabbassankhāresu anīṭha-saṁññā)
10. Mindfulness of in and out-breathing (Ānāpānasati)”

(D Ill 29, as quoted in Phra Brahmagunabhom, 2008, pp.244-245)

Buddhadāsa Bhikkhu focused on the form of meditation practiced by the Buddha before his enlightenment; ‘mindfulness of in and out-breathing’ (ānāpānasati).

This kind of meditation is related to his second mention of discourse, the ‘Seven Enlightenment Factors’ (bojjhanga), which comprise that: “mindfulness (sati), ‘truth of investigation’ (dhammavicaya), ‘effort’ (viriya), ‘rapture or zest’ (pītī), ‘tranquility or calmness’ (passaddhi), ‘concentration’ (samādhi) and ‘equanimity’ (upekkhā)” (D III 251, as quoted in Phra Brahmagunabhorn, 2008, p.205-206).

The Buddha stated the relationship of ‘mindfulness of in and out-breathing’ (ānāpānasati), and ‘the seven enlightenment factors’ (bojjhanga), as follows:

“Monks, mindfulness of in-breathing and out-breathing, if developed and made much of, lead to the fulfillment of the four applications of mindfulness; the four applications of mindfulness, if developed and made much of, lead to the fulfillment of the seven links of awakening; the seven links of awakening, if developed and made much of, lead to the
fulfillment of freedom, through knowledge.” (M III 82, Horner, tr, 1995, p.124)29

In practice, Buddhadasa Bhikkhu suggested a simple method to practice this contemplation for the good of physical and spiritual well-being, as follows:

“For example, when there is good ‘concentration’ (samâdhi) in the mind then there will be enough mindfulness to drive one towards a life of clean hygiene, sound physical health and proper spiritual well-being. Here, let us not talk about such a lofty thing as Nibbâna, but first, instead, let us turn to such simple matters such as our physical well-being and mental or spiritual happiness. To possess good health means it is also possible to have sound mind. Ânâpânasati meditation offers the ability to make the mind function well.” (Buddhadasa Bhikkhu, 2003, pp.28-29)

Various memorandums, through the hearsay of his disciples and his attending doctors, about Buddhadasa Bhikkhu’s aftercare from an ischemic stroke, on 24th February 1992, are very useful to know how he prepared himself to die with full consciousness and at peace, and which ‘Buddha teachings’ (dhamma) he applied. Buddhadasa Bhikkhu’s secretary, Phra Ponthep Thitapâñwo, and his attendant monk, Phra Singhathong Khemiyo, said that Buddhadasa Bhikkhu’s daily routine had been changed noticeably. He listened to radio journalism, but only to dhamma programs. Both of his close disciples said that:

“He told his attendant monks to read dhamma books, such as kaivalyadhama and suññatâ, to him. Most of them are books regarding

29 Ânâpânasati, bhikkhave, bhâvitâ bahulikatâ cattâro satipaṭṭhâne paripüreti; cattâro satipaṭṭhâna bhâvitâ bahulikatâ satta bojjhange paripürenti; satta bojjhaṅgâ bhâvitâ bahulikatâ vijjāvimuttim paripürenti. (M III 82)
nibbāna. In that period, he also trained his attendant monks and simultaneously prepared various dhāmmana topics for his revision. He asked, 'Thong, can you memorize ‘ten rightness or ten right states’ (sammatta), or not? I can memorize them.' He always said that at the time of listening or reading dhāmma he felt like he was taking good medicine regularly.” (Komol Kimthong Foundation, eds, 1994, pp.2-3)

One of his attending doctors, Associate Professor Doctor Nitipat Jearakul, wrote down in his verbal notes that:

“He mentioned that he was bored with ‘compounded things’ (sāṅkhāra), and he deemed he could live for only one more year through the consideration of his physical condition. Afterwards, everyone heard that he often spoke more about nibbāna. He spoke about it often with everyone who came to see him.” (Jerakul, 2012, p.94)

From these memoranda, it can be seen that Buddhadasa Bhikkhu held on to the un-heedlessness principle. He used this opportunity as a suitable time to reconsider ‘the ten rightness or ten right states’ (sammatta). That, together with the practice of ‘mindfulness of in and out-breathing’ (ānāpānasati), was in order to make stand a single-pointed mind, which has ‘absolute extinction’ (nibbāna) as its mind-object. He described the correlation of these two groups of ‘Buddha’s teachings’ (dhāmmana) as follows:

“But, if we talk about the sixteen steps of Ānāpānasati, then we are talking about both the way of the actual practice and the fruits or results of that practice! Even if we try to express Buddhism through the ‘Noble Eightfold Paths’ then that would not be perfect enough, because it does not show us explicitly even a slightest part of the fruits of the Buddhist practice. It only shows the way of practicing; ‘Right View’ (Sammādiṭṭhi), ‘Right Thought’ (Sammāsankappa), ‘Right speech’ (Sammākammantta), ‘Right livelihood’ (Sammājīvita), ‘Right Effort’ (Sammāvāyāma), ‘Right Mindfulness’ (Sammāsati) and ‘Right Concentration’ (Sammāsamādhi). It ends here! It has not yet shown the
kind of fruits to be reaped! When two more paths—‘Sammāñāṇa’ (Right insight) and ‘Samma-vimutti’ (Right deliverance) are being added to the Noble Eightfold Paths then the whole Path becomes a way of ten paths or Sammatta, thus creating a big Path of perfect deliverance or liberation.” (Buddhadāsa Bhikkhu, 2003, pp.36-37)

To die without the attachment of whole things, or to achieve the absolute extinction of all cravings and ‘suffering’ (nibbāna), is the main purpose of Buddhadāsa Bhikkhu. Aside from the repetition of ‘the ten rightness or ten right states’ (sammatta), Buddhadāsa Bhikkhu considered Nibbāna Sutta as the characteristic of ‘the absolute extinction of attachment to selfhood’ (nibbāna). One of his close disciples, Phra Dusadee Medhaṅkuro, described a significant event before Buddhadāsa Bhikkhu lost consciousness when suffering a stroke, as follows:

“He elaborated on Nibbāna Sutta. His last statement, which his attending doctors could remember, is that he said that he had no feeling of I and mine, neither positive nor negative peace, tranquility and nibbāna. His words signify the neutral mind; neither happiness nor suffering, neither positive nor negative, neither good nor bad.” (Dusadee Medhaṅkuro, 2001, p.21)

Buddhadāsa Bhikkhu raised the Buddhist proverb: “never let time slip away uselessly” (Buddhadāsa Bhikkhu, 2005b, p.29) to make people become aware of the significance of using ‘mindfulness’ (sati), in order to consider the reality of their bodies and mind in times of illness, or times of trouble. From learning his practice ways during his illness, the researcher realizes that we should spend our time making our minds progress through the development of quality levels of ‘concentration’ (samādhi), the process of ‘mindfulness of in and out-breathing’ (ānāpānasati), or any kind of
meditation in which we believe. When the mind has good ‘concentration’ (samaññha) we will have enough ‘mindfulness’ (sati) to accept things which disturb the mind. In other words, accept pain from illness which brings both physical and mental suffering, as we are in good shape to be able let them go. Good ‘concentration’ (samaññha), together with ‘mindfulness’ (sati), can help us to develop a steady neutral mind which is able to exert power over the mind. We can have good spiritual well-being; including being calm-hearted when the time of death arrives.

4.2 The application of Buddhadasa Bhikkhu’s teachings to prepare hospice care for helping a patient to die peacefully

The general principle of hospice care is to help terminally ill patients, and their families, to accept and confront death with a peaceful mind. Spiritual support is a significant component of hospice philosophy and practice. Although somebody may be a non-religious believer or has their own personal spiritual beliefs, we cannot deny that religious doctrines and practices become a part of spiritual care in the hospice environment. However, hospice providers should not force, or tightly crowd, spiritual support upon the patients, but they should let the patients know it is available, if and when needed. Sister Anne Munley referred to the general unwritten norms of spiritual care as being guidelines for hospice providers in their daily work, as follows:

“1. Don’t impose personal beliefs upon patients or their families.
2. Respond to patients as if they were at home.
3. A deathbed scene is not a proper time for proselytizing.
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4. Whatever a patient asks for in terms of spiritual support then gives it yourself, or gets someone who can.” (Munley, 1983, p.254)

In the Buddhist texts, it is found that there are two kinds of the diseases, namely: physical disease and mental disease. The Buddha stated that:

“O bhikkhus, there are two kind of illness. What are those two? Physical illness and mental illness. There seem to be people who enjoy freedom from physical illness even for a year or two ... even for a hundred years or more. But, O bhikkhus, rare in this world are those who enjoy freedom from mental illness even for one moment, except those who are free from mental defilements.” (A II 142-143, as quoted in Rahula, 1988, p.48)

However, Buddhadāsa Bhikkhu used his own interpretation to separate the diseases into three kinds; physical diseases, mental diseases and spiritual diseases. He discussed the different of three kinds of diseases that:

“In the times of Buddha, a mental disease referred to an illness of view or desires. Let us consider physical and mental diseases as both being physical, and use the term spiritual disease as an equivalent of the term mental disease, as used in the Buddha’s time. The words ‘spiritual’ and ‘mental’ have widely divergent meanings. Mental refers to the mental factors that are connected to, and associated with, the mind. If we suffer from mental illnesses, we go to a psychiatric hospital or an asylum - It’s not a spiritual matter.” (Buddhadāsa Bhikkhu, 1984, p.6)

The researcher intends to apply and offer ‘Buddhist doctrines’ (dhamma), through Buddhadāsa Bhikkhu’s interpretation, as one guideline for healing the patient’s mind and thus experience a peaceful and natural death. It can be called Buddhist Hospice Care according to the view of Buddhadāsa Bhikkhu. These three terms of diseases can be brought into discussion according to Buddhadāsa Bhikkhu’s explanation, respectively.
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4.2.1 Buddhadasa’s Care for Physical Disease:

The researcher starts with physical disease. Buddhadasa Bhikkhu described that physical disease caused by the conditions of housing, eating and the way of living are not hygienic and sanitary, and notably include a lack of physical exercise. Sometimes, carelessness causes wounds and injury. Buddhadasa Bhikkhu proposed the principles to take care of the physical body, which can be summarized into subtopics for easier understanding, as follows.

1. To practice the way of ‘morality’ (sīla), or ‘monastic daily routines’ (vatta). The fifth precept of a lay person is to abstain from intoxicants causing heedlessness. Alcoholic beverage is one kind of intoxicant. If you drive a car when you get drunk, you may have a car accident. Besides, the effects of alcohol consumption cause the additional risk of major health problems, such as liver cancer and cardiovascular disease.

2. To manage the proper sanitation of the four requisites; food, clothing, shelter and medicines. To eat clean food, to wear appropriate clothing suited to the weather, to clean up the room or shelter, and to take correct medicines that are in accordance with the disease syndrome.

3. To properly manage ‘the four postures’ (iriyāpatha); standing up, walking, sitting down and lying down. For example, be mindful about walking when
you are walking. In addition, walking is regarded as one of the various methods of exercising and being healthy.

4. The arising feeling from illness is not only a ‘suffering-feeling’ (dukkha-vedanā), but also a ‘happy feeling’ (sukha-vedanā), and ‘neither a happy nor a sad feeling’ (adukkhamasukha-vedanā), as Buddhadasa Bhikkhu explained that: “In some cases the patient may have ‘happy feelings’ (sukha-vedanā), such as when taking medicine for relieving pain. The patient may be absent-minded, or may be pleased in temporary happiness, for a moment” (Buddhadasa Bhikkhu, 2005b, p.46); and yet, “not happy and not sad feeling (adukkhamasukha-vedanā) are mainly due to ‘ignorance’ (avijjā), because they are feelings of doubtfulness” (Buddhadasa Bhikkhu, 2005b, p.49). Therefore, we should bring the painful and ‘feelings’ (vedanā) which arise from illness, to be the mind-object in ‘the contemplation of the feelings’ (vedanānupassanā) of ‘the four foundations of mindfulness’ (satipaṭṭhāna); in order to contemplate until we see and realize that the ‘feelings’ (vedanā) change, in accordance with their own factors and reasons. That is ‘suchness’ (tathatā). Therefore, we can be freed from the controls and the powers of ‘feelings’ (vedanā). We can have ‘mindfulness’ (sati) and ‘clear consciousness’ (sampajānīna) at every moment, if we can eliminate all power of ‘feelings’ (vedanā), because we do not attach to anything or any feelings at all.
5. In times of trouble we should observe and learn to recognize the nature of the changes of breathing, using the way of 'mindfulness of in and out-breathing' (ānāpānasati). When other feelings intervene, such as pain, we should contemplate that feeling in every breath until that feeling disappears, and after that we return to contemplate breathing yet again. When the breathing settles in calmness then both the mind and the body also become calm.

Buddhadāsa Bhikkhu explains more details about that:

"The study of breathing is to learn the signs of life and death. If the breath becomes like this then life is closer to death, or the breath of being alive is like this. Try to learn it to the best of your ability, and develop it further into new and higher levels. It does not have bad effects. The good effect is no 'suffering' (dukkha). We live without 'suffering' (dukkha). We die without 'suffering' (dukkha)." (Buddhadāsa Bhikkhu, 2005c, p.42)

4.2.2 Buddhadāsa’s Care for Mental Disease:

To cure mental diseases, Buddhadāsa Bhikkhu also suggested practicing the way of ‘mindfulness of in and out-breathing’ (ānāpānasati), in daily life. He argued that mental diseases occur from grasping and clinging to feelings of anxiousness, mourning, autism etc. To concentrate on in and out-breathing can help the mind to have considerable ‘concentration’ (samādhi), and greater calmness. The feelings of anxiousness, mourning and autism will decrease, because the mind has steady ‘concentration’ (samādhi), and does not have enough time to take interest in the feelings of ‘I and mine'. Buddhadāsa Bhikkhu described that:
“When worrying about whatever thoughts or anger is carried by someone or something then please turn to see what long breath is like, and then focus on the nature of the breath continuously. The bad feeling disappears because the mind is occupied with ‘concentration’ *(samādhi).*” (Buddhadāsa Bhikkhu, 1991a, p.18)

He also argued that, “Without anxiousness, you do not have mental disease. Mental disease occurs from clinging to something as being mine or that I am its owner” (Buddhadāsa Bhikkhu, 1991a, p.21).

In practice, Buddhadāsa Bhikkhu suggested the simple method to practice this contemplation for good physical and spiritual well-being as follows:

“The most simply way is using mind to control of in and out-breathing... Then, to focus on the nature of breath and see what shortness of breath is like? What is long breath like? What is rough breath like? What is fine breath like? When the mind has more concentration on breathing, the mind has more ‘concentration’ *(samādhi).*” (Buddhadāsa Bhikkhu, 2005c, pp.34-38)

Buddhadāsa Bhikkhu explained further thus:

“For example, when there is good concentration in the mind, there will be enough mindfulness to drive one towards a life of good hygiene, sound physical health and proper spiritual well-being. Here let us not talk about such a lofty thing as Nibbāna. First; instead, let us turn to such simple matters like our physical well-being and mental or spiritual happiness. To possess good health means it is possible to have a sound mind as well. Ānāpānasati meditation helps to make the mind function well.” (Buddhadāsa Bhikkhu, 2003, pp.28-29)

4.2.3 Buddhadāsa’s Care for Spiritual Disease:

Moreover, the grasping and clinging to the feeling of ‘I and mine’ is the main cause of spiritual disease. Spiritual disease is the most important disease, based upon Buddhadāsa Bhikkhu’s perspective. He defined what spiritual disease is: “Spiritual
disease is the disease whose germ lies within the feelings of 'us and ours' and 'I and mine' that are regularly present in the mind” (Buddhadāsa Bhikkhu, 1984, p.9). This kind of disease can happen not only for ill patients, but also for everyone. Examples of this disease are; love, anger, hate, jealousy, excitement, being scared, anxiety and doubtfulness. Furthermore, this spiritual disease can cause both physical and mental diseases. The researcher raises one simple example to make it clear, in that when you seriously feel anxious about things which disturb your mind or you feel bad emotions, then you may develop a headache resulting from sleeplessness. That is caused by inadequate rest, and your body may soon become weary and ill. If you attach to things which disturb your mind for a long time, you may suffer from neurosis as a result of no peace of mind. Buddhadāsa Bhikkhu applied 'Buddha's teachings' (dhamma) as a medicine to cure spiritual disease through seven correlated methods. The researcher summarizes them in short briefs, respectively.

1. To be ignored, or do not be too fussy. Don’t make a mountain out of a molehill. If you grumble over everything then you will be anxious and worried all of the time.

2. Let it be a means to understand that everything is in line with the process of 'dependent origination' (paṭiccasamuppāda), or 'specific conditionality' (idappaccayatā). Nothing is a thing in itself, but is dependent for its existence upon another thing through the arising of this that arises, and so
through the end of this that arose then, therefore, that ends. We cannot
control everything as we want. We must understand the reality of everything
and let it be, according to the law of ‘dependent origination’
\( \text{pa\text{\textcircled{}}tice\text{\textcircled{}}cop\text{\textcircled{}}samup\text{\textcircled{}}p\text{\textcircled{}}d\text{\textcircled{}}a} \).

3. ‘Suchness’ (Tathatā) expresses appreciation of the true nature of reality at
any given moment. Illness is natural. Death is natural. It does not belong to a
‘mine’. Buddhadasa Bhikkhu described illness as thus:

“It is ‘impermanence’ (anicca). It changes all the time. Because of its
change it causes for difficulty and distress, so it is ‘suffering’ (dukkha).
No one can catch it or resist it, because it is not a part of ‘self’ (anattā). It
is ‘suchness’ (tathatā). It is in keeping with the law of ‘specific
conditionality’ (idappacceyyatā). If we see it as ‘suchness’ (tathatā), we
will see ‘the emptiness of self’ (suññatā).” (Buddhadasa Bhikkhu,
1991b, p.27)

4. No ‘I and mine’. I and mine are just an ‘illusion’ (maya). I and mine, or self,
is a condition that arises when there is grasping and clinging, within the
mind, to ‘ignorance’ (avijja). Buddhadasa Bhikkhu pointed out that:

“Just as with the seeing of I and mine as an illusion, because they are
conditioned by sense-objects; then so with the seeing of the sense-objects
themselves as also being illusory, through the principle of aniccam-
dukkhañ-anattā, the disease of ‘suffering’ (dukkha) does not break
out.” (Buddhadasa Bhikkhu, 1984, p.28)

5. Not-having and not-being. Nowadays, we cling to something to make it
‘ours’. When we cannot gain it or lose it, ‘suffering’ (dukkha) arises in the
mind. We should actually contemplate what is worth having or being that it
will not be a cause of ‘suffering’ (dukkha). If we understand that there is
nothing, anywhere, worthy of the feelings of having or being, the mind becomes insensible towards all things, and so nowhere for ‘suffering’ (dukkha) can arise.

6. Death before death (Tai Kawn Tai). Buddhadāsa Bhikkhu insisted that death before death (tai kawn tai) is the Degree of his monastery, Suan Mokkh, and explained this concept as follows:

“A Degree from Suan Mokkh qualifies one in the knowledge and actual practice of the concept that one is ‘to die before death’. This ‘death before death’ implies a condition of the mind in which the sense of attachment to the state of being, ‘I’ and ‘mine’, has died out before the actual physical death occurs. What remains then is just pure and mindful wisdom in the ensuing life. Therefore, the sooner we ‘die’ the more will our lives be benefitted” (Buddhadāsa Bhikkhu, 2007a, p.7)

7. Remainder-less extinction. Buddhadāsa Bhikkhu placed emphasis on viewing all possessions as emptiness, and the emptiness is the remainder-less extinction of the idea of ‘I and mine’ or ‘self’. This principle is very significant for every person, in order to prepare the proper mind to confront death peacefully when it comes. He reiterated to practice the remainder-less extinction on a routine basis, until the absolute remainder-less of self is achieved.

Buddhadāsa Bhikkhu argued that people in the Buddha’s period were well prepared for a good death, as follows:

“So they prepared themselves for death by abstaining from food, and taking only water and medicine. As death approached they would stop taking even water or medicine, in order to focus their mindfulness and
self-awareness; and so die in the way of remainder-less extinction. People who cling to goodness and virtue prepare themselves for death by clinging to goodness and virtue. The wise prepare themselves to let go and thus meet their remainder-less extinction.” (Buddhadāsa Bhikkhu, 1984, p.97)

He insisted that most of the people of today try to escape death by finding the best hospitals and the most expensive foods and medicines, in order to save their life even if it is only for a single minute. He argued that: “They start having all sorts of injections and treatments and die with no mindfulness or self-awareness. It is an action of delusion” (Buddhadāsa Bhikkhu, 1984, p.97).

Therefore, he suggested that people can learn the practice of the way to live with ‘emptiness of self’ (suññata), in order to prevent the arising of self-consciousness or the attachment to the illusion idea of ‘I and mine’ and thus achieve ‘remainder-less of self’ (nibbāna) in the here and now, through three divided occasions:

1. The normal times when we’re doing our normal tasks.
2. The moments of sense contact - how to deal with those, so as to produce emptiness.
3. The moment of death - what to do when the five 'aggregates' khandas meet their inevitable disintegration.” (Buddhadāsa Bhikkhu, 1984, p.98)

Furthermore, he reiterated that illness comes to warn us, giving us the knowledge to prepare ourselves to die being remainder-less of ‘I and mine’. It does not come to make anyone feel more ‘suffering’ (dukkha). He proposed three preparation methods for achieving being remainder-less of ‘I and mine’, as follows.
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1. To remember that I have finished all secular activities, such as livelihood and the taking care of our children and parents.

2. To remember my making merit, that I did it completely and accordingly to the best of my abilities and conditions in life.

3. To remember that it is enough for me to be caught in 'the cycles of birth and death' (samsara).

The demise of desires, and the awareness of non-entities, should always be practiced regularly, until they reach the permanent state and bear steadily in the mind. Buddhadasa Bhikkhu affirmed that we must practice, until receiving the fruits of the heart of the 'Buddhist teachings' (dhamma), that is, "Nothing whatsoever should be clung to" (Sabbe dhammā nālam abhinivesāya) (Buddhadasa Bhikkhu, 1984, p.13). As a consequence, 'the remainder-less of self', or 'the absolute extinction of self' (nibbāna), can be attained. Buddhadasa Bhikkhu claimed that good death in Buddhism is the death of the attachment to the false ideas of 'I and mine'. To die in the right way we must die realizing 'emptiness of self' (suññatā) in the last second of life.

From what Buddhadasa Bhikkhu recommended about the three types of diseases and how to care for them, it shows that he prepared himself for the death, and his theory should be proved true through his death.
4.3 Factors and obstacles for the application of Buddhāsā Bhikkhu's teachings to prepare hospice care for helping a patient to die peacefully

Buddhāsā Bhikkhu's widely held reputation has had an extremely large effect on the propagation of his teachings. Not only is his reputation important, but also other factors that can be used in applying his teachings to help Thai medical practitioners improve hospice services for helping a patient to die peacefully. However, there have also been some obstacles. The researcher proposes to start with the various supporting factors.

Factors:

1. Psychological and spiritual support movement in Thailand.

The Ministry of Public Health promotes health care in Thailand. This ministry has a duty to improve the population's health and to develop a health management system and mechanism with quality, efficiency and equality for Thai citizens. In the early 1990s, the Thai government and some medical practitioners sought to find the proper treatment to relieve patients from the pain they were suffering from as a result of cancer. So, to that end, the Thai Association for the Study of Pain (TASP) was established and as a result hospice and palliative care began to become a topic of interest in Thai society. Then, in 1992, the first two faith-based organizations were established, namely that of the Bangkok-based Camilian (Christian) Missionaries, Rayong, and Phrabat Nampu Temple, Lopburi.
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At Camilian Social Center, the Camilian missionaries have provided health care to Thailand’s poor since the 1950s. The Center provides a range of activities designed to improve the patient’s well-being. They also help terminally ill patients to achieve a peaceful death with total human dignity by providing spiritual support from the application of Christian doctrines (Wright, Hamzah, Phungrassami & Claudio, 2010, pp.104-105).

In the same way, at Phrabatnampu Temple, Lopburi, the founder of a small hospice center, ‘Thammarung Niwat’ (the place of true protection), Phra Udom Prachatorn, applied the ‘Buddha’s teachings’ (dhamma) for providing Buddhist palliative care, psychological and spiritual support to those suffering from HIV AIDS, in order to relieve their physical and mental suffering, help them live with others and to assist them in being able to die peacefully, with dignity (Wright, Hamzah, Phungrassami & Claudio, 2010, pp.100-103).

Anothai Jeasathawong, a Dhamma lecturer and writer, said during a personal interview that:

“Nowadays, we have a program entitled ‘Towards dying peacefully’ formed from mutual coordination with many organizations and foundations such as the Faculty of Medicine at Siriraj hospital, Songklanagarind hospital and the Buddhika Network aimed at providing both mental and spiritual support to terminally ill patients and promoting a way to live and die with ‘mindfulness’ (sati) in Thai society. Phra Paisal Visalo is the main lecturer. He also applies the teachings of Buddhadasa Bhikkhu concerning life and death when he teaches participants in the program. In addition, the Buddhadasa Indapanno Archives in Bangkok, have a number of highly suitable activities for helping everyone achieve a good death by themselves, and these...
teachings are available for everyone” (A. Jeasathawong, personal communication, August 29, 2013; See an interview question in Appendix F)

From my own personal experience in having participated in this ‘Designing Death’ activity, at Buddhadasa Indapanno Archives, Bangkok, was such that the researcher found that the main purpose is to let one understand that death is indeed just one part of our life, and how to live our lives with mindfulness (sati) so as to be free from the attachment to the notion of self.

Moreover, Anne Munley discussed about the essence of spiritual caregiving as follows:

"The essence of spiritual caregiving is not doctrine or dogma but the capacity to enter into the world of the other and to respond with feeling. This fundamental human capacity involves touching another at a level that is deeper than ideological or doctrinal differences." (Munley, 1983, p.268)

2. Hospice and Palliative care in Thai medical study programs

Jaruwan Manasurakarn et al. studied values underlying end-of-life decisions of Thai Buddhist patients and their families by gathering data from Thai Buddhists aged 40 years or above and who were recruited systematically and in a random fashion. The sample comprised three groups: 70 chronically ill patients, 70 patients’ families who had experience, and 70 that had no experience of making end-of-life decisions, and it was found that:

"More than half of Thai Buddhist patients and their families (51.9%) decided to forgo life-sustaining treatment. Almost one-third of them allowed the physician (18.1%) or their family (10.5%) to make the
decisions for them. Only 19.5% decided to continue the treatment. The most important values for continuing and forgoing the treatment were hope (92.7%) and becoming free from suffering (47.7%), respectively. Respect was the most important value for Thai Buddhists, who allowed their physician or family to make the decisions for them (84.2% and 59.1%, respectively).” (Manasurakarn et al, 2008, p.550)

From this data, the researcher also observes that the most important value for those who allowed doctors to make decisions on their behalf, was that of respect. My own opinion is that sometimes, hope is a defense mechanism for escaping from reality, such as not accepting that we are dying soon. However, hope allows us to have the willpower to face the truth, and if we can accept that truth, then we have the chance to have a good death without ‘suffering’ (dukkha). Therefore, it can be seen that the assistance of medical practitioners is necessary for helping patients to die peacefully through means of psychological and spiritual support. Therefore, in 1999, the Red Cross College of Nursing (Bangkok) incorporated palliative care into its undergraduate course, and this was followed by Chulalongkorn University, which later incorporated terminal care into its medical curriculum at the Faculty of Medicine in 2002. Please see more details about hospice and palliative care education in Thai medical programs in Appendices C, D, and E.

In 2009, Medical Schools Palliative Care Network (MS-PCARE) was established by a consortium of Thai medical schools cooperating through financial support from the Thai Health Promotion Foundation. The objectives of this network focused on developing knowledge, building a good Thai medical school network,
training medical providers for assisting dying patients, and improving the quality of Thai medical care for those dying in order to help them to die with dignity.

Kittikorn Nilmanat, the Faculty of Nursing, Prince of Songkhla University, presented a network model interconnecting the dying process and those involved with it as follows:

![Network model interconnecting experiences and issues surrounding dying](image)

From Figure 1, we can see that medical providers should know and understand the meaning of what constitutes a good death. Sumalee Nimmannit highlighted Buddhadasa Bhikkhu’s words by saying that: “Both physical and spiritual deaths are the center point of all our fears.” (Lertsanguansinchari, Nuchprayoon, Chatrkaw & Sittipunt, eds, 2007, p.25). Therefore, she suggested medical practitioners in medical education programs should learn about death from a religious perspective and indicated that: “the meaning of a good death from a religious perspective has more profoundness than the
meaning of death from a Western medical perspective” (Lertsanguansinchai, Nuchprayoon, Chatrkaw & Sittipunt, eds., 2007, p.31). Therefore, we should apply Buddhadasa’s teachings about how to respond to the three types of disease, which are physical disease, mental disease and spiritual disease, to fulfill the quality of hospice and palliative care for helping patients to die in true peace.

Obstacles:

1. Medical standard practice.

Sumalee Nimmannit explained the general medical standard practice in Thailand as follows:

“Doctors and medical providers want to protect their patients’ lives and try to prolong life for as long as possible, no matter what the cost of neither treatment nor the condition of the patients’ lives, because of their good intentions towards always helping the patients.” (Lertsanguansinchai, Nuchprayoon, Chatrkaw & Sittipunt, eds., 2007, p.25)

However, she argued that:

“These problems occur from a lack of knowledge and understanding of the dying process and death and furthermore, create suffering for the patients, families, and medical providers. It is also a problem for society at large and brings to the forefront the issue of euthanasia and the controversy over the right to die.” (Lertsanguansinchai, Nuchprayoon, Chatrkaw & Sittipunt, eds., 2007, p.25)

Banphot Huajai, a hematologist at the Laboratory and Blood Processing, Army Institute of Pathology, Royal Thai Army Medical department, said the same during a telephone interview: “In cases where decisions are required regarding the turning off of respirators or incubators, doctors must make sure that the patients die or that all the
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patient’s brain cells has already died” (B. Huajai, personal communication, August 30, 2013; See an interview question 1, in Appendix F). He also commented on the issue of living wills that:

“Although the Medical Council of Thailand accepted section 12 of the National Health Act of 2007, which allows patients to refuse the prolonging of treatment, doctors still take the risk of being accused if they turn life-support machines off. Although doctors perform such actions according to their families’ requests, some family members may not agree with this decision.” (B. Huajai, personal communication, August 30, 2013; See an interview question 2, in Appendix F)

Thongchai Uttham, general practice doctor of Princess Mother’s Medical Volunteer Foundation and Wiang Haeng hospital, Chiangmai, said in a telephone interview thus:

“When an unconscious patient is sent to hospital, doctors must try to do everything to save their life such as through the use of artificial respirators or incubation, and then, even though doctors make a decision that the life-support systems are useless in helping to save the patient’s life, they cannot turn them off immediately because they may face prosecution from relatives accusing them of intentionally killing the patient. Therefore, they must consult with the families, or guardians or surrogates of the patients. Although some families decide to stop treatment, there are a number of doctors who will not carry out such an action. They do not want to commit what some may consider a sin in Buddhist terms by killing a dying person because they know their patient is still alive at that time.” (T. Uttham, personal communication, August 30, 2013; See an interview question 1, in Appendix F)

Thongchai Uttham suggested that:

“If doctors already know that patients want to refuse extraordinary treatment if they are beyond medical help, a hospice or palliative care program is the proper alternative method of treatment. Doctors should not ignore the patients. They must help them to reduce the pain until the
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patients eventually die.” (T.Utkham, personal communication, August 30, 2013; See an interview question 2, in Appendix F)

According to the researcher’s opinion, bioethics, financial and legislative reasons are not sufficient for solving the problems that each of the above have mentioned. It is my belief that we should apply religious teachings about life and death in searching for the proper solution to this problem. If everyone can accept illness and death as an integral part of life, in the way Buddhadāsa Bhikkhu did, then the problem of euthanasia problem need not occur.

2. Individual belief

We cannot ignore different religious belief, although most Thai people are Buddhists and ‘Buddhist teachings’ (dhamma) have become integrated within Thai medical care in terms of the relief of ‘suffering’ (dukkha) to attain a good death, we cannot ignore other religious beliefs. Sometimes Buddhadāsa Bhikkhu’s teachings from his Buddhist perspective may not be appropriate for those of other religions, so we should also apply their religious doctrines to improve the quality of psychological and spiritual services in hospice and palliative care. We should learn and understand more of the meaning and the practice towards life and death of each of the major religions.

Below are a number of examples:

In Christianity, death can be a teacher of wisdom of how to live as seen in this passage, as follows:

“It is death that enables one to see this ephemeralness, according to Ecclesiastes. It is death that exposes the insubstantial quality of all
distinctions based on culture. And it is death that can teach one how to live: ‘It is better to go to the house of mourning than to the house of feasting; for this is the end of all men, and the living will lay it to heart. The heart of the wise is in the house of mourning’ (7:2-41)” (Borg, 1986, p.203)

In Islam, the word of Allah in the Quran confirms that if you are a good believer, you do not need to fear death, and that the door of heaven will always be open: “As for those who affirm, Our Lord is God, and then remain steadfast, the angels will descend on them, saying, have no fear and do not grieve. Rejoice in the (good news for the) garden that you have been promised” (Fussilat 41:30). Even though each religion uses different language and different methods of teaching, they still share the same goal, which propose intellectual and spiritual approaches towards eradicating suffering.

Nevertheless, each person has his or her own individual opinions and beliefs. Some people are non-religious and have no beliefs. For example, utilitarian use the principle of logical reasoning through considering the course of action that should maximize happiness and reduce suffering; however, some of them have different viewpoints. Pinit Ratanakul concluded the argument of different ideas of various utilitarianism groups as follows:

“One can see that the basis of such an argument is an Act-Utilitarian approach where the end justifies the means only and, therefore, it is thought that the actions themselves of allowing dying or killing represent only a bare difference, not morally relevant. For the Rule-Utilitarian and Mixed Rule-Deontologist, the prohibition against killing directly is, for the one position, so important a social rule that it can have few classes of exceptions and medical practice cannot be one of them and, for the latter position, it is thought that the practice of mercy-killing would fail to stand up under the weight of the prima facie duties of fidelity, respect for
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persons, beneficence, non-maleficence and justice in medicine.” (Ratanakul, 2007, p.146)

Even though euthanasia has become a legal action in some countries such as the Netherlands, it is hard for most Thai people to accept euthanasia legally because it contradicts moral religious doctrines. Therefore, the researcher affirms that hospice care through providing spiritual services is the proper method to relieve the suffering of patients.

3. Lack of government support

Temsak Phunggrassami conducted a survey and found that:

“Currently, at least 13 organizations provide 40 hospice-palliative care services, mostly to in-patients. Eight of these organizations are government facilities (tertiary hospitals and cancer centers), one is a private hospital, and two are faith-based institutions.” (Wright, Hamzah, Phunggrassami & Claudio, 2010, p.88)

However, Thailand is a country where hospice and palliative services are achieving a measure of integration with mainstream service providers, however, it remains only localized hospice and palliative service provision. Most Thai people do not even know about a patient’s rights or the right to be able to refuse extraordinary treatment, including that of information regarding living wills. Thongchai Utkham told me, “Almost all patients I treated did not know what the rights of the patient were. They think that only a doctor has the right to treat or reject them” (T. Utkham, personal communication, August 30, 2013).
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From my perspective, it is not only medical practitioners that should find ways to promote a broader view of the patient’s rights and hospice-palliative services to Thai society, but also the Royal Thai government. Moreover, the writers of the book, ‘Hospice and Palliative Care in Southeast Asia’, gave useful comments and suggestions as follows:

“Yet if palliative care is to become available to all of Thailand’s needy, there are formidable barriers to overcome. Only a small percentage of the patients die in tertiary hospitals and the continuity of care from hospital to community remains weak. Morphine and other strong drugs are mostly inaccessible in a domiciliary setting and such care falls outside of the 30 baht insurance scheme. There is no national overview of palliative care education and training courses, nor a database of the number of health professionals who have undertaken basic and specialist courses.” (Wright, Hamzah, Phungrassami & Claudio, 2010, pp.129-130)

Although it can be considered good news that the National Health Commission Office of Thailand (NHCO) held a health assembly meeting in January 2013 to consider a National Strategic Plan on Health Promotion for Good Death, this strategic plan does not yet feature in any Thai national health policies.

4.4 Critical application of the lessons from Buddhadasa Bhikkhu’s death

The researcher focuses only on the lessons learned from the issues raised in the case of Buddhadasa Bhikkhu’s death and his practice during his illness, and do not include his testament for his funeral and the lessons also learned from his funeral. San Hatteerat wrote about four critical issues, in his article ‘the lessons learned in the case of Buddhadasa Bhikkhu’s illnesses’, in order to condemn the conduct of Buddhadasa Bhikkhu’s attending doctors, as follows.
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1. Physician’s issue. San Hatteerat argued that the promises of his attending doctors could not be trusted, when he wrote, “No tracheotomy certainly, but they performed one!” (Hatteerat, 1993a, p.3). In addition, he also mentioned that their (the attending doctors’) official statements were unreliable, and caused confusion that:

“Instead of making a statement that his symptoms got better or worse or stable, they simply announced his pulse rate, temperature, blood pressure, urine and blood test results; and concluded that his symptoms were normal or nearly normal. However, with more treatment his illness became worse” (Hatteerat, 1993a, p.3).

2. Medical treatment issue. In the case of Buddhadāsa Bhikkhu, it can see that medical treatment can be performed in Thailand, even though it may contradict a patient’s desires and intentions. San Hatteerat also argued that:

“In spite of a patient not wanting to go to hospital a doctor can still force him from his home. Even though the medical treatment for prolonging death may be excruciating for a patient, and harrowing for a patient’s relatives, plus being an encroachment of the resources for other patients and society, it is still accepted as correct.” (Hatteerat, 1993a, p.3)

3. Religion issue. He pointed out that, “we possibly agree that the prolonging of death caused his dying process to be intermittently prevented, and so he may not have attained eternal peace” (Hatteerat, 1993a, p.3).

4. Social values and cultural issues. San Hatteerat also mentioned that the medical treatment of Buddhadāsa Bhikkhu built stability in new social values and new cultures, as follows:
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“For example, the acceptance of death in a hospital, especially in the intensive care unit (ICU) is the best death. A doctor’s diagnosis is accepted, even if a doctor breaks a promise or lacks good judgment. The intervention by a third party, such as a doctor, in the placement and the medical treatment of a patient is still accepted.” (Hatteearat, 1993a, p.3)

San Hatteearat described the results of the attempts to save the life of an unconscious patient who suffers from the causes of stroke, as Buddhadasa Bhikkhu had done, as follows:

“If we try to preserve life by using; an artificial respirator, a cardiac pacemaker, a placenta or a supporting circulatory system machine amongst others, and we are unable to maintain a normal brain then we are only prolonging the suffering of patients, as in the examples of Buddhadasa Bhikkhu and Juling Plonggunmoon in their last illnesses.” (Hatteearat, 2009, pp.88-89)

Vitoon Eungprabhanth mentioned the requests of relatives to prolong patients’ lives, even though their requests were against the wishes of patients. He said that if doctors prolong patients’ lives when in a persistent vegetative stage, and if violating their intentions, then doctors should be reprimanded for the encroachment of the patient’s rights. On the other hand, he argued that if doctors let their patients die, or they perform active euthanasia, then they may be judged to have carried out a criminal act and so legislation in such cases is necessary that:

“When either letting a patient die without treatment or helping a patient to die, by using drugs, then doctors take criminal risks. Therefore, a patient’s right to die forces doctors to confront such risks. However, if doctors save a patients’ life in either case then it may be considered that they must have violated the patient’s rights; so doctors must regularly stand in the crossfire. The law needs to find a solution for such cases.” (Eungprabhanth, 1994, pp.142-143)
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As the researcher has mentioned before, nowadays the World Medical Association has declarations that reject the actions of active euthanasia. In the same way, even though there is no legal provision for active euthanasia prohibition in Thailand, the ‘Thai Criminal Code’ contains matters of law that pertain to the punishment of a person who either takes another life or incites, or helps, anyone to commit suicide: “Section 288: Whoever murders another person shall be sentenced to death, or imprisoned for a minimum of fifteen to twenty years” (Kanetnog, 2008, pp.288).

“Section 290: Whoever causes death to another person by inflicting injury to the body of such a person, without the intent of causing death, shall be punished with imprisonment of between three to fifteen years.

Section 291: Whoever causes death to another person by being negligent shall be imprisoned for not more than ten years, or fined not more than twenty thousand Baht.

Section 292: Whoever acts cruelly to, or acts in a similar fashion, to a person and makes him depend upon him for subsistence or any other activities, causing that person to commit suicide, and if suicide has occurred or has been attempted, then that person shall be imprisoned for no more than seven years, or fined not more than fourteen thousand baht.

Section 293: Whoever aids or instigates a child under the age of sixteen to commit suicide, or is a person who is unable to understand the nature and importance of his acts, or who is unable to control his acts, shall, if suicide has occurred or has been attempted, be punished with imprisonment not exceeding five years, or fined not more than ten thousand baht, or both.” (Kanetnog, 2008, pp.289-294)

Therefore, the injection of a poison or the causing of a drug overdose in helping a patient to commit suicide should be judged as illegal. However, both the World Medical Association and the Thai government accepted the rights of a patient to refuse treatment.
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When we see the actions of medical practitioners, such as in the case of Buddhadasa Bhikkhu, the researcher reiterates that their actions are in conflict with the third topic of the declaration of a patient’s rights in Thailand, in that patients can voluntarily refuse treatment after receiving complete medical treatment information; and also that their actions are in conflict with section 12 of the Thai National Health Act of 2007, which allows fully conscious patients to make a living will, and in order to refuse medical intervention for the prolonging of their life. Upon seeing this problem from the Buddhist perspective, it seems to guarantee that the medical practitioner does, indeed, violate the rights of a patient. In Buddhism, human beings have equal rights. However, according to the five precepts, medical practitioners must avoid doing harm, and also avoid violating the rights of each person. They must not take possession of another’s life, but they should cure the patient with ‘loving-kindness’ (mettā) and ‘compassion’ (karunā).

Therefore, the relationship between medical practitioners and their patients and families is important. During the processes of medical treatment, regular communication between medical practitioners and their patients, and their families, is helpful for maintaining mutual cooperation and understanding. Normally, doctors decide treatment methods based upon their own knowledge and opinions. In the same way, most patients hand all decisions over to their doctors because they have confidence in their knowledge of modern science. Nitipat Jearakul spoke of his experience, in the treatment of Buddhadasa Bhikkhu, in that he always questioned his symptoms and his
Chapter IV: Critical application of the lessons from Buddhadasa Bhikkhu’s death to help Thai medical practice on the issue of euthanasia

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In times of illness he tried to understand the happening of events; and he somewhat tried to control whatever happened to him, in order to remain within the scope of actions that he could accept as pertaining to his beliefs. He considered both sides of the argument, including the refusal of modern medical treatment, and before he agreed or refused, he asked about and duly considered all of the information given to him by his doctors, each and every time.” (Jearakul, 2012, p.124)

Buddhadasa Bhikkhu advised a practical way for doctors to provide spiritual care when faced with patients, and families, who have not prepared their mind to receive it, as follows:

“If we (doctors) have enough knowledge then surely we can clarify that you should prepare your mind not to endure ‘suffering’ (dukkha)? It is only your physical body is becoming like this. In order to have no ‘suffering’ (dukkha) you should consider it. We should become a psychiatrist as well. We must provide both physical and mental care to make a recovery without ‘suffering’ (dukkha). Not ‘suffering’ (dukkha) is most important. To live with ‘suffering’ (dukkha) then death is better. To live with ‘suffering’ (dukkha) is badness” (Komol Kimthong Foundation, eds, 1993, pp.39-40).

From his explanation, ‘to live with ‘suffering’ (dukkha) then death is better’ does not mean he supports the committing of suicide, or the request of somebody to help end their life. Nitipat Jearakul explained Buddhadasa Bhikkhu’s views about illness and death that: “Illness and death for Buddhadasa Bhikkhu are suchness. They are neither something that will have to suffer nor struggle, nor carry ‘compounded things’ (sankāra), nor carry the physical body away from death” (Jearakul, 2012, pp.118-119).
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As a result of the above reasons he also suggested that medical practitioners study 'Buddhist teachings' (dhamma), in order to understand the change of 'mind' (citta) of 'compounded things' (sankāra) for the benefit of their patients, as follows:

"Modern medicine should find a way to harmonize current sciences which focus upon the physical subject and dhamma, which are related to the 'mind' (citta) and the story of 'compounded things' (sankāra). If we can do that, then it will be truly beneficial to the patient." (Jearakul, 2012, pp.72-73)

Not only medical practitioners should learn religious doctrines. Patients and families should also study and learn religious doctrines, in order to understand the reality of death and avoid the needless hastening or postponement of death; and therefore the acceptance of death, especially in the intensive care unit (ICU), in allowing medical practitioners to prolong the dying process. The use of a defibrillator or the performance of euthanasia is not regarded as a good way to die in Buddhism. A good death in Buddhism, through Buddhadasa Bhikkhu's interpretations, is a death without 'suffering' (dukkha) from attachment of 'self' (atta), and without the false idea of 'I and mine'. The greatest fruits of none clinging to the feeling of I and mine is true and 'absolute extinction' (nibbāna). Buddhadasa Bhikkhu pointed out that: "when there is no feeling of taking anything as I or mine, then one is not a thief stealing from nature, or from God. Simply, this is the supreme being in the way of spiritual culture" (Buddhadāsa Bhikkhu, 2008, p.251).
CHAPTER V

CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

When viewing the issues of euthanasia from the perspective of Buddhism's first five precepts, a person must not only avoid harming his own life or that of another, but must also not violate the rights of another. Medical practitioners should, therefore, not actively perform euthanasia. The researcher agrees that if a patient who is conscious, and under no pressure, calls for the withholding or the withdrawal of unnecessary and extraordinary medical treatment and prefers to die naturally, then medical practitioners should accept and respect that patient's rights to autonomy. Regardless, medical practitioners must refrain from deliberate acts that would end a patient's life, and make that quite clear to the patient, even if the patient or his legal guardian requests it.

In the case of Buddhadasa Bhikkhu the importance of having a living will has been highlighted, as have been the rights of a patient; and certainly in the case of an unconscious patient. In such a case, there are two possible scenarios. Firstly, if the patient voices his intent or prepares a living will refusing medical treatment, then the doctor should accept and respect the patient's wishes. However, a living will may be written while the patient is still healthy and unaware of future events. Thus, at the time of actually confronting death, the patient may change their mind concerning an original refusal of not wanting to receive all treatment that prolongs life. As a result, the doctor should consult with the close relatives of the patient, in order to ensure that the patient
has always previously, and strongly, intended to refuse medical treatment which simply prolongs life; especially when they are clearly beyond awareness of the surrounding medical help. Secondly, if a patient does not voice his intent and has not prepared a living will then the doctor should use any means possible to save him. If a patient’s condition has no prospect of recovery then his doctor should not use extraordinary means to prolong his life, but should allow the patient to die naturally. However, the doctor should provide hospice and palliative care to relieve pain and ‘suffering’ (dukkha).

In the case of a patient in a persistent vegetative state, if doctors decide to put a patient on life-support then they should not take them off it. That removal of support would violate Buddhism’s first precept, and create bad results of kamma. In Buddhist scriptures and the ‘Middle Length Discourses’ (Majjhimanikāya) death is clearly explained in the three qualities that determine the presence of life in the physical body; these being vitality, heat and consciousness. It is difficult to determine whether or not a patient is conscious if the patient is in a coma. If the patient has vitality and body heat then he is alive. In medical principles, brain stem death is used to judge and confirm the death of a person. A persistent vegetative state person is not a dead person, because this symptom occurs by the death of the cerebral cortex and not the brain stem. If they don’t put a patient on life-support in the first place, then that does not violate the first precept. Sometimes people try to impose their will upon another’s matter, as if they were their life’s owners. Doctor’s tend not to ask a patient whether they want to live or die. No
matter the case, no one should take the liberty of deciding another’s fate. The performance of euthanasia, perhaps, is not an altruistic method of relieving the patients’ suffering, but it is just the medical practitioners’ way of preventing further suffering.

From the traditional viewpoint of Buddhism, one should not seek to prolong life beyond its natural span. To do so is a futile action, and which creates more ‘suffering’ (dukkha) from fears and anxiety about dying, for the aware that is. The idea of hospice care is supported by most Buddhists, because it focuses on providing palliative care for a terminally ill patient’s pain and symptoms, and it attends to their psychological and spiritual needs.

However, hospices and palliative care are not well-known in Thai public society. Most of the Thai population do not know that they have an alternative choice, whereby they can receive hospice and palliative care services. Therefore, the government should pay attention to developing the quality of public health systems, for the well-being of their citizens, from birth to death; publicizing and giving knowledge about a patient’s rights and hospice services in broader ways, such as publishing reports in public newspapers or on television. Therefore, the Royal Thai government should hold a meeting with all concerned organizations such as the Ministry of Public Health, the Medical Council of Thailand, the Courts of Thailand and other departments and organizations, for a covenant agreement in order to legislate for specific laws which provide both punishments to medical practitioners or whomsoever acts in a manner considered not in accordance with bioethical medical practice, and at the same time for
providing protection for those medical practitioners who strictly follow the wishes of a patient who wants to refuse extraordinary treatment for prolonging life legally, and who have found themselves being prosecuted as a result. The patients and families should receive a full diagnosis from the medical practitioner, especially including information about hospice services. The researcher suggests that all medical programs should teach about hospice and palliative care, certainly pointing to the provision of psychological and spiritual support.

Spiritual care is a basic component of hospice philosophy and practice. The practice of ‘compassion’ (karuṇā) and the practical way of Buddhaddāsa Bhikkhu during his illness can be applied to hospice care, in order to help patients confront death consciously, be unafraid, and without interfering with the law of kamma. Not only do medical practitioners, patients and their families, but everybody needs to open their mind and learn view death as a natural phenomenon of life, as simply as Buddhaddāsa Bhikkhu did. Based on Buddhist teachings, anyone who wants to be happy and be reborn into a higher realm should be mindful of death on a daily basis, in order to experience their last moments of life fully conscious and with an untarnished mind.

The researcher proposes that we can apply the teachings of the Buddha, and of Buddhaddāsa Bhikkhu, as guidelines to the proper approach to death. The Buddha taught that the awareness of ‘death’ (marāṇa) is auspicious and beneficial to daily life. He also emphasized that we should be aware of it with every breath we take, in order to see truth. This will bring mindfulness, and allow us to live being fully aware. The Buddha
stressed that the greatest fruit from being mindful of death is immortality. Buddhadāsa Bhikkhu insisted that a good death was a peaceful death with full consciousness. The point to consider is not the circumstances of death, but the cultivation of a fully conscious mind that naturally accepts death. He advises us of the proper way to contemplate death; namely “death before death” (tai kawn tai). This means to expunge all of one’s ‘defilements’ (kilesa), and the attachment to ‘self’ (atta) before one dies. This should be a daily practice for all people. He suggested that the practice of the remainder-less extinction of any concept, of self, should be practiced on a routine basis until it is achieved. Its aim is to overcome death, when in preparation for one’s mind to accept that death is a truth of life; as well as to renounce one’s own self, when death arrives. From the Buddhist moral perspective, that is a good and proper death.

5.2 Recommendations for further research

The researcher would like to recommend further research into the field of euthanasia, from a world religion perspective, in order to find the interfaith ethical and moral solutions. These should be used as guidelines for the setting up of legal issues surrounding the rights to die, or to improve and rectify current patients’ rights for proper support within the moral practices of all religious beliefs. The case study of Buddhadāsa Bhikkhu can be used and compared with other case studies that can become a part of the various biomedical ethical lessons which are needed, in order to find the proper way to reach a good death. This study should help medical practitioners to provide and
encourage more efficient hospices and palliative care, and relieve the suffering of patients and families in more practical ways, especially when considering the teachings of Buddhadāsa Bhikkhu about illness and death. In addition, the benefits of this study can help patients and families to gain a greater understanding of the decisions made by medical practitioners. Furthermore, the researcher hopes everyone is able to receive the benefits of ‘Buddhist teachings’ (dhamma) through Buddhadāsa Bhikkhu’s interpretations as to apply contemplation and development of the mind, in preparing oneself to die peacefully.

The following topics can be taken as further researches:

1. An Analytical Study of Hospice and Palliative Care in the view of Buddhadāsa Bhikkhu.

2. An Integration of Buddhist Doctrines to the Hospice and Palliative Care in general.

Buddhism and India’s therapeutics are the Thai traditional medicine’s basis. Therefore, Buddhist Hospice Care according to the view of Buddhadāsa Bhikkhu can be applied in Thai medical study programs in being able to help the patient to die in peace, naturally.
References:

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Religious sacred texts:


BuddhadāsaBhikkhu’s Works:


(1991a). *Thamma-ösotThiThan Yang Mai-rüjak (Dhamma-medicine you have never known).* Bangkok: Atammayo.


B. Secondary sources:


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Phaisarn Kittiphattho (Bamrungkawan), PhraAthikarn (2002). *A critical study of application of Buddhist philosophy to heal patients’ mind.* The Degree of Master of Arts in Philosophy. Graduate School. Mahachulalongkornrajavidyalaya University, Bangkok, Thailand.


D. Articles and Essays:


E. Internet sources:


F. Personal interviews:


Huajai, B. (2013, August 30). Telephone interview.

Appendix A

Standards of a Hospice program

All of the material in this appendix is from the National Hospice Organization’s Standards of a Hospice Program of Care, 1982, in which is quoted by Anne Munley, I.H.M., in her book, The Hospice Alternative.

Definition of a Hospice Program of Care

A Hospice is a program of palliative and supportive services which provides physical, psychological, social, and spiritual care for dying persons and their families. Services are provided by a medically supervised interdisciplinary team of professionals and volunteers. Hospice services are available in both the home and an inpatient setting. Home care is provided on a part-time, intermittent, regularly scheduled, and around-the-clock on-call basis. Bereavement services are available to the family. Admission to a Hospice program of care is on the basis of patient and family need. Hospice affirms life. Hospice exists to provide support and care for persons in the last phases of incurable disease so that they might live as fully and comfortably as possible. Hospice recognizes dying as a normal process whether or not resulting from disease. Hospice neither hastens nor postpones death. Hospice exists in the hope and belief that, through appropriate care and the promotion of a caring community sensitive to their needs, patients and families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.
Standards of a Hospice Program of Care

1. The hospice program complies with applicable local, State and Federal law and regulation governing the organization and delivery of health care to patients and families.

2. The hospice program provides a continuum of inpatient and home care services through an integrated administrative structure.

3. The home care services are available 24 hours a day, seven days a week.

4. The patient/family is the unit of care.

5. The hospice program has admission criteria and procedures that reflect:
   a. The patient/family’s desire and need for service.
   b. Physician participation.
   c. Diagnosis and prognosis.

6. The hospice program seeks to identify, teach, coordinate, and supervise persons to give care to patients who do not have a family member available.

7. The hospice program acknowledges that each patient/family has its own beliefs and/or value system and is respectful of them.

8. Hospice care consists of a blending of professional and nonprofessional services, provided by an interdisciplinary team, including a medical director.

9. Staff support is an integral part of the hospice program.

10. In-service training and continuing education are offered on a regular basis.
11. The goal of hospice care is to provide symptom control through appropriate palliative therapies.

12. Symptom control includes assessing and responding to the physical, emotional, social, and spiritual needs of the patient/family.

13. The hospice program provides bereavement services to survivors for a period of at least one year.

14. There will be a quality assurance program that includes:
   a. Evaluation of services.
   b. Regular chart audits.
   c. Organizational review.

15. The hospice program maintains accurate and current integrated records on all patients/families.

16. The hospice complies with all applicable State and Federal regulations.

17. The hospice inpatient unit provides space for:
   a. Patient/family privacy.
   b. Visitation and viewing.
   c. Food preparation by the family.
Appendix B

All of the material in this appendix is from The IAHPC Manual of Palliative Care 2nd Edition, 2008.

Withholding or Withdrawing Treatments

The goal of palliative care is to maintain the quality of life while neither hastening nor postponing death.

- Death is the natural end of life.
- There is no ethic, in any culture or religion, which says that a terminally ill patient must be kept alive by any means.
- What matters is the quality of life left to the patient, not the time which is left to them.
- Palliative care must never become an exercise in prolonging life.

Whether it is appropriate to offer or to withhold or withdraw a particular therapy depends on the balance between the possible benefits and the potential risks of the treatment, i.e. what is in the patient's best interests.

- It will depend on individual clinical circumstances.
- It is often difficult and complex.
- Futile therapy, with no chance of benefit ("You have to do something!"), can never be justified.

Example 1

Should terminally patients receive antibiotics for chest infection?
- Depends on many factors, including
  - the patients' nearness to death
  - the wishes of the patients and their families
  - the expected benefits from the patients' point of view
- If the antibiotics
  - will merely prolong the dying process, they are probably best withheld.
  - will control distressing symptoms unresponsive to other measures, such as pyrexia or delirium, they may be of benefit

Example 2

How should renal failure caused by ureteric obstruction due to advanced cancer be managed?

- If the patient was terminally ill because of cancer before renal failure supervened, active therapy is probably inappropriate
- If the patient was previously relatively well and has a reasonable life expectancy except for the effects of renal failure, consideration for stenting or nephrostomy insertion is appropriate

Artificial Nutrition

The question is whether or not a particular treatment or intervention will restore or enhance the quality of life for a particular patient

- If the answer is yes, and it can be justified on the best clinical grounds, then it is ethically right to do it
• If not, it should not be done
• In developing countries, cost may be a major additional consideration

Weight loss and wasting in advanced cancer

• is nearly always due to the cachexia syndrome
• is caused by changes to metabolism secondary to the cancer
• is never responsive to enteral or parenteral nutrition
  • i.e. they are futile
  • parenteral nutrition is associated with
    • central venous catheterization
    • infections
    • expense
  • enteral nutrition is associated with
    • abdominal cramps
    • diarrhea
    • feeding tubes
• is occasionally due to malnutrition and starvation
  • patients with upper gastrointestinal obstruction, not terminally ill
    from their cancer warrant feeding by a nasogastric tube or gastrostomy.
  • patients receiving therapy that will prevent them eating for 2 weeks
    or more warrant consideration for parenteral feeding.
for patients with persistent or recurrent bowel obstruction, whether parenteral nutrition is warranted depends on individual clinical.

"You have to do something!" is never a justification for artificial nutrition.

**Artificial Hydration**

The question is whether or not a particular treatment or intervention will restore or enhance the quality of life for a particular patient

- if the answer is yes, and it can be justified on the best clinical grounds, then it is ethically right to do it
- if not, it should not be done

Effects of dehydration in terminally ill patients

- dry mouth
  - but this can be well palliated topically
- thirst
  - although dying patients do not complain of thirst
- diminished conscious state
  - several reports and a single randomized controlled trial showed no correlation between hydration and cognition in these patients

Possible benefits of dehydration in terminally ill patients

- less urine output means less movement and less incontinence
- less pulmonary secretions reduce dyspnea and terminal congestion
- less gastrointestinal secretions will lessen nausea and diarrhea
• less problems with edema and effusions

Possible disadvantages of artificial hydration in terminally ill patients

• may have the opposite effects and worsen the patient's situation
• may give an ambiguous signal or false hope to the patient or family
• drips act as a physical barrier between patient and family

Dehydration in patients not terminally ill

• causes thirst, dry mouth and postural hypotension
• Patients unable to take or retain adequate fluids warrant parenteral hydration

"You have to do something!" is never a justification for artificial hydration.
Appendix C

All of the material in this appendix is from the book, Hospice and Palliative Care in Southeast Asia: A review of developments and challenges in Malaysia, Thailand and the Philippines, 2010, page 96.

Palliative care education in Thailand’s undergraduate medical curriculum

<table>
<thead>
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<th>Hospital/ University</th>
<th>Status in curriculum</th>
<th>Teaching hours</th>
<th>Year and details</th>
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<tr>
<td>Chiang Mai Project</td>
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<tr>
<td>Chulalongkorn Included</td>
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<td>Mainly Y5/ some Y2, Y3</td>
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<tr>
<td>KhonKaen Included</td>
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<td></td>
<td>Y2: in medical ethics</td>
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<td></td>
<td></td>
<td></td>
<td>Y5: anaesthesiology rotation (pain assessment)</td>
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<td></td>
<td></td>
<td></td>
<td>Y5: paediatric rotation (lecture, what is pc?)</td>
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<td>2-hour bioethics conference topic</td>
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<td>(e.g. truth-telling)</td>
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<td>PC in teaching and ward rounds</td>
</tr>
<tr>
<td>Prince of Songkla Included</td>
<td>17</td>
<td></td>
<td>Y3: case discussion in haematology; oncology</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Y5: 12 hours in family and community medicine</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>(pc principles, pain management, death and dying, role play, communications skills, case studies, site visits)</td>
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<td></td>
<td></td>
<td></td>
<td>Y6: pc ward round in surgical and gynaecology rotations</td>
</tr>
<tr>
<td>Siriraj (Mahidol University)</td>
<td>Included</td>
<td>2</td>
<td>Y4</td>
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<tr>
<td>Ramathibodi (Mahidol University)</td>
<td>Included</td>
<td>2</td>
<td>Y5</td>
</tr>
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Source: Survey undertaken by Temsak Phunggrassami, 2006.
Appendix D

All of the material in this appendix is from the book, Hospice and Palliative Care in Southeast Asia: A review of developments and challenges in Malaysia, Thailand and the Philippines, 2010, page 97.

Palliative care education in Thailand’s postgraduate medical programmes

<table>
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<th>Details</th>
</tr>
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<tr>
<td>Chulalongkorn</td>
<td>Included</td>
<td>An element of many specialties: medicine, surgery, paediatrics, anaesthesiology</td>
</tr>
<tr>
<td>KhonKaen</td>
<td>Included</td>
<td>2-day intensive course for all new residents (including communication skills, palliative care concept, symptom management, psycho-social care) Anaesthesiology (pain management) Paediatrics (teaching ward round, lectures, videos, home visits, non-pharmacological pain management, involvement in academic palliative care programme)</td>
</tr>
<tr>
<td>Prince of Songkla</td>
<td>Included</td>
<td>Core curriculum for every specialty (includes principles, pain management, communication skills, role play)</td>
</tr>
<tr>
<td>Siriraj (Mahidol University)</td>
<td>Included</td>
<td>Part of the postgraduate basic science course</td>
</tr>
<tr>
<td>Ramathibodi (Mahidol University)</td>
<td>Included</td>
<td>20 hours per year</td>
</tr>
</tbody>
</table>

Appendix E

All of the material in this appendix is from the book, Hospice and Palliative Care in Southeast Asia: A review of developments and challenges in Malaysia, Thailand and the Philippines, 2010, page 98.

Palliative care education in Thailand’s nursing programmes

<table>
<thead>
<tr>
<th>Hospital/ University</th>
<th>Status in curriculum</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Undergraduate programmes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thai Red Cross College of Nursing, Bangkok</td>
<td>Included</td>
<td>Lectures in palliative nursing began in 1999</td>
</tr>
<tr>
<td>Ramathibodi Hospital, (Mahidol University)</td>
<td>Included</td>
<td>Year 2: 2 credits in fundamentals of nursing, (including lecture and case studies – nursing care for the dying) 1 credit in nursing ethics (lecture and discussion on life and death)</td>
</tr>
<tr>
<td><strong>Postgraduate programmes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thai Red Cross College of Nursing, Bangkok</td>
<td>Included</td>
<td>Certificate in Palliative Nursing offered 12 lecturers (palliative nursing) 1 chair (palliative nursing, appointed 2003)</td>
</tr>
<tr>
<td>Ramathibodi Hospital, (Mahidol University)</td>
<td>Included</td>
<td>Certificate and Master programmes in palliative nursing offered in addition to short training courses</td>
</tr>
</tbody>
</table>

Appendix F

An interview question for Anothai Jeasathawong, a Dhamma lecturer and writer, is: Does Thai society has spiritual support programs for helping people to prepare themselves to die in peace?

Interview questions for Banphot Huajai, a hematologist at the Laboratory and Blood Processing, Army Institute of Pathology, Royal Thai Army Medical department, and for Thongchai Utkham, general practice doctor of Princess Mother's Medical Volunteer Foundation and Wiang Haeng hospital, Chiangmai, are thus:

1. What is the criterion for taking the decision to stop life-prolonging treatments?
2. What do you think about the patient’s right to refuse life-prolonging treatments, including the use of living wills?
AUTOBIOGRAPHY

Mr. Supre Kanjanaphitsarn was born in September 1983, in Bangkok. He completed his primary and secondary education at Assumption College School. He graduated in Bachelors of Business Administration in Marketing at Assumption University, Thailand in year 2007. While studying in Bachelor degree, he was promoted to be Executive Committee of Young Buddhist Association of Thailand under Royal Patronage during March 2006 to July 2010. Later he received his Master Degree in Graduate School of Philosophy and Religion, majoring in Religious studies, Assumption University, Thailand. He decides to study Ph.D. Degree in the same major field in Graduate School of Philosophy and Religion, Assumption University, Thailand.

He began his career as a Marketing Manager at Grand Printing and Label Partnership in year 2007, and later became an owner of this partnership.