Buddhism and Medical Ethics: Principles and Practice

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I. INTRODUCTION

The religious life in Buddhism consists in living in accordance with Dharma, and it is believed that anyone who follows the Eightfold Path can replicate the spiritual transformation achieved by the founder. Given the central importance of the concept of a Path in the teachings, and the need to cultivate specific habits and a certain type of character as one progresses along that Path, it seems that in terms of ethical typology, Buddhism is best understood as a teleological virtue ethic. This means that Buddhism postulates a certain goal or end (*telos*) as the fulfillment of human potential, and maintains that this goal is to be realized through the cultivation of particular virtues. This kind of ethical system is familiar in the West where it is mainly associated with Aristotle and his concept of human flourishing or *eudaimonia*. In Buddhism, the goal of human perfection is known as nirvana, and is attained through a process of moral and intellectual self-transformation that comes about through following the teachings described above, and in particular cultivating the virtues generically referred to in Pāli as *kusala dhammas*.

Buddhist teachings are encapsulated in the form of four basic propositions known as the Four Noble Truths. These maintain i) that life as we now know it is imperfect and unsatisfactory (*dukkha*); ii) that the causes of this unsatisfactoriness are craving (*taṇhā*) and ignorance (*avijjā*); iii) that there exists a state of perfection free from all deficiencies (nirvana); and iv) that the way to perfection is by following the Eightfold Path. The Eightfold Path is a program for right living consisting of:

1. Right understanding
2. Right resolve
3. Right speech
4. Right action
5. Right livelihood

6. Right effort
7. Right mindfulness
8. Right meditation

These eight factors are grouped into three categories: 1-2 wisdom (*paññā*), 3-5 moral cultivation (*sīla*), and 7-8-meditation (*samādhi*). Morality is thus given a central place in the Path to nirvana, and the Buddha laid down certain precepts, the most well known of which are the Five Precepts for laymen. The Five Precepts forbid:

1.Taking life
2.Stealing
3.Sexual misconduct
4.Lying
5.Taking intoxicants

According to Buddhism, individuals have free will and their destiny is a function of their moral choices. This is known as the doctrine of karma. Karma is an important concept in Buddhist ethics and may be defined as a principle of moral retribution, which holds that one inevitably suffers the good or bad consequences of one's moral deeds. Karma is linked to a belief in rebirth such that good and bad moral deeds in one life lead to rebirth in a better or worse condition in the subsequent life. There are six possible realms of rebirth, and in terms of this teaching a human being who is wicked can be rebc· ı in a lower state, for example as an animal, while one ho is virtuous may be reborn in a heavenly paradise. The belief in rebirth has important implications for some issues in bioethics, such as the question when life begins.

Since Buddhism is an amorphous movement with no cl ar hierarchy or locus of authority, it is difficult to make authoritative statements of the kind 'The Buddhist view on issue x is...' without qualification. Lay Buddhists typically turn to their clergy for

religious and moral guidance, and these in turn base their opinions mainly on canonical scriptures. Despite the variety of Buddhist schools and sects, however, it does make sense to speak of a 'Buddhist view' at least as far as our present purposes are concerned. There is a good deal of consistency amongst the major schools in the field of ethics, both in terms of the dominant pattern of reasoning employed and in the conclusions reached on specific issues. It therefore seems fair to speak of a 'mainstream tradition,' a term which here denotes the common moral core which can be extracted from the different movements, schools and sects.

Apart from the problem of establishing a locus of authority, a further difficulty arises from the diversity of cultures involved. Some scholars regard cross-cultural ethics as a methodological minefield and contend there are fundamental epistemological problems in understanding alien cultures and deciphering their moral language. Awareness of these problems has been heightened by recognition of the increasing diversity and pluralism in the moral discourse of the West itself. Nevertheless, this concern is balanced by a countervailing trend toward globalism found in beliefs such as universal human rights, and a position of extreme relativism is nowadays difficult to maintain. While cultures influence the evolution of ethical beliefs, many feel that the beliefs themselves cannot be immune from scrutiny simply because they are the product of a particular culture. Pellegrino rightly points out that ethics is not grounded by culture:

> The ethical system of any culture is morally defensible because it is grounded in truths that transcend that culture; it is not morally defensible simply because it is a product of a particular culture. Respect for culture and ethics other than our own is the beginning of any intercultural dialogue, not its ending.[1]

There are sufficient common denominators between Buddhist and Western thought to permit a fruitful intercultural dialogue. The ethics of medicine is an important bridgehead, and the fact that disease is a cultural universal means that the ethics of medicine has a vital contribution to make to the dialogue. As Pellegrino puts it:

> As the biosphere expands to embrace the whole globe, every nation has a stake in every other nation's health. For these reasons, the practical and conceptual questions of transcultural biomedical ethics are more sharply defined than in some other domains of knowledge (1992:14).

II. BACKGROUND

The study of Buddhist ethics is a recent development brought about by the arrival of Buddhism in the West, and largely in response to the demands of Westerners for clarification of where Buddhism stands on a range of contemporary moral issues.

Although Buddhism is widely respected for its humane and benevolent moral values, there is an apparent absence in traditional Buddhist thought of a branch of learning devoted to reflection on ethical issues. Accordingly, very few issues in bioethics have received attention from Buddhist teachers or scholars. There is silence on many questions, and it is difficult to find position papers or pronouncements on controversial matters. Some commentators suggest that there are cultural reasons for this, and that the desire for clear and categorical statements in ethics is a legacy of the distinctive Western religious practice of formulating definitive credal statements on matters of doctrine. This practice is not common in Asian traditions, which tend to see it as divisive, and prefer to seek consensus rather than draw boundaries.

Traditional societies, furthermore, do not appear to distinguish between ethics, law and politics in the way the West does. Societies in Asia tend to be much more

integrated and homogenous than in the West, and in the former, duties and obligations at all levels of society are ultimately derived from religious beliefs and customs. Thus what an individual should do, what the law should enforce, and how rulers and states should behave are essentially deductive questions which can be answered by reference to shared religious values and principles. Member of society, moreover, are identified primarily by their social role, and the smooth running of society depends upon them playing their preordained part. The Indian caste system is an example of this. In such a context, a system of ethics concerned with individual responsibility and personal choice is largely redundant since the course of one's life is determined to a large extent from birth. Western culture, on the other hand, gives primacy to the individual and it may be that the discipline of ethics has evolved in tandem with this distinctive notion of the independent self-directed moral agent who embarks on a self-directed quest for the good. One of the most important principles in contemporary Western medical ethics is autonomy, but this is not a priniciple thatis given a high profile in Buddhism or in many traditional Asian societies.

Another reason for the lacuna in ethics would seem to be the lack of precedent set by the tradition itself. Buddhism originated as a movement whose purpose was to renounce worldly life, not to become enmesh 1 in its problems. Accordingly, there never developed in Buddhism a science of religious law of the kind found in Hinduism, Judaism, Islam, and Christianity. In each of these traditions jurists and commentators have established codes and digests of laws in a systematic attempt to resolve conflicts between daily life and the demands of sacred law.

A further historical consideration is that much of the Buddhist world has been relatively untouched by modernism. One of the major centers of Buddhist learning, Tibet, was to all intents and purposes a medieval feudal state as recently as half a century ago. Elsewhere in Buddhist Asia there was nothing to compare with the revolutionary developments such the Enlightenment and the rise of science that swept away medievalism in Europe. Even in those Asian countries that have seen rapid modernization, such as Japan, it remains to be seen whether the arranged marriage between East and West will be a fruitful union

The study of Buddhist bioethics has only evolved within the last decade and the literature available is extremely limited.[2] Although Buddhism has only a short history of involvement in bioethics, however, it has a much longer history of involvement in the practice of medicine. R.L.Soni has written, 'It is indeed a matter of supreme interest that the noble profession of medicine and the corpus of thought known as Buddhism are both concerned in their own way in the alleviation, control and ultimately the removal of human sufferings.'[3] In a similar vein the *Dictionary of Medical Ethics* points out that 'The principles governing Buddhism and the practice of medicine have much in common.'[4]

The Buddhist monastic Order (*saṅgha*) has a claim to be the world's oldest and most widespread continuous social institution, and for over two thousand years it has had a close involvement with the treatment of the sick. Several centuries before Christ, Buddhist monks were developing treatments for many kinds of medical conditions, and, according to recent research, Buddhism played an important part in the development of traditional Indian medicine (*āyurveda*).[5]

According to Kenneth Zysk, the early Buddhist monasteries of India were the places where the most significant developments in Indian medicine took place.

> Like the Christian monasteries and nunneries of the European Middle Ages, communities of Buddhist monks and nuns played a significant role in the institutionalization of medicine ... The codification of medical practices within the monastic rules accomplished perhaps the first systematization of Indian medical knowledge and probably provided the model for later handbooks of medical practice; the monk-healers' extension of medical care to the populace and the appearance of specialized monastic structures serving as hospices and infirmaries ... ensured ongoing support of the monasteries by the laity; and the integration of medicine into the curricula of major monastic universities made it a scholastic discipline. In India and elsewhere in Asia, Buddhism throughout its history maintained a close relationship with the healing arts, held healers in high esteem, and perhaps best exemplified the efficacious blending of medicine and religion.[6]

At the same time, medical expertise was required as a means to securing the healthy physical constitution necessary to withstand the rigors of the monastic life. Without good health, as Birnbaum points out, the practice of the religious life would have been impossible.

> It is not surprising that medicine bears such significance, for surely great strains were placed upon the physical well being of monks due to their austere life and strenuous meditative practices. Since illness and its indisposition tend to weaken the mind, often causing it to lose its focus on its function as a liberating faculty, the prevention and proper treatment of illness held (and continues to hold) a great importance for the Buddhist monk.[7]

The Buddha pointed out that since monks had severed all other social ties it was incumbent on them to care for one another:

> You, O monks, have neither a father nor a mother who could nurse you. If, O monks, you do not nurse one another, who, then, will nurse you? Whoever, O monks, would nurse me, he should nurse the sick.[8]

With the passage of time restrictions on treating the laity were eased. The great Buddhist monarch Asoka claims, in an edict around 258 BC, to have instituted an early form of state health-care provision:

> Everywhere in the dominions of King Priyadarśī (i.e. Asoka) ... provision has been made for two kinds of medical treatment, treatment for men and for animals. Medicinal herbs, suitable for men and animals, have been imported and planted wherever they were not previously available. Also, where roots and fruits were lacking, they have been imported and planted.[9]

Asoka's interest in medicine may have been stimulated by his conversion to Buddhism, and Buddhist monks may well have had some role to play in his 'national health service' if, indeed, it involved anything more than the planting of herbs and the like. What is certain, however, is that his royal endorsement of medical provision would have provided a further stimulus to medicine in the monasteries. As Buddhism spread, moreover, the goodwill generated by the provision of medical care would doubtless have encouraged monks to develop their skills in this area. Today it is not uncommon to find monks qualified in traditional medicine, Western medicine, or both.

Given the close connection between medicine and monasticism, it will come as no surprise to find that the Buddhist attitude to the ethics of the care of patients is deeply influenced by its religious beliefs. What is to be done and not to be done by the physician will be determined by the same moral principles which determine what is to be done and not to be done by a monk, since the physician is a monk first and a physician second. Thus, as we might expect, medical ethics in Buddhism involves essentially the application of the wider principles of religious ethics to problems in a more specialized field.

The ancient monastic texts reveal that the Buddha resolved problematic matters on a case-by-case basis as new situations arose. The records of these case histories include medical issues and represent the earliest codification of medical knowledge in India.[10] As may be expected, the treatments described are not those of modern medicine, nor are the problems they raise identical in all respects. Given the primitive technology, for example, certain questions that have arisen today could scarcely be imagined. Nevertheless, we are not entirely bereft of guidance in the ancient sources, and although the circumstances today may be new, the moral issues that arise often turn out to be similar in principle.

III ISSUES

A Bioethics in General

It should be clear from the foregoing that there are few, if any, important institutions concerned with Buddhist ethics. The establishment of ethics centers, a common phenomenon in the West, has not caught on in Buddhist countries for reasons mentioned in the preceding section. The chief characteristic of Buddhist institutions in general is that they are local and autonomous rather than global and hierarchical. There is no precedent or mechanism for pro ducing statements or declarations that command universal assent among Buddhists. Most collaborative activity is at a national or regional level, and although international assemblies occasionally take place these are rare. Even then, it is rarer still for bioethical issues to feature on the agenda, although in more Westernized Buddhist communities there is some evidence that this is beginning to change. To date, however, as far as I am aware, there has not been a major international conference devoted to Buddhist bioethics, nor are there any research centers, university

departments or university chairs dedicated to Buddhist ethics. The contrast with Christian ethics could scarcely be greater. In Bangkok, the Center of Human Resources Development carries out some research on Buddhist bioethics under the directorship of Pinit Ratanakul, a Yale-educated Thai bioethicist, and more such institutions are urgently required.

Buddhist monks, who are the traditional source of authority on Buddhist teachings for most lay Buddhists, have, with very few exceptions, been largely silent on bioethics. The reason for this silence seems to be that monks are regarded as aloof from the concerns of worldly life and family affairs, and although they may consult them on religious and spiritual matters most lay Buddhists feel embarrassed to raise practical questions, particularly of a personal nature. For example, women who are considering an abortion are unlikely to consult a monk about their decision. Many monks, too, feel that these questions are not proper for one who has renounced the world and is pursuing the spiritual life. This attitude is slowly changing as more Westerners join the Order as monks and nuns.

At the present time it is premature to speak of a dominant bioethical theory in Buddhism. Too little research has been carried out for there to be a consensus among scholar In terms of Buddhist ethics in general, an earlier gene· .tion of scholars inclined to a utilitarian reading of Buddhism. In this they were influenced by an understanding of the doctrine of karma in terms of which acts were right simply because they led to the experience of pleasure in the future (such as a good rebirth). This ·nderstanding is now less common, partly because karma is too complex to be analyzed in such simple terms, but also because of the declining popularity of utilitarianism as an ethical theory. Linked

to the renascence of virtue ethics, more recent studies have characterized Buddhist ethics as Aristotelian in form,[11] as noted earlier, and it is this theoretical model that is most commonly applied to bioethical issues.

In terms of basic values, one aspect of Buddhist ethics that strikes all commentators is its profound respect for life. The Buddhist respect for life is enshrined in the principle of non-injury or non-harming (*ahiṃsā*). Non-injury, and the respect for life it presupposes, lies at the very heart of Buddhist teachings, and this principle plays a fundamental role in Buddhist bioethics. The fact that the imperative to respect life is enshrined in the first of the Five Precepts listed above leads us to conclude that Buddhism shares the respect for life that is fundamental to the moral and legal traditions of the West. This belief in the 'sanctity of life'[12] should not be understood as a commitment to 'vitalism' (the belief that life must be preserved at all costs) but as the notion that intentional killing always represents a failure to respect the inalienable dignity of living creatures. In the context of bioethics 'life' means human life, but some, particularly far-Eastern, schools of Buddhism come close to adopting a Schweitzerian 'reverence for life' whereby plants, micro-organisms, and even natural phenomena are given moral status. Indo-Tibetan schools, on the other hand, tend to see the relationship between plant, animal and human life as hierarchical rather than qualitarian. Human life occupies a place at the top of the hierarchy and is regarded as the most auspicious of all rebirths. It is only human subjects, of course, that concern us in the context of medical ethics, so it is with some relief that I leave the issue of the moral status of plant life in the hands of those infinitely more qualified to address them than myself.

B. PROFESSIONALISM

There is no one Buddhist perspective on the question of the nature of the ideal relationship among health care professionals. Attitudes and practices vary widely. In Asian countries in general, however, there is a stronger emphasis on respect for authority than is found in the West, and subordinates are less likely to challenge the views and opinions of senior members of the profession. In the earliest times monks provided medical and nursing treatment, and their conduct was regulated by a monastic code made up of some 250 rules. The rules emphasize non-harming, truthfulness, non self-aggrandizement, respect, modesty and decorum. Although these values are intended for those in monastic orders they may also be thought appropriate to the members of any professional body, including physicians and nurses. Members of the Order are encouraged to confess transgressions so as to unburden their conscience and be free to move ahead without remorse. When transgressions occur the monastic code lays down mechanisms for resolving breaches of the rules including sanctions ranging from a reprimand to temporary or permanent expulsion from the group, in a manner similar to the way doctors may be disbarred from practicing by their professional bodies.

Important Buddhist virtues that should inform the practice of any profession include generosity (with one's time and resources), sobriety, self-restraint, and compassion. A classical formulation of four important virtues includes generosity (*dāna*), kindly speech (*piyā-vācā*), helpful action (*attha-cariyā*) and impartiality (*samanattatā*).[13] Informed by these virtues the medical professional should act at all times in a manner consistent with his or her conscience. In the West conscience is understood as 'a mode of consciousness and thought about one's own acts (or proposed actions) by which we judge

whether they are blameworthy or praiseworthy according to our own standards.'[14] In Buddhism, conscience is analyzed into a small cluster of qualities in which the two most important are *hiri* or 'self-respect,' and *ottappa* or 'regard for consequences.' These are described as two 'bright states which guard the world'[15] and may be seen as concerned with the internal and external dimensions of conscience. *Hiri* causes one to avoid any action that is unworthy of one and causes one's moral integrity to be weakened. *Ottappa* is the concern for the blame or reproach (whether private or public), embarrassment before one's peers, legal sanctions, and also the karmic results of an action.[16] Another quality of great importance in one's personal and professional life is heedfulness (*appamāda*). This is described as the basis of all the virtues and is said to be composed of energy (*viriya*) and mindfulness (*sati*). Mindfulness is alert presence of mind that enables one to be focused on the action in hand as well as aware of one's inner mental states, including intentions and motives. Buddhism recommends the practice of meditation as a means of cultivating all the above qualities.

As regards the doctor-patient relationship, Buddhism would analyze this primarily in terms of duties. The language of rights is a peculiarly Western way of stating the requirements of justice, and traditional societies emphasize more the responsibility of the individual towards the collective rather than vice versa. Both doctors and patients therefore may be said to have duties towards one another. There is no Buddhist equivalent of the Hippocratic oath which lays down the duties of physicians, nor a Buddhist version of the Patient Bill of Rights of the American Hospital Association that lays down the standards of services and care patients can expect. Early Buddhist commentaries occasionally digress to discuss the practice of medicine by monks, but the

concern is mainly with the protocol for determining which members of society should be treated in the monastery. One ancient text, however, states: 'Medicine must be given to those who desire it, and for those who do not know how to prepare it, it must be prepared and administered.'[17] In general terms it may be said that the Buddhist health care professional has a duty to enhance the well being of the patient (the duty of beneficence) and not to cause any harm or injury (the duty of non-maleficence). Since it is generally held that duties and rights are to some degree correlative, we can extrapolate from the duties incumbent on the health care professional to establish a list of the basic rights of patients. For example, when a hospital agrees to treat someone as a patient, the doctors and nurses who care for that patient assume certain obligations towards him. Because of this we may say that the patient has certain rights, most generally the right to a professional standard of medical care, but also related rights such as a right to privacy. Seven major rights are outlined in the Patient Bill of Rights: 1) The right to considerate and respectful care; 2) The right to information; 3) The right to refuse treatment; 4) The right to privacy; 5) The right to confidentiality; 6) The right to know of research and experimentation being done. 7) The right to receive continuity of care.[18] All of these would seem acceptable from a Buddhist perspective. Respect for the autonomy of the patient is particularly important given the unequal nature of the physician-patient relationship. As a result of illness one party to the relationship is inherently more vulnerable. This inequality is exacerbated by the fact that one of the parties is a specialist and has much greater knowledge and experience than the other in the treatment of the condition. In order to redress this inequality patients must be treated as active partners in health care decisions and kept fully informed the available treatments and prognosis.

Of particular importance in this connection is the issue of truth telling. The traditional stance of 'Doctor knows best' has often meant that patients have been left in the dark about the true nature of their condition. This medical paternalism has been much criticized in recent decades, and greater emphasis is now placed on the duty of veracity. This is in accordance with Buddhist moral principles that regard lying as wrong, even when there is a benevolent motivation such as to shield the patient from unpleasant facts. The Buddhist principle of 'right speech' (*sammā vācā*) emphasizes that one should always be truthful while leaving scope for diplomacy and tact in speaking the truth at the right time and in the right way. A blunt statement of fact may not be always the best way to break bad news: it may have a demoralizing effect on patients and give the impression that the physician is anxious to wash his hands of the case. It must also be born in mind that in some cultures speaking forthrightly is regarded as rudeness. Good physicians will therefore seek to establish rapport with patients and communicate with sensitivity. The only exceptions to the duty of veracity are rare cases where there is a reasonable presumption that the patient may overreact and suffer physical or psychological injury, or where placebos are used.

Good communication is also important in ensuring that patients understand clearly the medical issues involved in their treatment and are in a position to give informed consent prior to the start of any procedure. For there to be valid consent the patient must understand the information given, the reasons for the treatment, the available alternative treatments (if any), and be able to foresee the consequences of his or her decision. The consent must be completely voluntary, that is to say given freely without any coercion or deception. In this and in many other respects the obligations upon the

Buddhist health care professional do not differ greatly from professional norms of conduct throughout the world. Codes of conduct laid down by professional bodies internationally often coincide, and although there are some cultural idiosyncrasies the similarities in the doctor-patient relationship across the world outweigh the differences, particularly where practitioners have been trained in the methods of modern scientific medicine.

C. REPRODUCTION

A distinctive feature of Buddhist thought is that it does not postulate an initial starting point to the series of lives lived by an individual. Instead, it regards the cyclic course of human existence as potentially eternal: it had no beginning and there is no certainty it will ever have an end. All conception is thus re-conception, and the belief that each individual exists prior to conception provides a distinctive perspective on the question of when life begins.

Although the basic Buddhist position on how and when individual life begins was formulated over two thousand years ago, the conclusions reached are in many respects remarkably modern. Buddhism has always seen conception as an event marking the start of a gradual process of development up to birth and beyond, through childhood into maturity. In adopting this view Buddhist thinking was very much ahead of the West, which until the modern era was hampered by Aristotelean theories of three stages of ensoulment in the embryo. By contrast, and in keeping with traditional Indian medical thought, the Buddha explained conception as a natural process that occurs when three specific conditions are fulfilled. In this understanding i) intercourse must take place ii) during the woman's fertile period, and iii) there must be available the spirit (*gandhabba*)

of a deceased person seeking rebirth. When these conditions are present a new life comes into being. Interpreting these requirements in the light of modern science most Buddhists regard fertilization as the point at which individual human life commences, and believe that the embryo is entitled to moral respect from that time onwards. Abortion is therefore seen as morally in the same category as the intentional killing of an adult. The only exception is likely to be when the procedure is necessary to save the life of the mother, although there is no explicit Buddhist teaching on this point, and there appear to be no examples in Buddhist canonical literature of abortion performed for therapeutic reasons.

Despite the condemnation of abortion in the ancient texts the sources disclose that as medical practitioners monks occasionally became illegally involved in such matters. The motives for the abortion include concealing extramarital affairs, preventing inheritances, and domestic rivalry between co-wives. The methods used to procure abortions included ointments, potions and charms, pressing or crushing the womb and scorching or heating it.

The contemporary legal position varies from country to country. The more conservative Buddhist countries of South East Asia such as Thailand and Sri Lanka have laws prohibiting abortion except when necessary to save the life of the mother. Nevertheless, ille al abortions are common. Somewhat surprising for a c untry in which Buddhism is the state religion, abortions in Thailand are as common as in the USA, and twice as frequent as in the UK. Married women, who appear to use it as a means of birth control, account for eighty-five per cent or more of abortions in Thailand. Recent studies refer to an estimated 300,000 abortions per year, the majority of which are illegal.[19]

Opinion polls in Thailand also reveal a paradox: while most Thais regard abortion as immoral, a majority also believes the legal grounds for obtaining it should be relaxed.[20]

In East Asian countries, attitudes are more liberal. The rate of abortion in Japan has been very high in recent years, perhaps peaking at over a million (some would put the figure much higher) before decreasing in the last few years as the contraceptive pill has become more easily available (it was only licensed in Japan last year). Central to the contemporary Japanese experience is the phenomenon of *mizuko kuyō*, a memorial service held for aborted children. This service involves erecting a small statue to commemorate the lost child and includes an apology to the spirit of the aborted fetus. William LaFleur, among others, has explored the complex symbolism and cultural history of the practice.[21]

Korea provides an interesting comparison with Japan. Both countries have a very high rate of abortion, but in Japan it is legal (since 1948) whereas in Korea, it is not. Annual figures of between one and two million are quoted for Korea, a country with a population of around 46 million. Over a quarter of the population are Buddhists, which makes them the majority religious group. Statistics quoted by Tedesco[22] reveal that Buddhists are slightly more likely to have abortions than other segments of the population. In 1985, an anti-abortic movement began to gain ground following the publication of a book by the Venerable Sŏk Myogak, a Buddhist monk of the Chogye order. His book, entitled *My Dear Baby, Please Forgive Me!* became popular, and readers began to demand rites and services for aborted children similar to the Japanese *mizuko kuyō* service, although distinctively Korean in form.

Some Western Buddhists take a more liberal stance on the abortion question than is found in the traditional sources. James Hughes suggests that 'clear and defensible distinctions can be made between fetuses and other human life,' and finds the moral logic of utilitarianism persuasive in the context of abortion, although tempered by the requirements of a virtue ethic which takes into account the mindset of the actors. Abortion may therefore be allowable, he suggests, where the intention is compassionate and the act achieves the best outcome for all concerned. One American Zen Buddhist group, the Diamond Sangha, has produced a liturgy that can be performed following an abortion or miscarriage.[23]

The above diversity of opinion is reflected in other reproductive issues such as embryo research. In terms of the more conservative majority view, any destructive experimentation on embryos is considered a breach of the first precept against taking human life. Practices such as IVF, or techniques that have some therapeutic end, for example the repair of chromosomal defects before an embryo returned to the womb, are unlikely to meet with any strong Buddhist objection. There are, however, certain aspects of the IVF technique that Buddhism would not approve of. Chief amongst these is the creation of spare embryos by drug-induced superovulation. Leaving aside the problem of the multiple pregnancies that sometimes arise fro . this practice (when the 'excess' fetuses may be deliberately destroyed in the womb), there is the question of the fate of the 'spare' embryos that have not been implanted. They are usually either discarded or used for research.

These aspects of the technique seem unacceptable to Buddhism. Essentially this is because they involve either the destruction of a living being (a breach of the First

Precept) or its use as an object for the benefit of others without its consent. Regardless of any benefits Buddhism could not countenance the use of a human subject as an object of research that is not in its own best interests and to which it has not consented.

Contraception is widely used and approved of in Buddhist countries, especially where the method does not involve the destruction of fertilized embryos. Methods that prevent implantation, such as the low-dose estrogen pill (the 'minipill') and the IUD, are less acceptable, although not uncommon. In Japan the high rate of abortion has been attributed to the fact that until very recently health officials refused to license the contraceptive pill due to concern about side effects. Some commentators, however, believe that doctors are unwilling to prescribe the pill because they derive a large income from managing profitable abortion clinics.

D. Death and Dying

Old age and death are two aspects of suffering (*dukkha*) which are constantly referred to in Buddhist sources. Buddhist teachings emphasize that phenomena are inherently impermanent (*anicca*); as the early sources put it, 'Whatever has the nature of arising, has the nature of cessation.' All forms of organic life have the nature of arising, since they come into being as integrated wholes at a definite moment in time, namely conception. As such they are compounded entities, and according to Buddhist philosophy it is the nature of all compounded entities eventually to lose cohesion and disintegrate. There is a sense in which death encapsulates all the unsatisfactoriness (*dukkha*) of the human condition since it reveals starkly the impermanence of individual life and also the attendant pain and suffering of old age. In this sense death is the paradigm problem for Buddhism since it is emblematic of all the ills to which karmic life is subject.

An important development in the West in recent years has been the formulation of a criterion for defining death in terms of the cessation of all brain functions. In 1968 an ad-hoc committee of the Harvard Medical School produced a report[24] recommending a definition of death in these terms. This definition has since become widely accepted in medical practice and has been incorporated, sometimes with modifications, into the legal definition of death in many countries. One country where this definition has not been accepted and remains the subject of much controversy is Japan. Although the majority of the medical profession is in favor of it, there is widespread popular dissatisfaction among the population at large due to its connection with organ transplantation. There is no Buddhist objection to organ transplantation in itself, and the distaste for it seems to arise from Confucian teachings that see the body as a gift and the plundering of organs, particularly from older members of the family who are soon to become revered ancestors, as a sacrilege. Some concern does exist among Buddhists concerning the criterion of brain stem death, to which organ transplantation from cadavers is closely linked. To declare death on the basis of this criterion seems premature to some, and not in keeping with Buddhist scriptural teachings concerning the point when death occurs. The ancient sources state that death occurs when three things—vitality (*āyus*), heat (*usmā*), and consciousness (*viññāṇa*)—leave the body. At the present time it is not clear whether the ancient criteria can be equated with the modern concept of brain stem death, although some authorities, such as the Thai physician-monk Mettanando, see the two as equivalent and believe Buddhism should accept a definition of death based on the loss of the functions of the brain stem.[25] What does seem clear, however, is that since the traditional Buddhist criteria for determining death are biological in nature, Buddhism would reject

any definition of death that focused solely on the loss of consciousness or the higher brain functions controlled by the neocortex. It would appear on this basis that patients in PVS (Persistent Vegetative State) cannot be regarded as dead, and Buddhist principles appear to require that such patients should continue to receive at least basic care including nutrition and hydration.[26]

As far as euthanasia is concerned (here understood to mean the intentional killing of a patient by act or omission) it appears that Buddhism would oppose it in all its forms on the grounds that it involves the deliberate taking of life. The Buddha forbade monks to take their own lives, or to play a direct or indirect part in assisting or inciting others to commit suicide.[27] Such acts were declared to be wrong even when motivated by compassion, in the light of which it seems that suicide whether assisted by one's physician or by friends or relatives is contrary to Buddhist ethics.

In recent decades there has been understandable concern about patients being kept alive as prisoners of technology, and allowing such patients to die rather than prolonging their lives through extraordinary means is sometimes confused with euthanasia. It is important to bear in mind here the difference between euthanasia and the withholding or withdrawal of burdensome and futile treatment. While Buddhism regards life as inviolable, it does ot follow that it is something that must be preserved a' .ll costs. In other words, Buddhism does not subscribe to the doctrine of vitalism. Instead, death is seen as a natural part of the cycle of life and to be accepted as such. The recognition that death is not a final en d but the doorway to rebirth and new life leads to the ab andonment of medical treatment that serves no useful purpose. From the perspective of Buddhist ethics, there is no obligation on doctors to keep patients alive at all costs. In the case of

elderly or terminal cases it is far more important to assist patients in developing the right mental attitude towards death rather than attempting to deny or postpone it. A caring environment, such as is offered by the hospice movement, is the type of response that Buddhism would endorse in these circumstances.

Buddhism regards death as the gateway to new life, and teaches that the dying person's state of mind can influence the circumstances of rebirth in the next life. Accordingly, it sees it as desirable to approach death ideally in a clear and mindful state rather than in a drugged or comatose condition. Nonetheless, it has no objection in principle to administering narcotics as part of a program of pain control. The administering of painkilling drugs to terminally ill patients which may coincidentally hasten their death does not count as euthanasia. Where patients are in great pain it may be necessary to administer drugs and other medication although recognizing that the quantities involved may shorten the patient's life. The doctor's aim here, however (in contrast to euthanasia), is to kill the pain, not kill the patient. What the physician is typically endeavoring to do is enhance through medical treatment the condition of the patient overall, in this case by freeing them from pain. In contrast to euthanasia, the physician wills the enhancement of life through the elimination of pain, while accepting that his efforts may haste the advent of death. Death, however, is neither intend d nor chosen either as a means or an end.

E. Access to Health Care

There is no general consensus among Buddhists concerning the financial issues arising in connection with access to health care. Arrangements vary from one country to

another and depend more on local customs, traditions, and the current political and economic situation than on Buddhist teachings. The majority of Buddhists live in the third world in countries where health care resources are limited or even non-existent. For the poor, treatment is available in government hospitals and clinics or from charitable foundations. The middle classes typically turn to private medicine for their needs. In this respect there is frequently a two-tier system in operation. Many governments put what resources they have into family planning programs in order to limit population, or to deal with the prevention of epidemics and diseases such as AIDS. No clear 'right' to health care can be established from Buddhist teachings, although it could be said that the state has a general duty to care for the wellbeing of its citizens, within which ambit the provision of at least basic health care would seem to fall.

F. Ethics consultation and Committees

This is an area where the West has evolved far beyond anything found in Buddhist countries. Over the last two or three decades, the concept of patient autonomy has become increasingly important in Western bioethics, as part of a more general program of consumer rights. Medical paternalism is now out of fashion, and patients no longer accept unquestioningly th opinions of their physicians. Against the background c this increasing conflict between physician and patient, ethics committees have evolved in order to monitor doctors' decisions in grey areas and arbitrate in cases of conflict between physician and patient. Buddhism itself allocates no specific role to ethics committees, and where these are found in Buddhist countries it is typically the result of imitating the West.

In general terms, the Buddha seems to have felt that it was good practice to meet regularly to discuss issues of common concern. He states that a community that conducts its business in this way can be expected to prosper rather than decline.[28] This, in fact, is the basis on which the Buddhist monastic community conducts its business, resolving disagreements by majority vote. The practice of developing good relations through regular meetings, and making important decisions after thorough discussion seems to accord with good practice for a Western ethics committee, and to be one that Buddhism would accept.

IV Conclusions

Caution must be exercised when drawing conclusions about Buddhist perspectives on bioethics. Ethics as a philosophical discipline is not found in traditional Buddhist canons of thought, and there is a risk of inadvertently superimposing Western categories on the discussion. Buddhism does not fit easily into Western categories nor does it resemble the Abrahamic family of religions with which the West is most familiar. Some doubt whether it constitutes a 'religion' at all in the conventional sense. The doctrine of karma and the belief in rebirth make it distinctive from an ethical perspective. Further difficulties arise from its fragmentary and culturally diverse nature, making it is unwise to be categorical about what Buddhists in general believe.

On the other hand, Buddhist moral values are not parochial and are universally held in high esteem. Buddhism is widely respected for espousing the virtues of benevolence and compassion and for its scrupulous respect for living beings, both human and non-human. Nor is Buddhist ethics 'alien' to us. Typologically, it resembles traditions of virtue ethics found in both Eastern and Western cultures—such as

Confucianism and Aristotelianism--which hold that the good life for man consists in a systematic lifelong program of character development that leads to the production of a sage.

The leading Western approach to bioethics is the so-called 'four principles' system of Tom Beauchamp and James Childress.[29] This gives primary importance to the four moral principles of Non-maleficence, Beneficence, Autonomy, and Justice. The Buddhist approach to medical ethics, I suggest, overlaps with this but has a different emphasis. The whole of Buddhist teachings, it is sometimes said, can be summed up in a single verse from the Dhammapada. That verse is:

> Not to do any evil
> To cultivate what is good
> To purify one's mind
> This is the teaching of the Buddhas
> (*Dhammapada*, verse 183).

It can be seen that in the first line we find expressed the principle of non-maleficence, to do no evil. In the second, we see the principle of beneficence, or the injunction to do good. In place of autonomy and justice, the third and fourth of the Western moral principles, we find instead in Buddhism the injunction to 'purify one's mind.' I do not think this means that Buddhism is opposed to either autonomy or justice, but simply that it believes that these and other principles will be spontaneously manifested in the virtuous conduct of the enlightened sage.

In terms of how this conduct will manifest itself in practice, I believe that with respect to many applied issues in bioethics Buddhism will take a conservative stance. This is because the centrality accorded to the principle of non-injury (*ahiṃsā*) (a specific principles derived from the general injunction to 'do no harm') means that any procedure

involving intentional harm is seen as immoral. Utilitarian arguments to the effect that bad acts may be justified by their good consequences are unlikely to find favor among most Buddhists. However, the detailed process of how one should reason to particular moral conclusions requires further precision and clarification. As yet little work has been done in this field, and as Buddhism continues to spread in the West there is an urgent need for dialogue with Western bioethicists in order to develop a framework in terms of which Buddhist responses to bioethical issues can be articulated with greater precision.

Notes

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[8] Trans. Zysk (1991:41).
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[10] Zysk (1991:71).
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[14] Ratanakul, P. (1986), *Bioethics, an introduction to the ethics of medicine and life sciences*. Bangkok: Mahidol University. p.196.
[15] *Anguttara Nikāya* i.51.
[16] Harvey, Peter (2000:11).
[17] *Samantapāsādikā* p.469.
[18] Ratanakul (1986:129).
[19] Florida, Robert (1999), 'Abortion in Buddhist Thailand,' in *Buddhism and Abortion*, ed. Damien Keown, London: Macmillan, pp. 11-29. p.23.
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[28] *Dīgha Nikāya*, ii.73.
[29] See *Principles of Biomedical Ethics* (Oxford University Press, various editions).

BUDDHISM AND MEDICAL ETHICS: PRINCIPLES AND PRACTICE

Damien Keown

Glossary of terms used in lecture

ahiṃsā	non-harming, respect for life
appamāda	heedfulness, carefulness
Asoka	Buddhist emperor
attha-cariya	helpful action
avijjā	ignorance
āyurveda	traditional Indian medicine
āyus	life
dāna	generosity
Dhammapada	Popular religious text
dukkha	suffering, unsatisfactoriness
eudaimonia	happiness, human flourishing
gandhabba	a spirit seeking rebirth
hiri	modesty, self-respect
karma	moral retribution
kusala dhamma	virtue, good quality
mizuko kuyo	memorial service following abortion
ottappa	shame, concern for consequences
paññā	insight
piyā-vācā	kindly speech
samanattatā	impartiality
sammā vācā	right speech
samādhi	meditation
sati	mindfulness
sīla	morality
taṇhā	craving
telos	goal or end
usmā	heat
viriya	energy
viññāṇa	consciousness