JAIN VOLUNTARY DEATH AS A MODEL FOR SECULAR END-OF-LIFE CARE

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Abstract

Jain voluntary death, a millennia-old practice in India, follows the three-fold process of *sallekhanā-santhārā-samādhimaraṇa* that has allowed countless Jain practitioners to enter death consciously and most effectively, departing smoothly on their own terms. As the interaction between cultures is possibly at a new height, given population diversity and information exchange, the existence of such a venerable and novel death methodology can lead to our asking: (1) Can aspects of Jain voluntary death be integrated into secular end-of-life care? and (2) Can Jains receive the end-of-life care they need in a secular healthcare setting? Both questions could be pursued for the betterment of multi-cultural end-of-life care delivery by introducing potentially transferable and distinctly Jain ideas/practices to secular healthcare practitioners and their clients. This paper observes that despite some tension between Jain ethics and contemporary bioethics, the answer to both questions is in the affirmative.

Keywords: Sallekhanā; Jain Voluntary Death; Healthcare; Bioethics

Introduction

Given that every human must not only die but also must stop eating, drinking, and moving at some point before death, the Jain systematic methodology for this time holds the potential for immense continued benefit to many more people in the future, both Jain and non-Jain. Among those who are non-Jain, some will embrace transmigration or some other post-death continuity of existence as part of their worldview and some will not. Holding to such religious concepts is not required for the essential elements of the Jain voluntary death to be useful to non-Jains. Additionally, for Jains in the diaspora or India who find themselves in a secular healthcare environment, modern bioethics are amenable to aspects of the Jain voluntary death based on respect for autonomy and the unique values and beliefs of the client. A secular end-of-life setting is not reserved for a palliative or hospice environment but can include emergency, critical care, acute, and chronic care settings where many people also die regularly. In any environment, the Jain emphasis on (1) voluntary and autonomous decision-making to withdraw treatment, including (but not limited to) nutrition, hydration and ambulation; and (2) qualified assistance and separation from objects of attachment and aversion, have great potential to assist the dying.

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Death in Jain Thought

Death is described as a time of destruction and provides a strong impetus for the development of means in Jain practice to prepare physically and psychically to meet this difficult experience in the best way possible. The trauma of death is the main reason not only for the existence of the Jain voluntary death practices but also for the great importance placed on them by the Jain community, to the point of reverence. It is a practice so highly considered, in fact, that the distinction between layperson and monastic dissolves in the asceticism of such a death. Jain voluntary death has three aspects: (1) *Sallekhanā;* "emaciation of body and passions through external and internal penances"[1], (2) *Santhārā*; the deathbed or, by extension, the environment in which the practitioner dies, and (3) *Samādhimaraṇa*; end practices for achieving death in equanimity.

The Jain voluntary death practices are also of crucial importance because the quality of death is the cause of the quality of the experience after death, which can be another birth or even, potentially, liberation. Since death is the cause of what comes afterward, death is subdivided into various qualitative levels based on commensurate levels of the state of mind of the dying person. The quality of death is measured by the spiritual realizations obtained from the progressive mastering of restrained conduct. The list is sometimes compressed into two types, or three, and *Bhagavatī Ārādhanā* enumerates and describes seventeen types of death. It also mentions five types of death:[2] (Jnanamati 240)

1. Extreme Prudent's Death (Paṇḍita-paṇḍita Maraṇa)
2. Prudent's Death (Paṇḍita Maraṇa)
3. Fool-Prudent's Death (Bāla-paṇḍita Maraṇa)
4. Fool's Death (Bāla Maraṇa)
5. Extreme Fool's Death (Bāla-bāla Maraṇa)

Often the highest type of death is a reserved designation for the death of a liberated being, or a death which results in liberation from *saṁsāra*, the cycle of existence. The worst type of death is described as "[t]he death of a wrong-faithed living being and death by suicide and accident etc." (Jnanamati 241). It would be problematic in modern bioethics, where even the word 'accident' has been replaced by terminology such as 'collision', to associate events causing sudden death with foolishness. This would be unfair to a pedestrian struck by no fault of their own. Additionally, 'wrong faith' (called *mithyātva* in Jain terms that causes transmigration) needs to be qualified because such logic would not survive outside of a Jain context. Betraying the above description of the worst type of death are indications in the Jain thought which shows that the last moments of life continue to hold the redemptive opportunity to improve one's death by way of supplementary purification practices. A sudden, traumatic death would, indeed,

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1 evaṁ bhāvemāṇo bhikkhu salleharh uvakkamahū |
ṇāṇāviheṇā tavasā vajjheṇabbharhtareṇa tahā || (*Bhagavatī Ārādhanā* 207)

2 paṁḍidapaṁḍidamaraṇaṁ paṁḍidayaṁ bālapaṁḍidaṁ ceva |
bālamaraṇaṁ caüttharh paṁcamayaṁ bālabālaṁ ca || (ibid 26)

make dying more problematic which does not allow enough time for one to ponder over their life. However, even if there is little time to prepare and only mere moments of consciousness remaining, the Jain death practice allows for the continued potential to transform the mind.

Fasting (anaśana) and Bodily Turmoil (kāyakleśa) Austerities (tapa) in Jain Voluntary Death

Austerities, particularly fasting and immobilization are a crucial part of understanding the Jain voluntary death practice. Generally, we can categorize fasts into three types: (1) instrumental; (2) protest; and (3) purificatory/liberative. The first would be those aimed at achieving a specific worldly end, the second would be those associated with social activism, and the last would be concerned with karma.

Instrumental fasting and that used for protest are rejected in Jain thought and practice. "[F]orms of instrumental fasting (*vrata*) are invariably criticized by the Jains" (Flugel 98: f 30), and it is also felt that "fasting unto death for specific purposes has an element of coercion which is against the spirit of non-violence" (Kalghatgi 185). They are distinguished as inappropriate types of fasting because they keep one caught in the wheel of *saṁsāra*, rather than being a cause of liberation from the cycle of existence.

Immobility austerity also is generally sub-divided into three: (1) taking certain postures to the exclusion of others; (2) restriction of motion to a certain limited area; and (3) refraining from all bodily motion altogether.

All Jain austerities are aimed only towards purification and liberation and are mainly concerned with karma. On a lower level, austerities make for the accumulation of merit (*puṇya*) which brings about good results. Some good results, such as material gain, can be counterproductive on the path to liberation by being a distraction to the goal. They can, however, be useful. Consider the good result of having resources and using them to support religious organizations. Such actions may bring some good but not spiritual purity because the soul's manifestations which result in earning merit or demerit, the indulging in them is deviated from its true conduct.[3] Merit is helpful, but ultimately still obstructs liberation. On a higher level, austerities are to stop the influx of all karma (*saṁvara*), positive and negative, and to destroy karma already bonded (*nirjarā*).

Most literature concerning Jain voluntary death practices focuses mainly on fasting, but it is important to keep in mind that the austerity of limiting mobility also features prominently. Since both fasting and mobility-restricting austerities could fall under the category of *kāyakleśa*, which "literally means to give turmoil to the body" (Shastri 209), and *kāyakleśa* is one of the twelve types of elimination of karma (*nirjarā*) (Shastri 204), both austerity-types destroy karma. Not only this, but they also both prevent the influx of new karma. This is so

[3] yataḥ sampadyate puṇyaṁ pāpaṁ vā pariṇāmataḥ |
vartamāno yata(tata)statra bhraṣṭo'sti svacaritraḥ || (*Yogasāra-Prābhṛta* 3.32)

because both are of the fifth of the five types of *saṁvara* [that of] "*ayoga* – stopping all the mental, vocal and bodily activities" (Shastri 196).

This overlap in the functions of fasting and immobility austerities carries over to their practice as well. The distinctions between the main fast types in Jain death practice are not based on the fasting itself, but rather with regard to mobility and assistance to oneself (by oneself or others). The three types of fast are:[4]

i. *Bhakta-pratijñā*, in which one renounces food and drink, and can receive help from oneself or others.
ii. *Iṅgini-maraṇa*, in which one renounces food and drink and limits physical movement and can receive help from oneself.
iii. *Pādopagamana maraṇa*, in which one renounces food and drink and all motion and receives no help from anyone (self or others).

Stoppage of oral intake & ambulation in secular end-of-life care

There are three main causes which lead people to stop oral intake and ambulation in a health care setting: (1) The requirement to stop such activities temporarily to prevent further deterioration of health and to allow for diagnostics and treatments; (2) debilitation; and (3) choice. For our purposes, it is this last cause that is most significant.

The Health Ethics Guide of the Catholic Health Association of Canada governs the principles of care in many hospitals that serve diverse patient populations. I have consciously chosen to use this document when looking at health ethics in the hospital because it comes from a religious organization that is often seen as having extreme views about euthanasia and assisted suicide, among other controversial issues. Since much of the controversy around Jain voluntary death stems from opponents accusing Jains of engaging in suicide, and much of the literature is in defense of Jaina voluntary death as not suicide, it seems that if the Jain voluntary death model can survive in Catholic ethics, then it can survive anywhere. The context that Catholic and Jain ethics share is the necessary interaction with secular healthcare within diverse populations. First, we will look at how Catholic health ethics deal with decision-making and the individual, and then we will look at how Catholic and Jain ethics interact in end-of-life practices.

Regarding 'The Primary Role of the Person Receiving Care', the Catholic Health Ethics Guide states (Dignity of the Human Person 30):

> **Article 25.** The competent person receiving care is the primary decision-maker with respect to proposed treatment and care options.

[4] pāyopagamaṇamaraṇaṁ bhattapaïṇṇā ya iṇgiṇī ceva |
tivihaṁ paṁḍitamaraṇaṁ sāhussa jahuttacārissa || (*Bhagavatī Ārādhanā* 28)

> **Article 27.** The competent person has the right to refuse, or withdraw consent to, any care or treatment, including life-sustaining treatment.

Further, regarding 'Criteria for Decision-making' the Catholic Health Ethics Guide states (Care of the Dying Person 57):

> **Article 92.** Decisions about end-of-life care should take into account the person's past and present expressed wishes, as well as the person's culture, religion, personal goals, relationships, values, and beliefs.

Lastly, in the same section, regarding 'Refusing or Stopping Treatment', the guide states (Care of the Dying Person 58):

> **Article 96**. Morally, a person can refuse life-sustaining treatment when it is determined that the procedure would impose strain or suffering out of proportion with the benefits to be gained from the procedure.

> **Article 97**. Even when life-sustaining treatment has been undertaken, this treatment may be interrupted when the burdens outweigh the benefits. The competent person receiving are makes this decision. When such a decision is being made for a non-competent person, his or her known needs, values, and wishes are to be followed.

Here it is demonstrated that, according to the principles of Catholic health ethics, decisions are guided both by the autonomy and uniqueness of each individual. Although arising from the ideology of a Christian religious group, there is nothing here that is faith-based or particularly Catholic and not transferable to a secular context.

Next, to properly set the stage for attempting an interaction between Jain and secular death practices, we will determine how the choice to engage in Jain voluntary death practice and the choice to withdraw treatment in secular end-of-life practice are arrived at. The choice to stop the oral intake and motion in the Jain voluntary death practice is a personal choice due to the inability to perform religious duties. It is a crucial point that the taking of death vows is not suggested or encouraged by others but chosen by oneself. This non-coercive decision is followed by a request to a qualified teacher to engage in the practice, and a subsequent permission or denial. It is a process initiated by the individual, but chosen interdependently with a preceptor.

What leads a person to want to engage in the Jain voluntary death practice? Most sources repeat the same main justifiable reasons for starting a fast unto death as we find in Samantabhadra's authoritative work entitled *Ratnakaraṇḍa-śrāvakācāra*, "When overtaken by a calamity, famine, old age, or incurable disease, to get rid of the body for '*dharma*' is called '*Sallekhanā*.' One should by degrees quit the body.[5] We could include any number of situations under

[5] upasarge durbhikkṣe jarasirujāyāṁ ca niḥpratikāre |
dharmāya tanu vimocanamāhuḥ sallekhanāmāryāḥ || (*Ratnakaraṇḍa Śrāvakācāra* 122)

'calamity,' such as environmental disasters, mortal injury, and so on. The crux of the matter is that these instances have in common the potential to leave a person unable to perform their religious duties, also often mentioned in Jai texts as the cause for choosing the Jain voluntary death. The *Ācārāṅga-sūtra* says:

> If this thought occurs to a monk: 'I am sick and not able, at this time, to regularly mortify the flesh,' that monk should regularly reduce his food; regularly reducing his food, and diminishing his sins, he should take proper care of his body, being immovable like a beam; exerting himself he dissolves his body. (The Ākārāṅga Sūtra 1.7.6.3)

Entrance into Jain voluntary death practices is considered, therefore, when religious duties are no longer able to be performed and when death approaches. This is to prevent the influx of negative karma from breaking commitments, which occurs naturally even if unintentional: "If...a person allows his vows to fall into disuse due to the onset of infirmity or senility, he will pass his final hours in *asaṁyama*, non-restraint; such an unfortunate circumstance, it is believed, will adversely affect his next birth" (Jaini 227-228). The importance of preparing for death is shown in the *Samaṇa Suttam*, which recommends that "when death is inevitable in any case, it is better to die possessed of a calm disposition"[6]. It calls for a discussion on secular healthcare and withdrawing life-sustaining treatment.

Immanency of death and quality of life

In medicine, educated guessing of how much time a person has to live is a frequent occurrence. It is part science and part prognostication and thus, only as good as the accuracy of the diagnostic means and experience of the physician. Such predicting can be misused, of course, if a physician makes a statement based on insufficient diagnostic evidence or with a confidence exceeding their ability. It can be devastating to a patient and their family if someone is told that they have less or more time than they actually do. A patient is at risk of giving up hope, or having too much hope for longevity and delaying preparations for the end of life. On the other hand, it can also be a useful tool if done well and used sensitively and appropriately, with the humility that comes with the use of an imperfect tool. Even with a reasonable margin of error, it is very helpful to decision-making to have some indication of the length of life remaining. For instance, some palliative care units disallow certain life-sustaining treatments, such as intravenous hydration and blood transfusion, because the focus in such a place is comfort and not curing. As such, they have parameters on whom to admit, given both their focus and the scarcity of beds. One of the prerequisites for admission has to do with the remaining length of life, which can be three weeks to a month in some places but varies with demand. So, having some idea of how long a person will live can contribute to their entrance into palliative care and all that comes with that shift, including the stoppage of certain treatments such as artificial hydration and nutrition.

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6 "tamha avassamaraṇe, varaṁ khu dhīrattaṇe mariuṁ" (*Samaṇ Suttaṁ* 569)

The usefulness of medical treatment is often based on assessing if it will at all improve a person's quality of life. If it does not, or if it is burdensome, it is considered futile. Quality of life is not determined by a person having all of their physical faculties intact or being able to take care of themselves. To be sure, many disabled people lead very rich and meaningful lives. Quality of life, which is of crucial importance in healthcare in deciding on treatments or withdrawal, is measured by conscious awareness and, based on that, the level of one's meaningful participation. It is determined primarily by mental status and not by physical ability.

Does the Jain voluntary death decision-making model fit secular end-of-life?

According to a secular health ethics model, determining quality of life by measuring a person's ability to perform duties would be unacceptable. Let us for a moment put aside Jain religious duties, such as the required performance of austerities (which require physical ability), and merely look at secular duties such as the duty a father has to support his family. It is a commitment taken for life, which continues even after a divorce. If this father falls ill, reasonable people would not begrudge his inability to work. The tides might turn and the children might then have to care for their father. Also, social systems can build accommodations that protect both the children and the father, such as disability, unemployment, and health insurance. This does not mean that the sick or disabled person themselves have an easy task finding fulfillment after losing certain functionalities and means of participation. Many of the disabled clients I have cared for over the years struggle with depression and suicidal feelings, especially when their injury is new. The saving grace in the Jain voluntary death practice is the inclusion of means to ensure that the choice to die voluntarily is not based on despondency.[7] The Jain system even eschews less negative motivations, such as wanting gain in the future, since such feelings are tipping the scale away from equanimity and renunciation.[8]

The disconnect between the Jain and secular approaches here, it seems, from the view that after a certain threshold, the negative consequences from the inability to fulfill commitments made do not outweigh the positive consequences of any good activities. It is a common understanding that a short life of high quality is better than a long life of low quality. Quality here could be measured by non-harm and the fulfillment of religious duties, both religious ideals. From the secular perspective of health care ethics, quality of life can never be defined this way. I would even go as far as to say that it would be dangerous to determine life being worthwhile in health care based on non-harm and the fulfillment of religious duties that rely on physical ability rather than mental capacity and meaningful participation in society. In this way, in principle, health ethics aim towards equal treatment in considering people equally worthwhile and

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7 śokaṁ bhayamavasādaṁ kledaṁ kāluṣyamaratimapi hitvā |
sattvotsāhamudīrya ca manaḥ prasādyaṁ śrutairamṛtaiḥ || (*Ratnakaraṇḍa Śrāvakācāra* 126)

8 "jīvitamaraṇāśṁsāmitrānurāgasukhānubandhanidānakaraṇāni" meaning: to wish for life, to wish for death, affection for friends, refreshing the memory of past pleasures, to wish for some sort of enjoyment as a result of penance and renunciation – these five are the failures of conduct connected with *sallekhanā* unto-death. (*Tattvārtha Sūtra* 7.32)

deserving of all means of help for cure or comfort even if clients are harmful or lack physical ability.

There are occasions in the Jain tradition, however, where exceptions are made for a monastic unable to fulfill certain religious obligations due to ill health. "[I]f an ascetic can no longer walk, he (or she) is temporar[ily] or [in]definitely exempted from the practice of wandering" (Amiel 225). In Jaipur, I saw a sort of bike used for monastics when they are unable to walk. A same-gendered monastic pushes the three-wheeled bike from the back, using handle-bars with brakes, and the monastic being pushed sits inside. This allows the monastic to fulfill the commitment to wander and not stay in one place beyond a certain length of time. This sort of creative flexibility shows an active concern for debilitated monastics, which can only be beneficial for those who require help, who help, and for the order itself in keeping the spirit of the vows in changing times.

It seems, therefore, that the Jain push towards choosing to engage in death practices when one can no longer fulfill religious commitments, such as self-study for the layperson or wandering for the ascetic, does not lend itself well to a secular end-of-life context. However, the Jain emphasis on choosing to engage in death practices to most effectively prepare for death when it is imminent can easily be accommodated in a secular end-of-life setting.

Can Jain voluntary death be practiced in secular health care?

We have already determined the importance placed on the autonomy and uniqueness of the individual in health ethics. Both would allow for the individual to choose to withdraw oral intake and ambulation. Next, let us go even further and look at an explicit reference to withdrawal of treatment that leads to death in the Catholic Health Ethics Guide. Under the 'Suicide and Euthanasia', we find this (Care of the Dying Person 59):

> **Article 105**. Refusal to begin or to continue to use a medical procedure where the burdens harm or risks of harm are out of proportion to any anticipated benefit is not the equivalent of suicide or euthanasia.

Altogether, autonomy, the unique background and perspective of the individual, and the Health Ethics Guide not equating withdrawal of treatment with suicide, make a secular end-of-life setting very amenable for the Jain voluntary death. There remains some tension, however.

In end-of-life care, people are offered food and drink by mouth but are not pressured to eat or drink. They are also not required to move. A palliative client can walk, sit in a chair or go for a stroll in a wheelchair if they wish, but they may also stay in bed. Here, based on the acceptance and understanding of the imminent approach of death in a palliative care environment, choosing to engage in Jain voluntary death practices such as taking any of the three types of fast-vows, such as to not take anything by mouth (*bhakta-pratyākhyāna* or *bhakta pratijñā*) and also to not move beyond a certain area (*iṅgini-maraṇa*), or to not move at all (*pādopagamana*), would fit easily. The third aspect of the vows regarding receiving help

from others might require negotiation. With *bhakta-pratyākhyāna* one can receive the full assistance of others, thus requiring no alteration of the delivery of personal care on the part of palliative caregivers. With *pādopagamana*, however, one can receive no help from others.[9]

Standard nursing care for a patient who cannot move themselves requires them to have their position changed in bed at least every two hours. Also, incontinent urine and feces must be cleaned immediately upon detection. I have often been a witness to cases where, after crossing a certain threshold in the dying process (which is often a dramatic change in respiration called 'Cheyne-stoking' which resembles a fish gasping when out of water), the family and staff decide to not turn the person anymore. In fact, turning the patient may be enough of a disturbance to the body systems to hasten death. Colloquially we refer to this as 'the last turn.' Because death is so near at this point, the development of bed-sores from an unchanging position is no longer relevant. It could happen that the decision is made to stop turning someone and they linger, perhaps for days on end. This might be tricky because of the caregiver's habit and injunction to turn patients. Here, the Jain tradition can offer a very good approach. It is recommended not to take final vows until it is sure there will be no improvement in one's illness or deterioration, because in the Jain tradition vows once taken cannot be taken back. This is not the case during the stage of preparation for *sallekhanā*, before taking formal voluntary death vows. One finds this in the *Ācārāṅga-sūtra*: "Subduing the passions and living on little food, he should endure (hardships). If a mendicant falls sick, let him again take food" (The Ākārāṅga Sūtra 1.7.8.3). But with vows, there is no turning back.

> Occasionally, it may happen that a supposedly "fatal" illness undergoes remission or complete cure during the course of progressive fasting. In such cases the vows which have been taken cannot be rescinded; the aspirant must continue to take no more food per day than his current allotment for as long as he lives. This possibility explains the usual practice of refraining from a vow of total fasting until such time as death is clearly at hand. (Jaini 231)

So, great care must be taken with the timeliness of vow-taking. The vow to not receive help can come at a time when definitely there will be no more mobility or improvement. Another problem arises here because at this point, generally, people become unconscious and an unconscious person cannot take a vow. This issue becomes very subtle and requires more investigation. It requires delving into advance directives and proxy decision-making and how they might relate to vows, which brevity prevents. Would a Jain death vow be valid if in advance, with a clear mind, competency, and consultation with a preceptor, a practitioner wanted a vow to be installed at a certain point even if they are not conscious or competent? It is a fascinating question. There is also the problem of bowel and bladder elimination. This is less of a problem close to death because, with the stoppage of oral intake, there is a reduction in elimination. Another way around this problem is to insert a urinary catheter and rectal tube which collect elimination. This way, elimination can continue without requiring bodily movement and the vow to not receive help anymore can be maintained. But this also can be

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[9] pāyopagamaṇamaraṇaṁ bhattapaïṇṇā ya iṇgiṇī ceva |
tivihaṁ paṁḍitamaraṇaṁ sāhussa jahuttacārissa || (*Bhagavatī Ārādhanā* 28)

considered as taking help to a certain extent. As with the initial choice to engage in death practices, when death is imminent the fulfillment of the various Jain voluntary death vows can also be accommodated in a secular end-of-life setting.

Qualifications of those caring for the dying in Jain voluntary death

The unique relations of a householder are quite complex. Attachment to loved ones and wealth can interfere with death in equanimity. To be qualified, the person observing the vow of *sallekhanā* should give up fondness, aversion, infatuation and worldly possessions.[10] This, of course, is very difficult. Even when someone considers themselves prepared for voluntary death practice and confirms it with the assessment of a highly qualified preceptor, one cannot predict what will happen as death approaches. The process of dying, when the elemental particles are coming to destruction or blowing up, "may give rise to emotional excitement and morbid thoughts, which are harmful to the undisturbed spiritual end (Kalghatgi 190). In service of equanimity, there are practical ways to improve the chances of the practitioner being "free from the memories of the friendly attachment (Kalghatgi 190)." The practitioner is not surrounded by family, but rather, monastic assistants.[11] The saints who ordain or cause other saints to undertake this vow in a prescribed way are called expiation/holy-death preceptors (*niryāpakas*)[12].

The head saints have advocated the presence of 48 saints when a saint undertakes the vow of holy death. They let him undertake the vow of holy death in a proper place and, then, perform various duties as described below (Bhagavatī Ārādhanā 647-669):

1) Four saints serve the mortified saint to raise him, to get him seated and so on so that there may be no difficulty in observance of restraint.
2) Four saints cause him to listen to religious scriptures.
3) Four saints cause him to take food .
4) Four saints arrange potable drinks for him.
5) Four saints try to protect him.
6) Four saints remove the filthy excretions of the body of the saint.
7) Four saints remain at the door of the place where the saint is undertaking his holy death vow.
8) Four saints arrange and address the visitors to the saint.
9) Four saints take care of the saint in the night while awake.
10) Four saints judge the situation of the country and the public.
11) Four saints tell religious stories to the outside visitors.
12) Four saints refute the alien doctrines through debates.

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10 sneham̐ vairam̐ saṅgam̐ parigraham̐ cāpahāya śuddhamanāḥ |
svajanam̐ parijanamapi ca kṣāntvā kṣamametpriyairvacanaiḥ || (*Ratnakaraṇḍa Śrāvakācāra* 124)

11 upavāsādibhiraṅge kaṣāyam̐ ca śrutāmṛtaiḥ |
saṁlikhya gaṇamadhye syāt samādhimaraṇodyamī || (*Dharmāmṛta Sāgāra* 8.15)

12 paṁcaccha sattasadāṇi joyaṇāṇam̐ tadoya ahiyāṇi |
ṇijjāvayamaṇuṇṇādam̐ gavesadi samādhikāmo du || (*Bhagavatī Ārādhanā* 403)

Thus, these forty-eight holy death preceptor-saints try to get the saint to cross the ocean of the weary world through their care in maintaining the meditation and equanimity of the mortified saint. If one does not get the required number of holy death preceptor saints, one can arrange the above activities with the number of saints available at the time. However, at least two saints must be there.[13]

We know that such death assistants must be monastics, and thus necessarily follow the "twenty-eight basic and primary properties (*mūla-guṇa*) of a Jain ascetic [which is] comprised of the five great vows (*mahāvrata*), the five 'cares' (*samiti*) [which aim to not harm beings], the six essential duties (*āvaśyaka*) [which consist of inner and outer practices], the five-fold abjuration (of indulgence in the pursuits of the five senses)" (Jain 109), and seven more bodily austerities. The five *mahāvratas* (five great vows) [are]: *ahiṃsā* (non-violence), *satya* (truthfulness), (taking nothing belonging to others, for own use, without permission of the owner), *brahmacharya* (chastity), and *aparigraha* (possessionlessness). This would ensure great discipline. A monastic, also, "must be obedient to his *upādhyāya* (preceptor) and his *ācārya* (the head of his order)" (Jaini 246), and thus has a two-fold accountability. Generally, then, Jain voluntary death assistants are both highly disciplined and highly accountable.

Significantly, those who assist a practitioner who is engaging in Jain voluntary death practice are expected to be highly qualified. Not only is this time the most crucial for the practitioner, one they have been preparing for their entire life and which will determine the quality of their rebirth, but there are also very subtle negotiations that need to occur between the practitioner and the community. The Jain voluntary death practice is done by monastics and householders, and in both cases, it must be supervised by a qualified teacher. In both cases, also, apologies are made. For the monk, the *Bṛhat-kathākośa* mentions "*kṣamāpanā*: an apology to the congregation" (Upadhye 51), and for the householder, many sources suggest that "[h]having called relatives and friends, one should seek their forgiveness for any transgressions in conduct" (Kalghatgi 190). This can be seen as the occasion for saying farewell. In both monastic and lay communities, there will be potential grief at the departure of a close one, but considering "*Sallekhanā* as the highest end... [there is] no cause for tears" (Kalghatgi 189). "Grieving around the practitioner can cause mental agitation, and thus hinder the dying process, and so separation from all but the death assistants after the farewell is recommended. Likewise, in what is a great parallel between Jain voluntary death and initiation (*dīkṣā*, or entrance into the monastic order), the practitioner gives all his belongings away and they are "practically a monk" (Kalghatgi 188). As such, separation from both loved ones and wealth is undertaken in preparation for death in Jain practice.

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[13] ṇijjāvayā ya doṇṇi vi hoṁti jahaṇṇeṇa kālasaṁsayaṇā | ekko ṇijjāvayao ṇa hoi kaïyā vi jiṇasutte ||
ego jaï ṇijjavao appā catto paro pavayaṇaṁ ca | vasaṇamasamādhimaraṇaṁ uḍḍāho duggadī cāvi ||
(*Bhagavatī Ārādhanā* 672-673)

Qualifications of those caring for the dying in secular end-of-life care

In a healthcare institution, the qualifications and accountability of the various members of the multidisciplinary end-of-life care team are well-known. We can draw many parallels between such a team and the Jain death assistants. But what are the qualifications of the others who remain at the bedside in end-of-life care, those whom we do not see in the Jain voluntary death model? Is the Jain voluntary death practice of separation from loved ones and wealth applicable to secular end-of-life care? What can people do to appropriately resolve issues around their wealth and estate in end-of-life care? To answer these questions, we can look to both the Health Care Consent Act, and to actual practice in the hospital. In determining the qualifications of those who are permitted to be at the bedside of the dying person, the Health Care Consent Act, 1966 (11-12) favors spouses, partners, and relatives about decision-making. 'Spouses' are defined by marriage, or cohabitation, or having a child together whereas 'partners' are defined as a "close personal relationship that is of primary importance in both persons' lives" which, happily, is accommodating to same-sex couples. These relationships are given prominence. Next, 'relatives' are defined by "blood, marriage or adoption." In hospitals, such people are favored as well. There is no mention of personal qualifications. Where in the Jain voluntary death practice those at the bedside are at least monastics holding to a code of discipline and accountability, in a secular hospital setting the qualifications of those at the bedside at death-time are dependent solely on interpersonal relations. These are useful indicators but because there are no behavioral or motivational expectations, they leave much room for difficulties around visitation of, and wealth distribution by (or inheritance from) the dying person. The Jain emphasis on relinquishing wealth in advance and separation from loved ones during voluntary death, after proper farewell exercises such as confession and forgiveness are performed, helps the dying person achieve maximal calmness and equanimity. In secular health care, such as in Canada, the majority of families wait for estate distribution until after death.

Additionally, the family typically wants to be around the dying person until their last breath. Both can cause disturbances to the dying person, as visitation and concerns over wealth distribution can be from the best or worst of intentions. Visitation and inheritance can be linked, as in the case of a child who has not been in contact with a parent and breaks the estrangement to show support at the end of life in order specifically to win favor and influence wealth distribution. This happens more frequently than most would like to admit. I would even be bold enough to say that fighting over inheritances is one of the leading causes of the destruction of family harmony. It is difficult in practice to distribute wealth in advance and to screen visitors in hospitals, especially around death because often everyone shows up. There are, however, precedents for both. It is possible to make wealth distribution known in advance, and for it to be dependent on conditions determined by the dying person. This would bring the person themselves much relief knowing that this has been adequately dealt with and will not cause fighting between family members nor inspire wrong actions about the dying person to try and shift the weight of their distributive share. With visitation, in some environments, such as intensive, emergency, and palliative care, ensuring that certain people whom the patient does not want in their presence are prevented entry and access is common. If a person does not want

family around the bed grieving after a certain point in the death process, to die undisturbed, they can make this request known and it will be followed.

I would suggest that the separation from wealth and family in Jain voluntary death is one that can be very helpful in the pursuit of a peaceful death in secular health care and is entirely possible to achieve given the respect for the patient's autonomous wishes. Further, I would suggest that despite the compulsion and habit for people to consider presence with and grieving around the dying person as a necessary and beneficial part of the process of death, it may not be in the best interest of the dying person. Grieving is not only important, it is necessary. Death and loss are a trauma and the experience of grief is a part of healing this trauma. Despite this, grief does not have to be displayed around the dying person. The Jain voluntary death model strongly recommends against it, and I feel that individuals should have the option not to have grief displayed at the bedside who may want to control their death environment in such a way, even though there may be great resistance to this novel approach. Grief can be experienced in an anticipatory way, also during the death either in the same location as the death or not, and after the death has occurred. Who is around the dying person and when they are present is entirely up to the individual. They may want family and grieve in their presence until the moment they are dead. However, they may not. In such a case, if a person truly has the best interest of the dying loved one at heart, it must be considered that their desire to grieve around the dying person against their wishes might be a self-centered act that actually will disturb the death process by triggering feelings of attachment or aversion in the mind of the dying person and make it more difficult for them to leave smoothly.

Conclusion

The Jain voluntary death practice believes in renunciation at a very early stage so that the family has no expectations from the dying and serves the person out of compassion. The paper highlights differences in the intentions behind death practices in the Jain context compared to secular healthcare. Serving the dying not for any personal gain but for the sake of serving is crucial. The one passing away also keeps their desires at bay and stays close to their spiritual self for their own well-being in the Jain voluntary death practice.

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