Medical Ethics and Buddhism— A Focus on Euthanasia and Death with Dignity

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I. Introduction: Medicine and Bioethics

IN the dialog between contemporary science and Buddhism, the area of bioethics has become critically important as advances in modern medical technology create increasingly complex situations. This is an area where views on human life, ways of thinking about life and death, and the dignity of human life have to be directly addressed.

Medical science and medical treatment have a long history, and in the East, this is also true in Buddhist medicine. There are numerous references in Buddhist texts related to medical practices. However, the advances in modern medicine have come so far, that we face many issues today that could not be imagined in the ages when those Buddhist texts were written. One reason for this is because the advances in the areas of genetics and molecular embryology within life science and the field of neuroscience have been implemented into practice at a rapid pace.

How should contemporary Buddhism respond to the current issues in bioethics which have been created by developments in medicine lead by advances in life science and neuroscience? This is not only a question posed to Buddhists, but to all other religions as well.

In addition, this question interconnects an incredibly wide variety of specializations. For example, to name areas related to the bioethics of birth, there is the issue of artificial termination of pregnancy, in-vitro fertilization, surrogate motherhood, genetic treatments, as well as embryo stem cells, iPS cells, and cloning. On the other hand, areas related to the bioethics of death are euthanasia, death with dignity, persistent

vegetative state, suicide, brain death, organ transplants, terminal health care and palliative care to name a few.

Within all of these issues, only abortion, euthanasia and suicide are at least somewhat mentioned in Buddhist texts, but even so, the contexts for these issues have dramatically changed since the days they were originally written. For example, the issue of euthanasia, which is one of the central themes in this paper, has already shifted in focus to dying with dignity.

This paper will discuss the dignity of human life in the realms of birth and death (as well as in the context of birth, old age, sickness and death) and how varied the areas of modern day medical ethics are. I will propose that all of these areas require deeper consideration, by elucidating why life is inherently respect-worthy. The issues of euthanasia, death with dignity and a persistent vegetative state (PVS) will receive particular focus.

II. Dignity for Human Beings—From Euthanasia to Death with Dignity

Euthanasia and death with dignity are similar in that they both present an approach to medical practice in the terminal stages of patient care and push the limits of medical technology. However, there is also an important difference. Whereas in euthanasia, the patient is conscious and the focus lies in lessening or alleviating physical pain, death with dignity focuses on whether or not to extend the life of patients who seem to have lost their dignity as a human being, including those who are in a vegetative state.

Here lies the divide between euthanasia and death with dignity. First, I would like to discuss issues surrounding euthanasia. Depending on whether the patient's free will is taken into consideration, euthanasia can be divided into two categories: voluntary euthanasia and involuntary (forced) euthanasia. When the will of the patient is ignored, forced euthanasia results in a situation such as Nazi Germany. Therefore, in the present day, when discussing euthanasia and death with dignity, it is under the presumption that consent has been given by the patient.

The next division is the difference between active euthanasia and passive euthanasia. Active euthanasia is "the shortening of a patient's life as a result of the administration of a lethal substance by a physician in order to alleviate pain caused by a terminal illness." This narrow definition of euthanasia is usually what is meant in general use. In contrast, passive euthanasia is "the termination of life-extending measures of

patients with an incurable disease or in an unconscious state," which is also referred to as death with dignity in contemporary terms.

In Japan, the four stipulations under which active euthanasia by a physician is accepted are based on a 1945 decision by a Yokohama court.

1. The patient is suffering from intolerable physical pain.
2. Unavoidable death of the patient is imminent.
3. All other measures to alleviate or lessen physical pain have been exhausted.
4. The wish to shorten life is explicit and consented to by the patient.

However, from the 1970s, discussions about active euthanasia have greatly shifted in focus to facing death while preserving one's dignity as a human being, in other words, death with dignity.

This has resulted from advances made by pain clinics. Shuhei Morita comments on the current state of pain clinics, "We have not completely uncovered all the mechanisms concerning the origins of pain, or the paths in the nervous system along which the signals for pain travel. However, methods for reliving or eliminating pain have advanced tremendously. Traditional approaches using nerve blockers or other drug therapies were the norm, but in recent years, improvements in traditional methods have been made, as well as the increased use of electric stimulation therapy and Eastern medicine approaches. The WHO's *Cancer Pain Relief* published in 1996 lists examples of various approaches… Using these approaches, about 95% of the pain experienced can be reduced."[1] In other words, the first stipulation referring to "intolerable pain" experienced by the patient has been made irrelevant, and it is hoped that advances in this area will continue to be made.

Secondly, advancements in life-extending measures make it possible to prolong life, but at the same time, create new questions such as how to view death in terms of those in a vegetative state or in cases of brain death. The invention of artificial ventilators has given rise to cases of brain death, and intravenous hyperalimentation (IVH), a method for delivering high calorie nutrition to patients who cannot utilize their digestive tract, has given rise to the vegetative state and prolonged the lives of those in the final stage of cancer or an incurable disease.

When patients were seen lying in an intensive care unit, separated from their families, being kept alive by a ventilator, people began to have doubts as to whether this way of greeting death can be said to have dignity as a human being. Especially those in a vegetative state, with minimal consciousness, and little prognosis for recovery, being connect-

ed to a ventilator and being fed through an IV tube, it was difficult to make a case that this was a dignified way to live, instead, lending argument against the case for prioritizing the prolonging of life, and thus eventually led to the idea of death with dignity.

Death with dignity directed the discussion toward the quality of life (QOL) of the patient and also heightened awareness of the patients' right to self-determination. In addition, the relationship between physician and patient also underwent a change from a paternalistic model to an equality model, where the physician aids patients as they fight illness together. From this arose "informed consent," or the right of the patient to choose their treatment based on information of all the choices available, and advocacy for this approach gained momentum. The American Hospital Association adopted a Patient's Bill of Rights in 1973 and the World Medical Assembly adopted the Declaration of Lisbon on the Rights of the Patient in 1981, clarifying the right of death with dignity with informed consent playing a central role.

In summary, on one hand, as the struggle to overcome physical pain continued as outlined above, life-extending measures and IVH created situations of brain death or vegetative states. The issue of the patient's right to self-determination has become an important issue in preserving dignity as a human being. This modern day phenomenon has prompted the death with dignity approach, often executed in the form of a living will.

III. The Condition of People in a Vegetative State

When considering the issue of death with dignity, the situation of people in a vegetative state is brought up as a point of discussion. It should be clarified that in this discussion about death with dignity that we are referring to those in a persistent vegetative state (PVS). This section examines the current conditions surrounding such patients.

The definition of those in PVS is as follows, "after experiencing severe brain damage, the state of being alive, but showing very little response to external stimuli." In 1972, the Japan Neurosurgical Society issued the following six guidelines for determining cases of PVS. If a patient fits these guidelines for over three months, that person is said to be in PVS:

1. Unable to move about on one's own
2. Unable to ingest food on one's own
3. Experiencing a state of incontinence
4. Although may be able to say something, communication is

unintelligible

5. Although may be able to open one's eyes or slightly respond by squeezing someone's hand when prompted, no further intelligible exchange can take place.
6. Although the eyes are able to follow objects presented to them, the patient does not indicate any recognition of that object.

In most cases, the patient is unable to continue in this state, and their condition usually worsens over time. Consciousness becomes unclear, breathing becomes irregular, eventually requiring a ventilator to breathe and tubes are inserted to deliver nourishment.

Shinichi Kogure, a brain researcher, comments on the vegetative state from a cerebral biology standpoint saying, "There is no doubt that patients (in PVS) are alive. Primitive functions such as self-defense mechanisms, maintaining posture, reflexes, breathing, circulatory functions and body temperature are regulated. Cycles of sleep and wakefulness can also be detected. Therefore, from a broad view, the brain stem and spinal cord are functioning at least minimally. In contrast, expressions of instinct such as hunger and sex, emotional responses such as anger, fear, pleasure or displeasure, and moreover the ability to perceive or react on one's own to external stimuli and other higher order functions are lost, indicating serious failure of the cerebral neocortex or cerebral limbic system…On the other hand, it is not always the case that a vegetative state results only from extensive damage to the neocortex or limbic cortex. Dysfunction of the white matter (the nerve fiber which connects the cortex to the brain stem) can also cause similar symptoms. Therefore, it is extremely difficult to pinpoint the damage to the part of the brain which is causing the vegetative state, and likewise, it is difficult to say whether damage to particular sections of the brain will definitely induce a vegetative state or not."[2]

Many specifics about the state of patients in a vegetative state are still unknown. According to one study carried out by the Japanese Ministry of Health and Welfare[3], it was reported that about 50 percent of cases result from failure of blood vessels within the brain such as hemorrhages, subarachnoid hemorrhages or strokes. The other half result from damage or trauma to the brain, brain tumors, or drug addiction. The population affected most by natural causes are men in their 60s and 70s, whereas many of those in a vegetative state due to brain damage are in their 30s and 40s.

The duration of vegetative states for those suffering cerebral trauma, considering the number of cases of survival from three months to one year as 100 percent, the number of survivors after two years is 55 per-

cent, and after three years only 30 percent. This decrease is due mostly to death, but there are rare cases where patients survive for more than 10 years or even revive from the vegetative state, although not to a fully restored condition. Most cases of revival are reported to be younger patients who suffered brain trauma.

The variety of symptoms experienced are also wide-ranging, making it difficult to narrowly define it, or to say with any certainty how patients will progress over time. The range of symptoms includes the possibility of those with extensive damage to the cerebral cortex or cerebral limbic cortex to recover, unlike those who are brain dead and have no hope of becoming functional ever again. In addition, recent brain research has revealed that beneath the superficial states of consciousness or ability to recognize stimuli, what has been called an "inner consciousness" may be functioning at a deeper level.

Dr. Tatsuya Mima lists functional magnetic resonance imaging (fMRI) as "one of the non-invasive technologies that allow for the imaging of brain functions. This technology has opened a new era of discussions on medicine and ethics as it relates to people in a vegetative state, as this is very often connected to the issue of death with dignity."[4]

In a 2006 Cambridge University study conducted by Dr. Adrian Owen, the following was discovered[5].

A 25-year-old female patient who had entered a vegetative state as a result of a traffic accident in July of 2005, underwent an fMRI, during which she was asked to envision playing tennis and envision walking around her room at home. Her brain activity revealed similar patterns as those doing the corresponding activities (tennis and walking around one's room have very different patterns.) In regards to this result, Mima says, "despite the fact that this young woman was in a vegetative state, unconscious and unable to physically move, she was able to follow the prompt, and imagined doing these two different tasks in her mind." This case seems to indicate that although patients may be in a vegetative state, partial consciousness (inner consciousness) still exists, suggesting the possibility of providing some kind of "inner experience" for patients.

The second case presented by Mima introduces the discovery of the Minimally Conscious State (MCS)[6]. This condition is one in which a patient despite having persistent disturbance of consciousness, can manage to show signs of an active mind or the possibility of communication. Regarding the diagnostic criteria for MCS, a patient is able to do one or more of the following:

1. follows simple instructions

2. indicates yes or no through physical action or using language
3. makes comprehensible output
4. shows purposeful action (laughing or crying when appropriate, responding to questions with a physical or verbal response, attempts to grasp something, touching or gripping a particular item, or to stare or follow something with one's own eyes, etc.)

In Japan, the ability to follow simple instructions and to follow something with one's own eyes is included in the diagnosis of PVS.

Mima comments on a case presented by Owen where one year after an accident, a patient stared at their reflection two times after being presented with a mirror. He writes, "This case recounts the slow but steady progress of a patient developing their abilities from a vegetative state to MCS. The core reason for developing high-tech medical equipment for brain research is to not marginalize those in a vegetative state simply because they are unconscious, but to provide a means for detecting even the smallest evidence of minimal consciousness, so that better care and support can be provided to patients in clinical care."[7]

The clinical application of fMRI seeks out minimal consciousness within patients in a vegetative state to help open paths of communication. Supported by this hope, efforts will continue in the direction of collecting more and more examples from these kinds of cases.

IV. Buddhist Viewpoint and Approach

(1) Regarding Euthanasia

First, to understand the base of Buddhist thinking about euthanasia, I would like to take up some relevant examples from early Buddhist texts. Of course, the state of development of medical procedures in these examples take place under conditions where today's advanced Western medicine is completely absent, therefore take place in a completely different setting. Put simply, there were no artificial ventilators to extend the lives of patients, or pain clinics to help manage pain. Only traditional Indian medicine (Ayurvedic medicine) was available at the time. However, learning from Shakyamuni's teachings concerning the sufferings of illness and death, we can gain insight into the Buddhist approach to modern medical situations.

Please also note that the following examples take place within the *samgha*, the body of Buddhist followers, and are not specific instances of a doctor dealing with a patient per se, but an approach toward euthanasia can be gleaned from the actions of the monks and laypersons that

appear in the narrative.

A monk became very sick, so a second monk asked him, "How is your illness? Will you be able to endure the suffering?" The sick monk replied, "No, I am not coping well, so could you please provide me with a sword or rope or poison?" The second monk honors the sick monk's request, and then, the sick monk takes his own life. Seeing this, the second monk is overcome with remorse, and together with Ananda, seeks an audience with the Buddha. The Buddha, upon hearing the news, reprimands the second monk saying, "How foolish of you! How could you provide another with the means to take their own life?" As punishment, that monk receives the strictest punishment, which is expulsion from the group—for violating a *pārājika*[8].

In a different section of the text, another monk refuses the request of a sick monk to provide him with a sword or poison to take his own life, but instead, asks a hunter to take the life of the sick monk. Here again, the Buddha says, "It should not be that one asks another to aid in the taking of life," regarding this also as a grounds for expulsion from the Buddhist Order[9].

From these examples, it can be seen that even if a person desires to terminate their own life, to provide them with the means of doing so, or asking someone to help terminate another's life, is among the gravest of offenses.

The times have greatly changed from Shakyamuni's time to that of contemporary medicine, however, in the spirit of Buddhism, to desire death as a means of escaping physical pain or suffering, in other words, voluntary active euthanasia, is not acceptable. Even if the aim is to take away someone's suffering to give them peace, ending a life is not an option as treatment.

In Buddhism, suffering is divided into three categories according to their characteristics. The first kind is physical suffering, in other words, physical pain. The second kind is psychological or mental suffering. The third kind is the suffering caused by death itself, or rather the fundamental pain of knowing the impermanence of our existence as a human being.

These three sufferings are all encapsulated within the suffering of those who contemplate an early death. Experiencing intolerable pain diminishes human dignity very quickly. Physical pain is closely linked with psychological pain, and feed off of each other to multiply the effect, heightening our awareness of the reality of the third suffering, i.e. the fear and unease that surrounds death.

Nowadays, more and more, physical pain can be controlled and in

many cases removed, without shortening our lifespan thanks to advancements made by pain clinics. Nevertheless, eliminating the psychological and mental suffering that magnifies physical pain requires utmost care from medical staff, a strong connection with family members and friends, as well as a robust system of welfare and administrative support.

This is where the wisdom and care of Buddhists can play a vital role. A more detailed description will follow later, but members of the SGI Nurses Group (Shirakaba Group) endeavor to take the compassion and wisdom learned through the Bodhisattva Way of Mahayana Buddhism, and put it into practical use.

The third suffering, which is a suffering embedded within all human beings, is most appropriate for religions to address. Buddhists should base their interactions with patients and their families on Buddhist views of life, death and happiness. Overcoming worries and fears about death and helping others achieve a serene state of life is the role of a Buddhist. One keyword in contemporary terminal care is Quality of Life (QOL). Buddhists, alongside health care professionals, have a responsibility to improve the QOL of patients and their families.

(2) Regarding the Persistent Vegetative State

Next I would like to share Buddhist perspectives on patients in PVS, as this is strongly linked with the discussion on death with dignity. Understandably, it is extremely difficult to find portions of Buddhist text that refer to this condition, because a vegetative state and brain death can only occur when life-prolonging machines such as ventilators are introduced. This condition of the final stage of human life simply did not exist before the implementation of new medical technology. Therefore, in order to introduce Buddhist principles that can be applied to approaches to PVS and brain death, I turn to the ideas presented by the Consciousness-Only (or Representation Only) school in the Mahayana Buddhist tradition.

Vasubandhu[10], in *The Thirty-Stanza Treatise on the Consciousness-Only Doctrine*, states that in the deepest regions of life, lies a "cosmos of the mind" which manifests in three forms of consciousness. Namely, from the fundamental base of the *alaya*-consciousness, arises the *mana*-consciousness, and from there the sixth sense (the mental consciousness), and finally the five senses. For the purposes of this presentation regarding vegetative states, I will focus the discussion on "the five senses and the mental consciousness" and the *mana*-consciousness.

Professor Koitsu Yokoyama, a Buddhist scholar, explains the functions of the mental consciousness and *mana*-consciousness in the

following way:

"In addition to the superficial ego consciousness (a.k.a. the mental consciousness) which regards the fusion of the five aggregates as the self, it was discovered that there is a deeper consciousness at the subconscious level. That deeper consciousness is what we referred to earlier as the *mana*-consciousness.

The main function of the *mana*-consciousness is to recognize the existence of an even deeper consciousness, the *alaya*-consciousness, and regard all that arises from the *alaya*-consciousness as 'the self' and to form an attachment with that 'self'…The shallower superficial ego consciousness which can manipulate concepts and observes one's mind or body, thinks that the observable mind and body is the 'self'—it keeps telling itself, 'this is me, this is me' on a day-to-day basis. In contrast, even a person in a vegetative state (whose superficial ego self is incapacitated) due to a traffic accident, still seeks nutrition and continues to try to maintain the self, proving that at a deeper subconscious level, there is some sort of attachment to the self that drives the will to continue living. In the Representation Only school, we refer to this function as the seventh, or *mana*-consciousness."[11]

In summary, the sixth level of consciousness (the superficial ego-consciousness/mental consciousness) is the self-consciousness which can manipulate concepts, and the seventh level of consciousness (*mana*-consciousness) is the fundamental ego consciousness which lies in the deeper layers of our psychology. Yokoyama points out that the *mana*-consciousness is active even in individuals who are in a vegetative state.

From the perspective of brain research, Kogure comments on the Consciousness-Only view saying,

"Thinking about the issue of patients in a vegetative state, especially when evaluating the condition of a patients' ability to maintain consciousness or awareness, we must be extremely careful in making a diagnosis. As explained earlier in the section concerning the definition of a vegetative state, patients are able to breathe on their own and have cycles of wakefulness and sleep indicating a functioning brain stem. Although difficult to detect, patients may be responsive in many other ways. Even in such a state, the fifth and sixth levels of consciousness are partially at work. It is highly possible that the seventh level, which contains the characteristics of internal existence and universality, and the levels of consciousness deeper than that may actually be more active in PVS patients, just as the other senses become more acute in those with visual and hearing impairments."[12]

According to Kogure, the fifth and sixth levels of consciousness are at work, albeit incompletely, and does not deny the possibility that the workings of the seventh (*mana*-consciousness) may be stronger than the more superficial levels of consciousness.

Even though the functions of the fifth and sixth levels of consciousness become subdued, the seventh level (*mana*-consciousness) is still functioning and if it is working stronger than normal, it means that the fundamental ego is optimally functional. In other words, the fundamental ego in PVS patients is striving to continue life.

Borrowing the words of the Consciousness-Only School, it can be said that patients like those introduced in the previous section by Owen, are people who are living in the sixth and seventh consciousnesses.

Examples of PVS patients living in the sixth and seventh levels of consciousness have been reported by nurses.

Yumi Nishimura reports the experiences of Nurse A. "The staff at Nurse A's workplace regard PVS patients not as people with impairments of their consciousness, but rather, as people with impairments in their motor and nervous capabilities which make them unable to express themselves. They care for patients with the understanding that they are aware, and Nurse A, of course, fully supports this approach."[13]

In other words, patients in PVS are not lacking a consciousness, but are experiencing disability in expressing their consciousness. Therefore, communication between nurses and patients during one-on-one care becomes possible. Nishimura introduces interactions between Nurse A and Ms. Sumida, a PVS patient.

In regards to Ms. Sumida's line of sight, Nishida writes, "Nurse A said, 'When I look into her eyes, I feel as though as she is looking back at me.' 'There are times when I feel our gazes meet.' 'I look at her eyes as I talk to her, and her eyes seem to understand what I am saying to her.' There are many instances when Nurse A feels that understanding takes place in their exchanges."[14]

There is another episode where Nurse A recalls a time when Ms. Sumida laughed.

"One day, I caught Ms. Sumida yawning, and in the middle of her yawn, I called out her name with a loud voice. Ms. Sumida's mouth stopped moving, and when I saw that, I said to her, 'I surprised you, didn't I?' to which she responded by slightly raising the corners of her mouth. I regarded this as a smile from Ms. Sumida."[15]

There is another instance when Nurse A received a reply from Ms. Sumida.

"Ms. Sumida was sitting up by herself on the bed, so I said to her,

'Su-san, you're sitting up by yourself!' to which she 'replied' by slightly moving her head and giving me a look. Then I said, 'If you can hear my voice, please blink' and Ms. Sumida blinked her eyes. I took that as a 'yes'."[16]

These examples clearly show that through attentive care, nurses are somewhat able to communicate with patients' sixth and seventh levels of consciousness.

Furthermore, among Jungian psychologists, there are those who claim to have developed a way to "converse" directly with a patient's *mana*-consciousness. Arnold Mindell, who founded process oriented psychology, developed a technique called coma work which aims to converse with those in PVS.[17]

Mindell and his wife worked with Sam, a PVS patient, over the course of several weeks. They were able to establish communication with him through Sam's eye movements. When the Mindells asked Sam whether he wanted to continue living, Sam gave the sign for yes, which consisted of contorting his face and opening his mouth. Sam also learned the technique of inner work from the Mindells, and relayed to them that he was engaged in an inner trip. Sam conveyed to the couple that in his fantasy, he was attempting to climb a mountain to meet with an unknown woman.

As can be observed from the above examples from brain research, Jungian psychology, and the experiences of nurses, PVS patients can be regarded as people trying to live in what Consciousness-Only scholars refer to as the *mana*-consciousness.

The next question is how to care for patients in PVS. This issue began receiving attention during the case of Karen Ann Quinlan in 1976.[18] After the ventilator was removed, she continued to breathe on her own and remained alive in PVS. She passed away in 1985 due to pneumonia.

Nishimura states her concerns regarding the changes in the medical field after this case, "In the United States, there have been many important decisions handed down by the courts concerning terminal care. The conclusions reached there indicate that when patients with incurable conditions have the cognitive wherewithal to decide, they can chose not to receive life-extending treatment including nourishment and water if they so desire."[19]

Nurse Reiko Inamitsu introduces the difference between "regular treatment" and "special treatment" in the context of terminal care. According to her, "providing nourishment through a tube" is included in "regular treatment." Therefore, discontinuing this means death for the patient. "Special treatment" includes treatment such as the adminis-

tration of antibiotics and the use of a ventilator. Inamitsu also states, "In the process of terminal care, it is the norm to cease treatments that do not seem to aid the patient in a meaningful way—especially those of a 'special treatment' nature."[20]

From the standpoint of the Consciousness-Only School, using a ventilator is critical in supporting the existence of the fundamental ego consciousness of patients in PVS and in those cases, should be employed as "regular treatment." It goes without saying that traditionally recognized "regular treatment" should be continued in all cases, as ceasing this discontinues life.

(3) Death with Dignity and Buddhist Nursing Care

Members of the SGI Nurses Group (Shirakaba Group) make efforts in providing terminal care to patients, including those in a persistent vegetative state, using a Buddhist teaching approach. Many examples of nursing care using a Buddhist approach exist, but here I will present just two cases.

The first case is of a seventy-six year-old female cancer patient S who passed away after having overcome the three sufferings: 1) physical suffering, 2) psychological suffering, and 3) the suffering of knowing the impermanence of our existence. She had bile duct cancer, which spread to other parts of her body, and had received surgery for drain insertion. The doctors predicted that she would live for about one more month after that. Patient S had helped raise four step-children from her husband's previous marriage. Every week the children came to visit her. After a successful surgery to remove the drain, she was able to leave the hospital and return home for a time. She completed some calligraphy artwork and even had some of her work displayed in a city-sponsored culture festival.

However, she had to be readmitted to the hospital and received an IV into her central artery, and also had a urinary catheter, which highly restricted her movement. It was during this time that a close friend of patient S helped locate her daughter, who she had not seen since she was three-years-old. They were able to have a moving reunion just three days before she passed away.

Inamitsu writes of their encounter, "there was a long silence at first, but then tears welled up in both their eyes, and with great effort, patient S was able to say to her daughter, 'Thank you for coming. I'm sorry, please forgive me. Please become happy!' Emotions that were bottled up for fifty years were released all at once. After that, she spent each fulfilling day meeting with all the other people that she wanted to say

farewell to. Finally, after asking those around her, 'I don't think there is anything left undone, is there?' she entered a peaceful sleep."[21]

The second example is of a patient in a vegetative state, and is similar in nature to the experience reported by Nishimura. This is an experience related by Nurse B of the SGI Nurses Group about patient U who suffered from multiple brain tumors. After the surgery, patient U's consciousness would come and go, but for the most part, she was unconscious the whole day. Despite this, Nurse B continued to talk to patient U while caring for her, saying, "You have just had surgery, so please try to get better. Let's talk again after you get better."

However, her lack of prolonged consciousness continued for several weeks, and she would go back and forth from being completely unresponsive to being drowsy. She was not able to move her body voluntarily, and was only able to show slight pain reflexes. Then, the night shift nurse noticed some behavior which was reported to the daytime staff. Patient U had her eyes open, and seemed to be looking up at the sky, but then her eyes met with the nurse. Patient U suddenly said, "It's not you," after looking at the nurse's face, and then seemed to point to another person. Shortly after that, Nurse B switched shifts with the night shift nurse. When she was changing patient U's body position, patient U called out, "It's you. You were the one that was nice to me." Nurse B recalls, "I was so surprised, that I asked patient U without thinking, 'Do you recognize me? Were you looking for me?' I really felt the incredible power of life, and I was filled with appreciation for patient U."[22] Patient U's *mana*-consciousness (fundamental ego consciousness) or the mental consciousness registered Nurse B's words, but until patient U's level of consciousness rose to a higher level, she was not able to express her thoughts. This was the last thing patient U said before passing away.

These two examples show that dignity of human beings is not dependent on whether or not someone is on a ventilator, or is receiving drain treatment, or looks as if they are not conscious. It is the function of the three sufferings that cause confusion in the mind which leads people away from a "good death" or "death with dignity."

Inamitsu presents four points of view regarding QOL that are essential in maintaining the dignity of human life:[23]

1. To be free of physical pain, and to have as much freedom of movement as possible.
2. To feel secure and satisfied in the psychological aspect.
3. To be fulfilled and satisfied in the social aspect, by having the freedom to exchange with family, friends and acquaintances.
4. To be fulfilled and satisfied in the religious aspect.

Of these points, 1) is related to physical suffering. Today, this is the area that pain clinics and other medical institutions specialize in. In the two examples of patients who overcame the three sufferings, this aspect was under control. 2) and 3) are related to psychological suffering. The range of social activities lessened compared to when they were healthy, but they were able to continue communicating with their family, friends and acquaintances. Until the end, both women were able to feel a sense of fulfillment and security, with appreciation and trust for those around them.

In the first case, Patient S was able to fulfill her wish of once again seeing her child after being separated for fifty years with the help of those around her. In this way, her psychological suffering was overcome. Likewise, Patient U, who was in a vegetative state, was also able to overcome her psychological suffering by having a chance to express her appreciation to Nurse B before she passed.

Point 4) corresponds to the third suffering of coming to terms with our own mortality. Overcoming this suffering is the role of religion. The two cases introduced here are of patients who practice Buddhism. They were able to completely overcome the real sufferings—insecurities and fears concerning death. As these two examples show, even if in a vegetative state, or receiving drain treatment or nutrition from a tube, both patients retained their dignity as human beings, and shining brightly, they were able to accept death in a state of peace.

This was possible because they were able to overcome the three sufferings caused by earthly desires that arise from the three poisons (greed, anger and foolishness). Their minds, i.e. their mental consciousness and *mana*-consciousness, were centered on goodness and shined with the state of Bodhi (free from all greed, anger, and foolishness). Buddhism defines the loss of dignity of human life as a mind controlled by the three poisons, as this prevents the peaceful acceptance of death. On the other hand, the condition of human life where a mind is ruled by feelings of goodness such as serenity, wisdom, trust, and gratitude in the mental and *mana*-consciousness enables a person to face death with dignity.

The members of the SGI Nurses Group who carry out Buddhist nursing care, aim to provide assistance to patients so that they are able to overcome earthly desires such as insecurity, fear, dissatisfaction and a feeling of leaving something undone, and transform their minds to one centered on serenity, fulfillment, gratitude, and trust. This exemplary approach to nursing improves the quality of life of patients and preserves patients' dignity as a human being.

Notes

[1] The Institute of Oriental Philosophy, ed. (2009) *Daijou Bukkyou no Chousen (4) Aratana Seishikan wo Motomete ‹Jou›* [Challenges by Mahayana Buddhism (4) Toward a new view of life and death, vol. 1], The Institute of Oriental Philosophy, p. 133. trans. from Japanese.

[2] Soka Gakkai Ethics Research Group and The Institute of Oriental Philosophy, ed. (2001) *Anrakushi / Songenshi wo Doumiruka* [How to view euthanasia and death with dignity], Daisan Bunmei, pp. 48–49. trans. from Japanese.

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[6] *Ibid*., pp. 122–3.

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