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Jaina Voluntary Death as a Model for Secular End-of-life Care

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Purpose of study

Jaina voluntary death has been practiced in India for millennia. The three-fold process of *Sallekhanā-santhārā-samādhimaraṇa* has allowed countless Jaina practitioners to enter death consciously and most effectively, departing smoothly and 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) Are there aspects of Jaina voluntary death that can be incorporated 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 Jaina ideas/practice to secular healthcare practitioners and their clients.

This paper will show that despite some tension between Jaina ethics and contemporary bioethics, the answer to both questions is in the affirmative. Given that every human must not only die but also must stop eating, drinking and moving at some point before death, I am convinced that the Jaina systematic methodology for this time holds the potential for immense continued benefit to many more people in the future, both Jaina and non-Jaina and regardless of context. Among those who are non-Jaina, some will embrace transmigration or some other post-death continuity of existence as part of their world-view and some will not. Holding to such religious concepts is not required for the essential elements of Jaina voluntary death to be useful to non-Jains. Additionally, for Jains in Diaspora or in India who find themselves in a secular healthcare environment, modern

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bioethics are amenable to aspects of Jaina 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 to a palliative or hospice environment but can include emergency, critical care, acute and chronic care settings where many people also die on a regular basis. In any environment, the Jaina 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.

Death in Jaina thought

Death is described in the *Paiṇayasuttāiṁ* as the "...last moment of earthly life...when the atoms disintegrate.[1]" . Even more dramatic, sometimes "[t]he Jains define death as the blowing up (samudghāta) of the atoms of life[2]." Since death is described as a time of destruction, explosive even, it provides a strong impetus for the development of means in Jaina 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 Jaina voluntary death practices, but also for the great importance placed on them by the Jaina 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. Jaina voluntary death has three aspects: (1) *Sallekhanā;* "emaciation of body and of passions through external and internal penances"[3], (2) *Santhārā*; the death-bed or, by extension, the environment in which the practitioner dies, and (3) *Samādhimaraṇa*; end practices for achieving death in equanimity.

Jaina 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 what comes afterwards, death is sub-divided into various qualitative levels based on commensurate levels of the state of mind of the dying person. The quality of the death is measured by the spiritual realizations attained from the

progressive mastering of restrained conduct. The list is sometimes compressed into two types, or three, and both the *Bhagavatī Ārādhanā* and *Uttarādhyayana-Niryukti* enumerate and describe seventeen types of death[4]. Mata Jnanamati gives a middling-length list which shows "death ha[ving] five varieties:

(1) Extreme Prudent's Death (Paṅḍita-paṅḍita Maraṇa)

(2) Prudent's Death (Paṅḍita Maraṇa)

(3) Fool-Prudent's Death (Bāla-paṅḍita Maraṇa)

(4) Fool's Death (Bāla Maraṇa)

(5) Extreme Fool's Death (Bāla-bāla Maraṇa)[5]"

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 by Mata Jnanamati as "[t]he death of a wrong-faithed living beings and death by suicide and accident etc[6]." It would 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' needs to be qualified because such logic would not survive outside of a Jaina context if it meant 'non-Jain.' Betraying the above description of the worst type of death are other indications in Jaina thought which show that, in fact, the last moments of life continue to hold the redemptive opportunity to improve one's death by way of supplementary purification practices, such as confession. A sudden, traumatic death would, indeed, make dying more problematic. However, even if there is little time to prepare and only mere moments of consciousness remaining, Jaina death practice allows for the continued potential to transform the mind.

Fasting (anasana) and bodily turmoil (kāyakleśa) austerities (tapa) in Jaina Voluntary Death

Austerities, particularly fasting and immobilization, are a crucial part of understanding Jaina 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 Jaina thought and practice. "[F]orms of instrumental fasting (*vrata*) are invariably criticized by the Jains[7].", and it is also felt that "[f]asting unto death for specific purposes has an element of coercion which is against the spirit of non-violence[8]." They are distinguished as inappropriate types of fasting because they keep one "caught in the wheel of *Saṁsāra*"[9], rather than being a cause of liberation from the cycle of existence.

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

All Jaina 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 (punya) 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. A commentary to Ācārya Amitagati's *Yogasāraprābhṛta* states that such actions "may bring some good (śubha) but not spiritual purity (*śuddhi*).[10]" Merit is helpful, but ultimately still obstructs liberation. On a higher level, austerities are for the purpose of stopping the influx of all *karma* (*saṁvara*), positive and negative, and for destroying *karma* already bonded (*nirjarā*).

Most literature concerning Jaina voluntary death practices focus 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[11]," and *kāyakleśa* is one of "the twelve types of elimination of *karma* (nirjarā)[12]", both austerity-types destroy *karma.* Not only

this, but they also both prevent the influx of new *karma*. This is so because both are of the fifth "of the five types of *saṁvara* [that of] *Ayoga* - stopping all the mental vocal, mental and bodily activities.[13]"

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 Jaina 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 fast-types are: (1) *bhatta-paccakkhāṇa,* in which one renounces food and drink, and can receive help from oneself or others; (2) *īvara* or *iṅgiṇī-maraṇa*, in which one renounces food and drink and limits physical movement, and can receive help from oneself; (3) *pāovagamana*, 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 which serve diverse patient populations. I have consciously chosen to use this document when looking at health ethics in hospital because it comes from a religious organisation that is often seen as having extreme views about euthanasia and assisted-suicide, among other controversial issues. Since much of the controversy around Jaina 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 Jaina voluntary death model can survive Catholic ethics then it can survive anywhere. The context that Catholic and Jaina 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 Jaina ethics interact in end-of-life practices.

Regarding 'The Primary Role of the Person Receiving Care' in Section II 'Dignity of the Human Person', the Catholic Health Ethics Guide states that:

> *Article 25. The competent person receiving care is the primary decision-maker with respect to proposed treatment and care options.*
>
> *Article 27. The competent person has the right to refuse, or withdraw consent to, any care or treatment, including life-sustaining treatment*[14].

Further, regarding 'Criteria for Decision-making' in Section V on the 'Care of the Dying Person':

> *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* [15].

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

> *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 care 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* [16].

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 Jaina and secular death practices, we will determine how the choice to engage in Jaina voluntary death practice and the choice to withdraw treatment in secular end-of-life practice are arrived at.

The Choice to stop oral intake and motion in Jaina and secular death practices

Jaina voluntary death practice: A personal choice from the inability to perform religious duties

It is a crucial point that in Jaina voluntary death practice 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 Jaina voluntary death practice? Most sources repeat the same main justifiable reasons for starting a fast unto death as we find in "Ācārya Samantabhadra['s] authoritative work entitled *Ratanakaranṇḍa-śrāvakācāra...*"When overtaken by a calamity, by famine, by old age, or by an incurable disease, to get rid of the body for '*dharma*' is called '*Sallekhanā*.' One should by degrees quit the body[17]". We could include any number of situations under '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 Jaina texts as the cause for choosing Jaina voluntary death. The *Ācārāṅga Sūtra* says this:

> *"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.[18]"

Entrance into Jaina 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.[19]" The importance of preparing for death is shown in the *Samaṇa Suttaṁ*, which recommends that "when death is inevitable in any case, it is better to die possessed of a calm disposition.[20]"

Secular healthcare and withdrawing life-sustaining treatment: Iminency 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 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 scarcity of beds. One of the pre-requisites for admission has to do with 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 stoppage of certain treatments such as artificial hydration and nutrition.

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 their 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 Jaina 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 Jaina 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. Actually, the tides might turn and the children might then have to care for their father. Also, social systems can build in accommodations that protect both the children and father, such as disability, unemployment and health insurances. This does not mean that the sick or disabled person themselves has 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 during the time when their injury is new. The saving grace in the Jaina voluntary death practice is the inclusion of means to ensure that the choice to die voluntarily is not based on despondency. The

Jaina 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.

The disconnect between the Jaina and secular approaches here, it seems, from the view that after a certain threshold the negative consequences from the inability to fulfill commitments made does not outweigh positive consequences from any good activities. Even if a person can still participate, such as an ascetic being confined to a chair but still being able to give discourses and which surely causes the influx of positive *karma*, the inability to perform other ascetic duties is still causing the influx of negative *karma*. Jaina karmic theory, here, does not leave much room for intention. Even for the Jaina who sincerely wishes they could continue fulfilling their religious commitments, and feels remorse for not being able to, negative *karma* relentlessly bonds. In all the traditions that embrace *karma* and rebirth, it is usually said in one way or another 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 ever 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 fulfilment 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 deserving of all means of help for cure or comfort even if clients are harmful or lack physical ability.

There are occasions in the Jaina 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.[21]" 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, those who help and for the order itself in keeping the spirit of the vows in changing times.

It seems, therefore, that the Jaina push towards choosing to engage in death practices when one can no longer fulfil 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 Jaina 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 Jaina voluntary death be practiced in secular healthcare?

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' section of the 'Care of the Dying Person' chapter we find this:

> *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* [22].

All together, 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 Jaina 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 Jaina voluntary death practices such as taking any of the three types of fast-vows, such as to not take anything by mouth (bhatta-paccakkhāṇa) and also to not move beyond a certain area (inginī-maraṇa), or to not move at all (paovagamana), would fit easily. The third aspect of the vows regarding receiving help from others might require negotiation. With *bhatta-paccakkhāṇa* 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 *paovagamana*, however, one can receive no help from others. 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 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 Jaina tradition can offer a very good approach. It is recommended to not take final vows until it is sure there will be no improvement in one's illness or deterioration, because in the Jaina tradition vows once taken cannot be rescinded. 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.*[23] *"*
> *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 far 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.*[24] "

So, great care must be taken with the timeliness of vow-taking. The vow to not receive help can come at the 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 become 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 Jaina death vow be valid if in advance, with 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.

As with the initial choice to engage in death practices, when death is imminent the fulfillment of the various Jaina voluntary death vows can also be accommodated in a secular end-of-life setting.

Qualifications of those caring for the dying in Jaina 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, "[b]efore [voluntary death] can be resorted to, all worldly ties are to be severed: the individual will

already be out of this world [25]." 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.[26]" In service of equanimity, there are practical ways to improve the chances of the practitioner being "free from the memories of the friendly attachment[27]." In terms of attachment to wealth, one part of the process of voluntary death is in the "...intermediate phase of renunciation... [when h]e gives all his belongings away.[28]" In terms of attachment to loved-ones, the practitioner is not surrounded by family, but rather, monastic assistants.

"...the saints who ordain or cause the saints to undertake this vow in a prescribed way, are called 'Expiation/holy death preceptors' (niryāpakas).

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:

(1) Four saints serve the mortifier 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 foods as prescribed by Ācārāṅga (Book on Monastic Conduct).

(4) Four saints arrange for the 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 public.
(11) Four saints tell the religious stories to the outside visitors.
(12) Four saints refute the alien doctrines through debates.

Thus, these forty eight holy death preceptor saints try to get the saint cross the ocean of weary world through their care in maintaining the meditation and equanimity of the mortifier 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, it is necessary that at least two saints be there.[29] "

We know that such death assistants must be monastics, and thus necessarily follows the " twenty eight basic and primary properties (mūla-guṇa) of a Jaina ascetic [which is] comprise[d 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)[30]" and seven more bodily austerities. The "*mahāvratas* (five great vows) [are] - *ahiṁsā*, *satya* (truthfulness), *asteya* (taking nothing belonging to others, for own use, without permission of the owner), *brahmacarya* (chastity), and *aparigraha* (possessionlessness)[31]." This would ensure great discipline. A monastic, also, "must be totally obedient to his *upādhyāya* (preceptor) and to his *Ācārya* (the head of his order)[32]," and thus has a two-fold accountability. Generally, then, Jaina voluntary death assistants are both highly disciplined and highly accountable.

It is significant that those who assist a practitioner who is engaging in Jaina voluntary death practice is expected to be so 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. Jaina 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*: apology to the congregation"[33], and for the householder, many sources suggest that "[h]aving called relatives and friends, one should seek their forgiveness for any transgressions in conduct[34]." 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 "*Saṁlekhanā* as the highest end...[there is] no cause for tears.[35]" 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 Jaina voluntary death and initiation (*dīkṣā,* or entrance into the monastic order), the practitioner "gives all his belongings away[36]." and they are "practically a monk.[37]" As such, separation from both loved-ones and wealth is undertaken in preparation for death in Jaina practice.

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 Jaina 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 Jaina voluntary death model? Is the Jaina 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 hospital. In determining the qualifications of those who are permitted to be at the bedside of the dying person, the Health Care Consent Act favours spouses, partners and relatives in relation to decision-making. 'Spouses' are defined by marriage, or co-habitation, or having a child together[38] whereas 'partners' are defined as a "close personal

relationship that is of primary importance in both persons' lives[39]"which, happily, is accommodating to same-sex couples. These relationships are given prominence. Next, 'relatives' are defined by "blood, marriage or adoption[40]." In hospital, such people are favoured as well. There is no mention of personal qualifications. Where in the Jaina 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 is no behavioural or motivational expectations, they leave much room for difficulties around visitation of, and wealth distribution by (or inheritance from), the dying person. The Jaina 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, 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 in order to show support at the end of life in order specifically to win favour 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 hospital, 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 in relation to 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 who the patient does not want in their presence being 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, so as 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 entirely possible to achieve given the respect for patient 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 the option to not have grief displayed at the bedside needs to be made available to individuals 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 is entirely up to the individual. They may want family and grieving in their presence until the moment they are dead. However, they may not. In such a case, if a person does truly have 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.

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