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Calculations of Death

Hundreds of memorials (*niṣidhi*) in the form of carved stones, pillars, images, and temples are found at the Jain pilgrimage site of Śravaṇa Beḷgoḷa in the southern Indian state of Karnataka, commemorating Jains—both mendicant and lay—who pursued a unique form of voluntary religious death through fasting, called *sallekhanā* (also *saṃstāra, samādhi-maraṇa*), considered a wise way of dying in the Jain tradition (Wiley 2009, 201).[1] According to some Digambara sources, at a time of great famine, Candragupta Maurya (320–293 BCE), who founded the Mauryan empire of ancient India, accompanied his Jain preceptor Bhadrabāhu, along with members of the northern Jain mendicant community, from Pāṭaliputra to Śravaṇa Beḷgoḷa after renouncing his kingdom and wealth. In Śravaṇa Beḷgoḷa, Bhadrabāhu performed the ritual of *sallekhanā*, and a pair of rock-cut footprints mark the place where he is thought to have died. After living for another twelve years, Candragupta Maurya is also believed to have died there by fasting unto death (Caillat 1977, 64; Lalwani 1997, 88; Singh 1975, 64–65).

Jain texts deal at great length with the physical certainty of death and its spiritual significance. Like rebirth, death is a critical transition in a much longer journey within the Jain account of life, and maintaining equanimity as death approaches is considered to carry great significance, playing a determinative role in one's future existence.[2] The inevitability of old age and death motivates both mendicants and lay Jains to strive for right worldview and shed their karmic attachments in order to ensure a better rebirth—and perhaps, one day, liberation from the relentless cycles of repeated embodied existence and suffering (ĀS 1.3.1.3).

In this chapter, we explore the Jain understanding of death alongside modern bioethical definitions and legal precedents—primarily in the United States but also globally—that illuminate current tensions and debates in end-of-life issues. We explore the wise and voluntary death of *sallekhanā* in Jainism, and various Jain attitudes toward organ donation, life-sustaining treatment, advance directives, euthanasia, physician aid-in-dying, and refusal of food and fluids. We conclude

with five provisional principles of application through which Jain thought and practice might contribute to bioethical discourses and clinical practices related to death and dying well.

DEFINING DEATH IN THE JAIN TRADITION

The Jain medical treatise *Kalyāṇa-kāraka* describes the current life span—during the present epoch of time (*kali-yuga*)—to be one hundred years, divided into four stages of childhood (*śiśu*), adolescence (*yuvan*), adulthood (*madhyama*), and old age (*vṛddha*) (KK 2.8). Walther Schubring describes the second half of the ten-times-ten years of a normal human life as "a decline of the senses, loquacity, bending of the body, expectation of death, and the last bed" (2000/1962, 150; see also chapter 2). As many as forty-eight kinds of death are described in Jain texts (Settar 2016/1986, xv, 9). We will examine several of these varieties later in the chapter. At present, we will briefly identify key elements for understanding death in the Jain tradition, namely the decisive role of longevity-determining karma, death as a motivation for religious practice, and Jain funeral practices.

The Role of the Longevity-Determining Karma

Death itself is defined in the Jain tradition as the destruction of longevity-determining karma (*āyu-karman*) (Settar 2017/1990, 8). The nondestructive (*aghātiyā*) karma that governs the kind of embodiment a *jīva* will experience is of four types: longevity-determining karma decides life span, while name-, status-, and feeling-determining karmas govern birth form, status, and feelings, respectively (see chapter 2). As indicated in chapter 2, longevity-determining karma is unique in two ways: (1) by determining the life span, it sets the framework for the operation of all the other nondestructive karmas; and (2) unlike the other three nondestructive karmas, which bind to the *jīva* continuously, longevity-determining karma is said to be fixed *only one time* in a given life span, and to come to fruition in the life that immediately follows. The binding of the karma is understood to occur sometime during the last third of life,[3] and without any knowledge on the part of the individual (BhS 7.6§304a–b; Jaini 2001/1979, 126). This doctrine has implications for how an individual Jain may view the later years of their life. As Jaini explains, "by earnestly adhering to the path of proper conduct, a Jaina can hope, during the latter portion of his [*sic*] life, to greatly influence the determination of his āyu-karma and thus the character of his entire next existence" (2001/1979, 126).

The rise of longevity-determining karma energizes the body throughout the duration assigned in the previous life. Death occurs when some event interrupts the ten vitalities (*prāṇa*) responsible for strength, respiration, and the senses (see chapter 2). However, as Wiley emphasizes, the ultimate cause of death is the destruction of longevity-determining karma, which severs the *jīva*'s vitality of life

span, allowing another longevity-determining karma to rise in its place (2000a, 307; see chapter 2).

Death as Motivation for Religious Practice

Religious practice is considered the best way to influence one's longevity-determining karma, and Jainism understands death as a motivating factor in strengthening one's dedication to it as well as in initially propelling one onto the spiritual path. A ubiquitous theme in Jain narratives is that of the layperson who realizes the inevitability of decay and death and turns from the obsessive attachments of daily life toward right worldview, knowledge, and conduct. The realization of death can apply to one's present impending demise or to past experiences of death in earlier rebirths. As we described in chapter 6, the *Uttarādhyayana-sūtra* recounts the story of Prince Mṛgāputra, who remembers his gruesome earlier deaths. Having realized that life is full of suffering, including birth, old age, illness, and death, he petitions his parents for permission to leave the royal court and pursue the *śramaṇa* path (US 19.14–15).

Since developing a clear awareness of death and the transitoriness of life is such an important motivation for spiritual efforts, mendicants and laity are urged to see the body as perpetually in decline. To cultivate the proper attitude toward life and death, the Jain practitioners are to meditate regularly on the twelve mental reflections (*anuprekṣā*) of humanity's existence in the universe, including the realizations that we are helpless against death, that everything is transitory, that the cycle of rebirths is full of sorrow, that the body is afflicted, and that ultimately each individual must struggle alone (TS 9.7; Jaini 2001/1979, 248; see chapter 3). These meditative practices (*dhyāna*) are designed to reveal the unsatisfactoriness of embodied life and thereby prompt one to develop a sense of disillusionment with the world and an aspiration to seek a way beyond it (*saṃvega*).[4] Emphasizing that the experience of mortality is faced by each living being alone, with no familial or social relations being able to prevent death and suffering, is aimed at reminding individuals to seize the lifetime at hand, renounce their attachments, and strive to transcend the cycle of rebirths (US 13.22–23). Stated succinctly in the *Ācārāṅga-sūtra*, "Knowing birth and death (*jāti-maraṇa*), one should firmly walk on the path (*saṃkramaṇa*) [to liberation]" (ĀS 1.2.3.4).

Jain Funeral Rituals

Anne Vallely states that funerary rituals were not part of traditional Jainism, possibly because of the belief that rebirth of the deceased in a new life-form happens almost immediately (see chapters 2 and 5; see Jaini 1991b, 189), but that many lay Jains now nevertheless practice them (Vallely 2011, 70–71; see also Sangave 1959, 360–61). Robert Williams asserts that textual sources do not reference Jain funerary rites before the fifteenth century (1963, xxiv; see also Flügel 2010, 46–49). Phyllis Granoff, however, argues that "medieval Jain religious practices at least in

so far as they concern the dead and the dying did not deviate as sharply as has been thought from Hindu practices of the same period: Jains and Hindus alike prepared people for dying, ensured them the best possible rebirth through rituals conducted on their behalf and honored them by building them memorial monuments" (1994, 183; see also Dundas 2011; Flügel 2010, 46–47, and Flügel 2018, 123–25). Schubring writes that ordinarily the dead bodies were cremated (2000/1962, 290).[5]

Peter Flügel points out that apart from examples in narrative literature, comprehensive prescriptions for conducting funerary rituals and related ceremonies for deceased Jain mendicants do not exist in any text. He lists seven different rituals and ceremonies that are included in the mortuary practices for mendicants: (1) voluntary death (*sallekhanā*), (2) removal of the dead body (*nirharaṇa*),[6] (3) funeral ceremonies in relation to cremation (*dāha-saṃskāra*), (4) collection of the bone relics (*asthi-saṃcayana*), (5) disposal of the bone relics (*asthi-visarjana*) or construction of a funerary monument (*stupa/samādhi*),[7] (6) commemoration (*smṛti*), and (7) veneration (*vandanā*) and/or worship (*pūjā*) (2018, 120–22). In contrast to the funerary rituals for laity, funerals for mendicants have a celebratory character, since it is believed that the deceased has moved on to a good rebirth in the heavenly realm (125–26).

Contemporary Jain laity, Flügel notes, observe a broad variety of funerary rites "that represent variations of Brāhmaṇical custom" (2010, 60; see also Sangave 1959, 361). In his extensive sociological account of Jains in India in the mid-twentieth century, Vilas Sangave describes the diversity of regional funerary practices wherein some Jain communities may go immediately to the temple while others wait for various durations; some families may observe an "unclean" period of ten to thirteen days after the death of a relative before having a social gathering to commemorate the dead; and some may practice monthly or annual memorials while others do not (1959, 360–62). Flügel writes that the dead body of a common Jain layperson is "carried in a lying posture, covered from head to toe by a shroud, by male family members to the funeral pyre, on a simple bier (*siḍī* or *sīḍī*) constructed out of bamboo sticks that are laid out in the form of a ladder, as its name indicates (*siḍī* = *sīṛhī*), and is cremated with slight variations in a standard modern Hindu fashion" (2018, 125).[8] According to the "Guidelines for Healthcare Providers Interacting with Patients of the Jain Religion and Their Families," prepared by the Metropolitan Chicago Healthcare Council, Jain postmortem practices (perhaps in this case particularly as observed by the US Jain communities) involve washing and dressing the body after death, accompanied by prayers and possibly a lit lamp in the room with the body of the deceased. The process of cremation may be open to the community (2002).[9]

Christopher Chapple explains that these various social rites "are not performed for the benefit of the dead but to encourage devotion to Jaina ritual and ethical observances" among the surviving community (2010, 205). As indicated above, counterexamples exist, however, and Granoff writes that "both texts and inscriptions

indicate that Jains in fact both prayed for the dead and to the dead" (Granoff 1992b; see also Flügel 2018, 129). Maintaining various forms of relationships with the dead certainly seems to have a place in Jain communities, and is considered potentially beneficial for the parties involved. For example, even approving (*anumodana*) of the spiritual path of the deceased mendicant can, according to Flügel, accrue karmic merit. "Like the obligatory *kāyostarga* meditation, performed by mendicants after abandonment of the corpse of a deceased monk or nun, cremation rites performed by the laity are believed to offer opportunities for self-transformation, if they indeed result in an intensification of the personal realization of the Jaina perspective on the transience of worldly existence in contrast to the immortality of the soul" (2018, 128, see also 122). This shows that just as the Jain path invites discipline and restraint in preparing for one's own death, how one responds to the death of others is part of religious practice and may therefore be a valuable opportunity for spiritual advancement.

DEFINING DEATH IN MODERN MEDICINE

The definition of death remains an enduring dilemma in biomedical ethics. Prior to the advent of mechanical ventilation in the 1950s, death was determined by the cessation of respiration and heartbeat. This heart-lung definition could be detected by checking the pulse and observing the breath; if these ceased, the brain and other organs stopped functioning in quick succession.

Determining Death and the Dead Donor Rule

The development of the positive-pressure mechanical ventilator allowed physicians to maintain respiration and thus circulation, supporting patients as they recuperated from disease or injury. This technology also preserved vital signs in patients unlikely to recover, as in the case of traumatic brain injury, creating new dilemmas. If a patient is alive due to circulatory support—even if their brain has suffered irreversible injury—are they dead or alive? This question is critical, since removing organs for transplant or withdrawing life-sustaining treatments from a living patient would constitute killing, a grave breach of a physician's oath to "do no harm" (Bendorf et al. 2013). If those patients are dead, procuring organs and removing support pose no moral hurdle.

Consequently, ventilation technology necessitated a revised definition of death within the global medical community. In 1968, an ad hoc committee of the Harvard Medical School issued a report that introduced the criterion for "brain death." The report detailed a series of tests to identify the permanent cessation of functioning throughout the *whole brain*, what they called "irreversible coma." According to the committee, if a patient receives this diagnosis, "death is to be declared and then the respirator turned off" ("A Definition of Irreversible Coma" 1968, 338). "Brain

death" was to be considered "death," even if heart and lung function was maintained mechanically.

These guidelines were formalized in the United States through the Uniform Determination of Death Act (1980), drafted by the National Conference of Commissioners on Uniform State Laws, and that model legislation was soon after published in a report developed by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research ("Defining Death" 1981). In addition to retaining the heart-lung criteria, the Uniform Determination of Death Act stated that death could also be determined by "irreversible cessation of all functions of the entire brain, *including the brain stem*" (1980, 5; emphasis added). To clarify clinical diagnostics, the American Academy of Neurology (AAN) released a checklist for physicians in 1995—reaffirmed in 2010, 2014, and 2017—to standardize the determination of death by cessation of the whole-brain and brainstem criteria (Wijdicks et al. 2010).

The Uniform Determination of Death, along with the AAN criteria to assess cessation of the whole brain plus the brainstem, remains the standard in the United States and most European countries. The United Kingdom developed its own formulation in 1976, designating death of the *brainstem* alone as sufficient to terminate breathing and consciousness (Oram and Murphy 2011). India and Canada similarly use brainstem criteria; physicians in these countries can declare death without "whole-brain" confirmation (Dhanwate 2014; Gardiner et al. 2012; Smith 2012).

Although these two different criteria seem relatively straightforward, the category of "brain death" continues to generate controversy. At the bedside, many families are unclear on the meaning of brain death as it relates to death, especially when a patient's body appears to breathe, feels warm to the touch, and may display physical movements or vocalizations ("Controversies" 2009). Some clinicians and critics have persistently disputed whether brain death, in fact, constitutes the death of a human person (Verheijde and Rady 2014). Additionally, organ transplantation protocol requires that a patient be pronounced dead—known as "the Dead Donor Rule"—before organs are procured, though some physicians believe that this diagnosis can be made prior to whole-brain death, thereby increasing transplant success (Sade 2011). Perhaps most importantly, rare cases of patients recovering after being misdiagnosed with brain death, or being diagnosed too quickly after injury, invite a reconsideration of the consensus (Greenberg 2014). In an attempt to standardize the guidelines for determining brain death, the World Health Organization held several forums and published "International Guidelines for the Determination of Death" (2012), which establish minimum clinical standards, as well as additional test protocols, for assessing brain function.

An important lingering debate centers on the "higher-brain death" criteria (Smith 2012). Distinct from whole-brain or brainstem criteria, which identify

death as the loss of an organism's integrated bodily function, some advocates claim that loss of the "higher" cerebral cortex—the part of the brain that enables our sense of *personhood*—should be sufficient to determine death. In cases of traumatic brain injury, the portion of one's brain that corresponds to waking awareness, speech, vision, and motor function has been seriously damaged, but the parts of the hypothalamus and brainstem that maintain regulative functions—such as sleeping and waking cycles, body temperature, breathing, digestion, blood pressure, and heart rate—remain intact. In this "vegetative state" (increasingly called "unresponsive wakefulness syndrome") the markers of personhood are difficult, or impossible, to discern, leading some to equate such a state with death. The state can be temporary or persistent. In a "persistent vegetative state," the body is technically alive but one's personality and ability to engage in the world are nonfunctional, creating a situation in which, as described by philosopher Jeff McMahan, "you could be survived by your organism" (2006, 48).

In spite of arguments to include higher-brain death in the medical definition of death, the neurological criteria of whole-brain death remain standard in most countries, and brainstem death in a select few. Yet the definition of death is not only a medical decision, but an interdisciplinary question (Bagheri 2007; Lewis et al. 2018). As bioethicists Charles Culver and Bernard Gert have argued, "defining death is primarily a philosophical task" (2006, 313), for which medicine requires cultural and religious insights to more adequately engage our collective understanding of what constitutes a meaningful life of the body and mind—and, subsequently, what constitutes its death.

Contemporary Jain Views on the Biomedical Definitions of Death

In our survey of Jain medical professionals, when asked, "Which do you feel is the most adequate definition of death? Choose those that apply," the greatest number of participants chose heart and lung criteria (44%, $n = 36$), followed by whole-brain death, including integrated function of the cortex and brainstem (33%); and higher-brain death, including loss of cognitive function in the cortex (19%). Still, there was also considerable ambiguity, with a significant minority of participants selecting "I need more information to adequately understand these definitions of death" (25%), "I have not considered this before" (25%), or "Other; please describe" (11%). Explanatory comments included the following:

> "[W]e don't know for sure."
> "Depends on the decision for which you need the definition."
> "Death of the body or death of the soul?"

Moreover, when asked if they believed that "someone diagnosed to be in a vegetative state (or unresponsive wakefulness syndrome) should be considered dead," the majority of Jain medical professionals felt that such patients should not be presumed dead (42%, $n = 36$), while smaller minorities felt they should be

considered dead (25%), had not considered it before (25%), or did not know (8%). Their view of the vegetative state/unresponsive wakefulness syndrome was more informed by respondents' medical/healthcare education (33%, $n = 36$) than by clinical experience (19%) or the Jain tradition (14%). A significant minority felt that clinical experience, medical education, and the Jain tradition influenced them equally in their view of a persistent vegetative state (17%).

Relatedly, when asked, "Do you feel that cognitive abilities are synonymous with consciousness, that is, if one loses cognitive abilities, they have lost consciousness?," the majority disagreed (56%, $n = 36$), while fewer respondents agreed (14%) or had not considered it before (25%). When asked if the Jain tradition influenced their view on the relationship between cognitive abilities and consciousness, respondents selected Yes (42%, $n = 36$), No (44%), or Not applicable (11%).

Although longevity-determining karma was not an option on the survey, none of the participants referred to the exhaustion of karma within their comments, which could suggest that this technical aspect of death in the Jain tradition may not be widely discussed, or may not be perceived as in conflict with medical definitions. At the same time, not all respondents were satisfied with the provided survey options to capture their understanding of death.

Contemporary Jain Views on Organ Donation

While Jain professionals varied in their definitions of death, the majority of participants viewed organ donation from dead donors favorably. Nearly 64 percent of participants ($n = 35$) were registered donors, and over 90 percent of those donors lived in opt-in countries; 11% had elected not to opt in, while a small minority either did not know if they were donors (6%) or had not considered the issue before (9%). When asked, "Does the Jain tradition influence your view on whether or not to donate your organs?," participants responded Yes (44%, $n = 36$), No (47%), or Not applicable (8%). Asked to describe their "prime reason either for being an organ donor or for not being a donor," pro-donation respondents' answers ($n = 24$) fell along three primary lines: (1) helping another individual (with no mention of family ties); (2) a lesser desire to serve medical students and the advancement of medicine; and (3) a desire for one's material body to be of use after death (figure 18). One answer equated the decision of organ donation with "being Jain," while another considered it a karmically beneficial act of compassion. Anti-donation responses ($n = 3$) included going against one's conscience, violating a dead body, and uncertainty of the karmic ramifications (figure 18).

The positive orientation to organ donation among Jain medical professionals is significant, given that massive organ donation shortages persist worldwide (Beard and Osterkamp 2013) and organ donations from ethnic minorities are especially needed (Sharif 2013). Because of shortages in the United States, for example, from 2003 to 2013 the number of patients on a waiting list for kidney transplantation doubled to approximately one hundred thousand patients, with wait times extended to

FIGURE 18. Responses of Jain medical professionals ($n = 27$) to the question "What is your prime reason either for being an organ donor or for not being an organ donor?"

4.5 years; consequently, nearly five thousand patients die while awaiting a kidney transplant from a dead donor every year (Wu et al. 2017, 1287). Certain studies also show that religious concerns can negatively impact decisions to donate. In their research on organ donation and religion, Michael Oliver and colleagues describe various conflicting religious commitments: the importance of altruism in Islam and Judaism competing with requirements for burying a complete body within twenty-four hours after death, the value of compassion in Buddhism competing with the possibility of disrupting lingering consciousness that may persist for days after death, and the requirement for an intact body within Hindu funerary rites competing with a strong emphasis on selfless giving, among others (2011). While the reasoning for organ donation among Jain survey respondents is not uniform, the overwhelmingly positive orientation to the practice suggests that Jain medical professionals have fewer competing values at play.

Whether other lay Jains also view organ donation positively requires further investigation. A 2013 report from Mumbai shows that 85 percent of corneas donated for transplant and 95 percent of skin donations came from the state of Gujarat, namely from a community of Gujaratis from Kutch, and from the Jain community (Debroy 2013). The local liaison for soliciting donations, Kusum Vira, credited the communities for their positive perspective on donation, describing their "religion-backed ideology that perceived donation as an ultimate form of charity" (Debroy 2013). One possible factor for the positive view of donation may be the fact that rebirth happens almost instantaneously in Jainism, so as soon as the *jīva* leaves the body, only the nonliving body remains (see chapters 2 and 5). Investigating other reasons for this communal support may provide insights for efforts to increase donations among religious communities in India and abroad.

VARIETIES OF DEATH IN THE JAIN TRADITION

As noted above, Jains have detailed at least forty-eight different kinds of death,[10] several of which we will consider here according to (1) timeliness and (2) manner of death.

Timely or Premature Death

Jain texts state that deaths can be timely or untimely. A timely death (*kāla-mṛtyu*) refers to a fully experienced life span that is exhausted at an appropriate time, while an untimely death (*akāla-mṛtyu*) depicts a premature end (Settar 2017/1990, 9). Wiley explains that in the case of human beings in our part of the cosmos, longevity-determining karma can be bound tightly or loosely depending on whether an individual has strong or weak mental effort/resolve (*adhyavasāya/adhyavasāna*) at the time of death. A strong mental effort/resolve causes this specific kind of karma to bind tightly so that the determined amount (rather than length; see chapter 2) of life (*sthiti*) is *not subject to reduction* in any circumstances (*anapavartanīya-āyu*), and, thus, life cannot end prematurely. A weak mental effort/determination results in loosely bound longevity-determining karma, the duration of which *may be subject to reduction* in certain cases (*apavartanīya-āyu*) (2021). Wiley notes that most mendicant authorities assert that all beings born in the present epoch in this part of the cosmos bind longevity-determining karma that is subject to reduction, meaning that it is always possible for death to be untimely (2000a, 49–52, 310–11).[11]

Manner of Death

There are several ways to classify the different manners of death listed in Jain texts (Settar 2017/1990, 15). For our purposes, we will examine forms of death shared by all beings, as well as deaths considered wise or unwise and involuntary or voluntary.

The moment of death that each of us will experience when our body ceases to function is called *tadbhava-maraṇa*, representing that which we ordinarily refer

to as "death" (Wiley 2000a, 312). In the Jain tradition, this event is followed by rebirth into another body. Each of the forty-eight kinds of death is considered *tadbhava-maraṇa* (Settar 2017/1990, 9, 11). The moment of death can occur due to the presence (*upakrama*) of efficient external causes (*nimitta*) or without them (*nirupakrama*) (Wiley 2000a, 49–52; see chapter 2).[12] For example, an efficient external cause might be disease, being killed with a weapon, or falling victim to a natural disaster. This kind of death could be considered timely or untimely. As discussed above, tightly bound longevity-determining karma ensures that life can never end prematurely, and that holds even in the presence of external efficient causes (Wiley 2000a, 49–50).

Every being will also undergo death as a slow loss of vitality that does not reach the level of awareness. This continuous process of perpetual death is called *nitya-maraṇa*, also known as *āvīci-maraṇa*, meaning death like the disappearance of a wave. The Digambara text *Bhagavatī-ārādhanā* (Pkt. *Bhagavaī-ārāhaṇa*; first to second centuries CE) written by Śivārya (also called Śivakoṭi)—one of the primary Jain treatises devoted to the subject of death—describes this gradual form of dying with a story: The Cakravartin emperor Sanatkumāra is visited by heavenly beings who inform him of his approaching death. When he asks how they could perceive his loss of *āyu*, the guests fill a bowl with water and dip in a fly whisk to sprinkle water on the crowd gathered there. With each dip of the whisk the water level lowers, though so gradually that none can detect the decrease during the process. "Just as the loss of water cannot be assessed by observing the movement of the whisk," they explain, "the loss of lifespan cannot be realized from the tick of every second of time" (Settar 2017/1990, 9; Wiley 2000a, 312–13).

As indicated above, the manner of death is also classified as unwise or wise, as well as voluntary (*sakāma-maraṇa*) or involuntary (*akāma-maraṇa*). We will discuss these kinds of death in the next three sections.

Unwise Voluntary and Involuntary Death. S. Settar states that unwise deaths (*bāla-maraṇa*) can be voluntary or involuntary (2017/1990, 10–11). An unwise *voluntary* death is described as death conditioned by a desire to die (*icchā-pravṛtta*). These deaths are usually violent in nature. They result in the accumulation of inauspicious kinds of karma, and may lead to a low type of rebirth (Wiley 2000a, 329; Jaini 2001/1979, 228). The *Bhagavatī-sūtra* describes twelve forms of unwise death, including jumping from a mountain or tree, drowning oneself, self-immolation,[13] ingesting poison, killing oneself by using a weapon, hanging oneself, and allowing oneself to be eaten by vultures (BhS 2.1§118a; Wiley 2000a, 329; see also ĀS 2.10.13; cf. ĀS 1.7.4.2). The *Sthānāṅga-sūtra* describes a similar list of deaths condemned by Mahāvīra (SthS 2.4.411). All of these deaths are considered untimely not only because they prematurely exhaust longevity-determining karma, but also because the body is terminated while it is not yet a hindrance to spiritual progress (Wiley 2000a, 329).

According to Settar, an unwise *involuntary* death (*anicchā-pravṛtta*) involves the desire to prolong life or active resistance to death when it comes (2017/1990, 10). Wiley notes that this kind of death might be unavoidable in the case of deaths of very young persons (2002a, 330). We have not been able to determine whether dying in an unwise and involuntary manner primarily concerns mental dispositions at the time of death or whether it is also associated with self-directed physical violence. Wiley notes that this type of death is not accompanied by violent acts (2002a, 330). She classifies the first four kinds of unwise death that are listed in the *Bhagavatī-sūtra* before the types mentioned above (BhS 2.1§118a) as involuntary and interprets them as reflecting mental states at the time of dying. These are (1) "weariness" (*valan-maraṇa*) (Deleu 1996/1970, 89), which is variously explained as "death while straying from restraint, of one whose mind is attached because it is afflicted by the condition of being desirous of enjoyment or pleasure" (Wiley 2002a, 330–31, explaining Abhayadevasūri's commentary), "to die after abandoning ascetic-discipline in a disturbed state of mind due to pain caused by afflictions" (Bothra 2004, 160; see also Deo 1954–1955, 202), and death "in consequence of moral weakness" (Caillat 1977, 49); (2) "incapacity" (*vaśārta-maraṇa*) (Deleu 1996/1970, 89), which is described as being "afflicted by the power of the senses" (Wiley 2002a, 331), "to die after succumbing to indulgence in mundane sensual pleasures" (Bothra 2004, 160; see also Deo 1954–1955, 202), and "physical weakness" (Caillat 1977, 49); (3) "an interior dart" (*antaḥśalya-maraṇa*) (Deleu 1996/1970, 89), which is explained as "death of one . . . who is subject to transgressions" (Wiley 2002a, 331), and as dying "without confession" (Caillat 1977, 49; see also Deo 1954–1955, 203); and finally, (4) "the desire for a certain rebirth" (*tadbhava-maraṇa*) (Deleu 1996/1970, 89), which according to Wiley may include a wish to be reborn either as a human or a heavenly being (2002a, 331). S.B. Deo, on the other hand, explains it as the death that occurs "at the time of which the person does a karman [i.e., action] due to which he [*sic*] gets the same rebirth" (1954–1955, 202; cf. Bothra 2004, 160). In contrast to Wiley's interpretation, Colette Caillat, describes all these as conditions in consequence of which individuals kill themselves and so highlights them as causes rather than only mental states at the time of death (49; see also Settar 2017/1990, 10, cf. 11). Jozef Deleu similarly designates the first three kinds of death on the list as "suicide"; however, it must be noted that he also defines them as voluntary rather than involuntary (1996/1970, 89–90). In any case, death in these "unwise" circumstances can also result in an undesirable rebirth, since they do not attract the auspicious kinds of longevity-determining karma (Wiley 2000a, 330).

Wise Voluntary Death: Sallekhanā. Wise voluntary death (*paṇḍita-maraṇa*) within Jainism is achieved through fasting (*anaśana*) and is today often referred to as *saṃthāra* (Skt. *saṃstāra*, lit. "deathbed") or *samādhi-maraṇa* (lit. "meditative death") by Śvetāmbaras, and as *sallekhanā* (also *saṃlekhanā*, Pkt. *saṃlehaṇā*) by

Digambaras. The term *sallekhanā* derives from the Sanskrit verbal root *likh*-, with the prefix *sam*-, meaning "to scratch out or scrape." The "scratching out" refers to the thinning of the physical body through the restriction of nourishment, as well as of the karmic body through the restriction of the passions (Wiley 2000a, 316; Williams, 1963, 166). Chapple describes his experience observing this fast in 1989 while visiting a Jain university in Ladnun, Rajasthan. During his stay, an eighty-year-old nun of the Terāpanthī Śvetāmbara sect by the name of Kesharji had taken the vow of fasting unto death twenty-eight days prior, after being unsuccessfully treated for advanced kidney disease. The community of nuns—as well as the Terāpanthī leader Ācārya Tulsī—had gathered to encourage Kesharji on her fast in a calm but joyful gathering that venerated the nun's life and efforts toward a peaceful death, which took place twelve days after Chapple's visit (1993, 104–6). Other scholars have also witnessed or recounted various aspects of this kind of ritual death within the Jain community (Braun 2008; Deo 1954–1955, 420, fn. 217, 562, fn. 433; Jaini 2001/1979, 1; Renou and Renou 1951; Vallely 2002a, 132–36).

Three kinds of wise voluntary deaths are listed in Śvetāmbara and Digambara texts: (1) fasting to death with the care and companionship of others (*bhakta-pratyākhyāna-maraṇa*), during which mendicants support the practitioner's resolve to forgo nourishment (*bhakta*) by telling religious stories of other exemplars, reciting prayers, and uplifting the vows; (2) fasting to death by aiding oneself but without others (*iṅgiṇī-maraṇa* or *itvara-maraṇa*) with limited movement allowed; and (3) fasting to death without any movement or self-aid (*prāyopagamana-maraṇa*) (Settar 2017/1990, 12–13; Soni 2014, 6–8; Wiley 2000a, 314). The *Ācārāṅga-sūtra* and the *Bhagavatī-ārādhanā* describe all three of these deaths; the *Bhagavatī-sūtra* mentions the first and third (ĀS 1.7.5.1–1.7.8.25;[14] BhĀ 28; BhS 2.1§118a; see also US 5.32).[15]

In the early texts, these deaths are prescribed only for mendicants who have had years of experience practicing vows and austerities and, thus, possess right knowledge of the relationship between the *jīva* and transient body, and control over the passions (Caillat 1977, 53–54, 57–60).[16] However, later texts tend to be more flexible with regard to the requirement of lengthy prior ascetic training (62–64). For example, while still demanding "preparatory purification," Caillat observes that "preparation for death is milder" and "considerably shortened" in the Śvetāmbara *Prakīrṇaka-sūtra*s (Pkt. *Paiṇṇa-sutta*) (1977, 63).[17] "They do not insist on the necessity of a hard, lifelong training; this, apparently, could be replaced by the ceremonial which they teach" (62). The *Prakīrṇaka-sūtra*s include several texts explaining preparations for death, including how to renounce food, maintain consciousness, and assume the vows (Kamptz 1929; Wiley 2009, xxiv). The *Bhagavatī-ārādhanā* acknowledges a possibility of attaining a "perfect death," even without prior spiritual preparation; however, it emphasizes that such occasions are not standard and sometimes even interprets them as a result of previously accumulated auspicious karma (Soni 2014, 3–4)

Later texts, further, open the practice to laypeople. Already in the early Śvetāmbara canon some laypeople are seen as surpassing mendicants in control as death approaches (US 5.19–32), and narratives of laity fasting unto death are found in the canonical *Upāsaka-daśāḥ* (Caillat 1977, 56–57; Jaini 2001/1979, 233–40; Wiley 2000a, 318). Caillat writes that with regard to fasting unto death, *Prakīrṇaka-sūtra*s "apparently make no basic difference between the lay-follower and the monk, whose case they examine jointly" (1977, 62). In line with this, Umāsvāti states in the *Śrāvaka-prajñapti* that the practice of fasting unto death is not restricted to mendicants (Williams 1963, 166), and in his *Tattvārtha-sūtra*, authoritative for all Jains, he asserts that at the end of life the householder undergoes *saṃlekhanā* (TS^{Dig} 7.22[18]). In the Digambara tradition, the *Bhagavatī-ārādhanā*, cited above, explains various attainments (*ārādhanā*) that are available at the end of life for both mendicants and laity (BhĀ 2; Soni 2014, 2). Williams notes that texts on lay conduct (*śrāvaka-ācāra*) describe the fast unto death as a supplement to the twelve lay vows, with some Digambaras incorporating it into the twelfth vow (1963, 166).[19] Among the Śvetāmbara texts on lay conduct, Williams points out Devagupta's *Navapada-prakaraṇa* (eleventh century CE) as the only one that treats *sallekhanā* in detail, describing the three forms of voluntary death permissible for a Jain (1963, 166).[20]

Additionally, later Jain texts introduce the importance of a teacher overseeing the process of fasting unto death (Caillat 1977, 115; Dundas 2002a, 180). Jaini points out that today, only mendicants are usually allowed to undertake the fast unto death on their own accord, whereas mendicants administer the vow to laity, except in cases of emergency (Jaini 2001/1979, 231; Wiley 2000a, 319, fn. 45). "Jainas are quick to point out," Jaini says, "the difference between such a practice and that of common suicide, wherein a person tells no one of his [*sic*] deed and commits it in secret" (2001/1979, 231). The role of the mendicant who administers the vow is to assess whether the lay aspirant possesses sufficient control and spiritual level to undertake the fast (232; Wiley 2000a, 324, 326–28).

Fasting unto death is believed to bring positive spiritual results. While the earliest canonical sources indicate that "there might be no future rebirth" for mendicants who pursue such a mode of dying (Wiley 2000a, 316), the *Bhagavatī-sūtra* states that ending one's life with a wise kind of death reduces the length of wandering in *saṃsāra* (BhS 2.1§118a; see also Caillat 1977, 63). In one specific story, Mahāvīra suggests that the person who had fasted unto death would be first reborn as a heavenly being and then attain liberation as a human being in a part of the cosmos where liberation is always possible (BhS 2.1§120a; see also Jaini 2001/1979, 240). The author of the *Bhagavatī-ārādhanā*, Śivāraya, promises liberation in seven or eight births for those who, even once, die in a state of equanimity (*samādhi*) (Jain 2015, 21).

Sallekhanā can be undertaken by Jain mendicants and laity only in certain circumstances, and the process requires several specific steps. In the early canonical

sources, mendicants are advised to pursue fasting unto death when they can no longer maintain their vows or austerities, being too weak due to factors such as disease (Wiley 2000a, 314). The *Ratnakaraṇḍa-śrāvakācāra*, a text on lay conduct, authored by Samantabhadra, describes the valid circumstances as calamity (*upasarga*), severe famine (*durbhikṣā*), old age (*jarā*), or terminal illness (*niḥpratīkārarujā*) (RŚ 5.1). With old age are associated physical weakness, blindness, the inability to walk, senility, and so on (Wiley 2000a, 322). Samantabhadra details the unfolding process of *sallekhanā* by, first, giving up all attachments and possessiveness as well as desire and enmity. The aspirant then confesses all transgressions (*ālocanā*), and forgives friends and family for any wrongdoings while also seeking forgiveness from them (*kṣāmaṇā*) (RŚ 5.3–5). At that point the individual begins a ritual fast in three stages that involve the gradual reduction, first of solid food, then of fatty liquids (*snigdha-pāna*) such as milk or yogurt, then of acidic liquids (*kharapāna*) such as juice, until finally even water is abandoned (RŚ 5.6–7; see also Jaini 2001/1979, 230–31 and Wiley 2000a, 320–21). It was typically at the water-only stage, when death seems imminent, that a lay aspirant would take the great vows, including the vow of unlimited fasting, since traditionally these vows could not be rescinded once taken (RŚ 5.4; Jaini 2001/1979, 231; Wiley 2000a, 321). The aspirant should then keep the mind focused on the *pañca-namaskāra-mantra* and the five supreme beings (*pañca-parameṣṭhin*) until the arrival of death (see chapter 3).[21]

Texts of both traditions list five violations (*aticāra*) of the vow of *sallekhanā*. These are (1) desire for rebirth as a human being (*iha-loka-āśaṃsā*); (2) desire for rebirth as a heavenly being (*para-loka-āśaṃsā*); (3) desire to continue living (*jivita-āśaṃsā*); (4) desire to die (*maraṇa-āśaṃsā*); and (5) desire for sensual pleasures (*kāma-bhoga-āśaṃsā*; Dig. *nidāna*) (Jaini 2001/1979, 230–31; Williams 1963, 170; see also TS^{Dig} 9.33[22]). Samantabhadra lists the first one as fear (*bhaya*) (RŚ 5.8). Franklin Edgerton locates these Jain restrictions in opposition to the spiritual value of dying wishes in certain Hindu and Buddhist practices (1927, 226–32). In the Jain tradition, Edgerton asserts, "you can wish for anything to which your ascetic practice entitles you, nothing more," without paying a high karmic price (229).

Giving in to desires is considered a waste of previous religious practice. According to the *Bhagavatī-ārādhanā*, maintaining the mastery of worldview, knowledge, conduct, and asceticism (*ārādhanā*) has tremendous power at life's end; a lifelong path of austere conduct will be in vain if one fails, while a lifelong path of mistakes will be transformed into perfection for one who succeeds (BhĀ 15, 17; see also Jaini 2001/1979, 232–33; Wiley 2000a, 325; Williams 1963, 172). Hemacandra's *Triṣaṣṭiśalākāpuruṣa-caritra* give several examples of people falling to the temptation of desires, frequently made as wishes to vanquish one's enemy.[23] For example, King Parvata, after a great loss on the battlefield to his rival King Vindhyaśakti, becomes a mendicant under a Jain teacher. Although he performs extremely difficult austerities, Parvata secretly wishes to kill Vindhyaśakti in a

future rebirth, undermining the benefits of his restraints. After fasting unto death, Parvata is reborn as a heavenly being; however, the text describes his dying desire as bartering "his great penance . . . like bartering a jewel for chaff" (TC 4.2.185–88, trans. Johnson). Although these wishes can be made or resisted at any time during life, psychological longing during the approach of death is considered particularly detrimental to the equanimity required for a wise death, as indicated above, and both mendicants and laity are instructed to avoid such violations.

Jain texts establish that animals are also able to undergo a wise death. A well-known story among Jains is that of Mahāvīra's encounter with the angry snake Caṇḍakauśika, born a serpent because of his persistent rage in previous lives. After unsuccessfully trying to strike and kill Mahāvīra, the Jina helps the snake remember his past existences. Upon recollecting these past lives of anger, the story concludes, the snake's "heart changed and the seeds of equanimity for all beings began to sprout in him. He sat motionless and performed *santhara* [i.e., *sallekhanā*]" (Vallely 2002a, 35–37).[24] Another prominent tale describes one of Mahāvīra's previous lives as a lion, a karmic consequence of an earlier life in which he viciously killed a lion. One day, while hunting, the lion (future Mahāvīra) was eating prey he had just killed when two Jain monks came upon the scene and, sensing that the lion was amenable to their teaching, conveyed to him the truth of nonviolence and karma, reminding him of his previous lives. The lion recollected his past existences and, moved by the Jain teaching, assumed the minor vows. He then undertook the voluntary fast unto death, and was later reborn as the twenty-fourth Jina, Mahāvīra (Jaini 2010d, 262–63; De Clercq 2013, 148–49).[25]

Death through fasting is the most well-documented end-of-life practice within the Jain tradition, though it is not undertaken with great frequency (Dundas 2002a, 180–81; Jaini 2001/1979, 227–33; Settar 1989, 2017; Tukol 1976; Wiley 2000a, 326–28). It is estimated that approximately two hundred lay Jains and mendicants undertake the death fast each year in India (McCarthy 2015). The *Times of India* has reported on one unique community of Jains living outside Mumbai that has recorded four hundred acts of voluntary death over a seven-year period, although this is a notable exception (Chhapia 2015). In spite of its relative rarity, the practice looms undeniably large in the textual imagination of the tradition and community.

Because of its perceived similarity to suicide, the practice of *sallekhanā* has drawn criticism historically and in the present, such that Jains have felt the need to defend the practice. Pūjyapāda, for example, claimed that *sallekhanā* was distinct from suicide because it lacks the passions present in those who violently end their life (SSi 7.22§705; Bhargava 1968, 139–41; Williams 1963, 171). Among modern commentators, T.K. Tukol offered a detailed response to critics in his 1976 book *Sallekhanā Is Not Suicide*. In 2006, a case was brought before the Rajasthan High Court in which petitioner Nikhil Soni argued that the Jain fast

unto death should be viewed as suicide according to Indian law—specifically Article 21, which safeguards the right to life but not the right to die. Soni alleged instances of abuse in which individuals may have been pressured into completing the fast (Braun 2008, 922; Sharma 2015). In 2015, the court banned the practice, making *sallekhanā* or its abetment punishable according to the Indian penal code. However, the court suspended this judgment in August of the same year after nationwide protests by Jains, and the case is currently under review (Mahapatra 2015; Sethi 2019).

Wise Involuntary Death. There is one last manner of death that is wise, but not voluntary, called *paṇḍita-paṇḍita-maraṇa*. This death is attained in the fourteenth *guṇa-sthāna* by *kevalin*s, those who have reached omniscience and exhausted all destructive karmas in the twelfth *guṇa-sthāna*. The Śvetāmbara and Digambara sources disagree about whether *kevalin*s consume any food upon reaching this advanced stage. According to Digambaras, *kevalin*s no longer need food in order to sustain their bodies and therefore also do not perform any fasts. Śvetāmbaras, on the other hand, who maintain that *kevalin*s continue to eat, describe them as sometimes undertaking different kinds of fasts, including the fast unto death. These fasts are, however, not prompted by the same reasons that motivate laity, such as reducing the amount of destructive types of karma or keeping in a state of equanimity as death approaches, since they have already eliminated all passions and destructive karmas. "Since *kevalin*s are omniscient," Wiley explains, "they know in advance when they will die and they stop eating food by mouth (*kavalāhāra*) when it is no longer needed to sustain the body." This occurs along with the cessastion of all gross and subtle activities that occurs in the last two *guṇasthāna*s (Wiley 2000a, 331–33; see chapter 3).

DYING WELL IN MODERN MEDICINE

While the orthodox Jain tradition places central emphasis on dying in a state of calm awareness for the sake of an auspicious rebirth and eventual liberation, modern medicine is also grappling with what it means to die well. What, if anything, might the Jain community offer contemporary debates about end-of-life decision making? Similarly, how do contemporary Jains within and beyond the medical community reflect on end-of-life dilemmas that may not be addressed by the historical practice of a voluntary fast unto death?

The litigation surrounding *sallekhanā* in the Rajasthan High Court brought a rare practice of the minority Jain community into the public spotlight. On one hand, the case raises the question of whether an individual has the right to bring about their own death. On the other hand, the case invites needed conversation about the diverse and personal values of dying well that cannot be answered by medicine or law alone.

Refusing Life-Sustaining Treatment, and Advance Directives

In her analysis of the Indian court case, bioethicist Whitny Braun argues that *sallekhanā* should be legally protected on the grounds of religious freedom and autonomy (2008, 913). The choice to fast unto death involves two decisions: the first to forgo additional treatment, the second to forgo nutrition and water. Indeed, at least according to US law, the right to refuse life-sustaining treatment rests on firm precedent, notably the landmark cases of Karen Quinlan and Nancy Cruzan.

In 1975, twenty-one-year-old Karen Quinlan lost consciousness and stopped breathing at a party after consuming alcohol and Quaaludes. She lapsed into a coma followed by a persistent vegetative/unresponsive wakefulness state, caused by irreversible brain damage due to respiratory failure. Quinlan's parents felt that the mechanical ventilator constituted an extraordinary means of prolonging her life and requested its removal. When doctors refused, under threat from prosecutors that the act would constitute homicide and a breach of the Hippocratic Oath, the Quinlans filed for a court order to remove the ventilator in the New Jersey Supreme Court. Ultimately, the court held that the right to privacy—in this case, the right of a patient to make a private decision regarding the future of her life—was broad enough to include the Quinlans' refusal (on their daughter's behalf) of life-sustaining treatment, and ordered that the ventilator be removed. To everyone's surprise, Quinlan continued to breathe after the vent was removed and her parents never attempted to withdraw her feeding tube. She survived for nine more years in a nursing facility until her death from respiratory failure in 1985.

Another key legal decision related to the refusal of medical treatment was in the later case of Nancy Cruzan. In 1983, at the age of twenty-five, Cruzan lost control of her car while driving at night near Carthage, Missouri. Paramedics found her thrown from the vehicle, face-down in a water-filled ditch and without vital signs, but managed to resuscitate her. After three weeks in a coma, Cruzan was diagnosed as being in a persistent vegetative/unresponsive wakefulness state and placed on a surgical feeding tube.

In 1988, Cruzan's parents requested that the feeding tube be removed. The physicians refused to do so without a court order, because the tube removal would cause Cruzan's death. The Missouri court granted the order to remove Cruzan's feeding tube on the basis that one could withdraw treatment that promises no chance of meaningful recovery, and that Nancy had effectively instructed such withdrawal when she told a friend, prior to the accident, that she would not want to continue living if she ever had severe impairments. The case was appealed, however, and the Missouri Supreme Court reversed the lower court's decision on the grounds that no third party could refuse treatment for another person without a living will or clear evidence of personal wishes. The Cruzans appealed to the US Supreme Court, which ruled 5–4 that competent individuals may refuse medical treatment under the Due Process Clause of the Fourteenth Amendment. However, in the case of *incompetent individuals* such as Nancy, their decision sided with the

Missouri court's requirement for a "higher standard" of evidence of a patient's previous wishes. The Cruzans gathered additional evidence of Nancy's preference not to live on life support and successfully won a court order to have their daughter's feeding tube removed in December 1990; she died two weeks later, almost eight years after her accident.

The Cruzan decision was instrumental in establishing what was required for a third party to refuse treatment for an incompetent patient. Without clear evidence of a patient's wishes, the state's interest to preserve life outweighed an individual's right to refuse treatment. In the United States, this decision generated increased interest in living wills and other advance directives and motivated support for the Patient Self-Determination Act (PSDA) passed by Congress in 1990, which requires many hospitals, hospices, and nursing facilities to provide information about advance directives upon admission.

In the United States today, advance directives for end-of-life care include naming a surrogate decision maker and opting for one or two important documents. The first is a do-not-resuscitate (DNR) order signed by a physician; this is a direct medical order for emergency personnel and healthcare providers not to perform cardiopulmonary resuscitation (CPR) if a patient is unconscious or if their heartbeat or breathing stops, but it does not include details about other end-of-life wishes. The second is a "POLST form," which addresses issues left out of the DNR (POLST stands for Physician Orders for Life-Sustaining Treatment; however, the "P" can refer to any medical professional or care provider and sometimes stands for Patient, Professional, Preferences, or Palliative). Often printed on bright pink paper and available in most but not all states, the POLST is signed by a physician after conversations with a patient who is elderly, seriously ill, frail, or near the end of life. The document is a formal medical order that offers greater detail on whether the patient desires CPR in the event they stop breathing or their heart stops; it also describes the conditions under which they want to be taken to the hospital or left where they are, the types of life-prolonging interventions they would want, their desires for pain management, and if they want a feeding tube and for how long.[26] Without a DNR or POLST, hospital staff and emergency technicians are required to resuscitate someone who is not breathing or lacks a heartbeat and transport them to a hospital. They cannot stop these efforts without a medical order.[27]

A related advance directive effort known as "Five Wishes" was begun in Florida in 1996, intended to make the legal, emotional, and spiritual wishes of a patient known in straightforward language. The first two wishes include legal documents and/or medical orders:

Wish 1: A designated decision maker if a patient becomes incapacitated

Wish 2: Treatment a patient wants or does not want (e.g., if a patient is found breathing/not breathing, if a patient wants to stay where they are or go to the hospital)

The remaining three wishes address additional personal desires at the end of life:

Wish 3: Desired comfort level through pain management, bathing, grooming, hospice care options, etc.

Wish 4: Desires for how others should treat the patient (e.g., to be kept at home, to have someone pray or offer other actions at the patient's bedside)

Wish 5: Desires for what loved ones should know regarding the patient's feelings, forgiveness, arrangements for funerals, memorial services, burial, cremation, etc.

Contemporary Jain Views on Life-Sustaining Treatment. The majority of Jain medical professionals in our survey wanted the ability to refuse life-sustaining treatment. When asked, "What is most true for your own personal end-of-life care?," the majority stated that they would choose a DNR order if they went into cardiac or respiratory failure (69%, $n = 36$), while a small minority wanted "doctors to do all they can to keep me alive at the end of life" (3%). The remainder did not know (6%), had not considered it before (8%), or chose "Other" (14%). Among those who selected "Other," one participant stated they "prefer death with *samādhi* [the meditative state sought in *sallekhanā*]," and three stated that use of a DNR would depend on the specific situation.

About half of the Jain medical professionals felt that the Jain community as a whole was open to dialoguing about death, dying, and end-of-life care (47%, $n = 36$), though significant minorities disagreed (19%) or did not know (25%). Likewise, just over half of respondents in our survey had their own "living will or advance directive for end-of-life care" (56%, $n = 36$); 28 percent did not have a directive; 8 percent had not considered it; and two individuals included comments regarding their intention to pursue a directive in the future. When asked, "Do you encourage your patients, family, or friends to complete a living will or advance directive for end-of-life care? Choose all that apply," a significant percentage of participants had recommended advance directives for their patients (50%, $n = 36$), family (61%), or friends (47%).

These responses suggest that Jain medical professionals are acquainted with the ethical dilemmas that might arise when one's decision-making capacity is compromised. As with the previous question, many respondents desired the ability to forgo resuscitative treatments at the end of life. However, DNR is just one of many aspects of life-sustaining treatment, and living wills and other advance directives have frequently been criticized as being too vague, and for lacking specific guidance for third-party decision makers (Teno et al. 1997). When asked what specific life-sustaining treatments they would accept at the end of life, survey participants present a more complex picture (figure 19).

The largest percentage would accept antibiotics (36%, $n = 36$)[28] and blood transfusion (31%), while a significant minority would also accept CPR (25%), dialysis

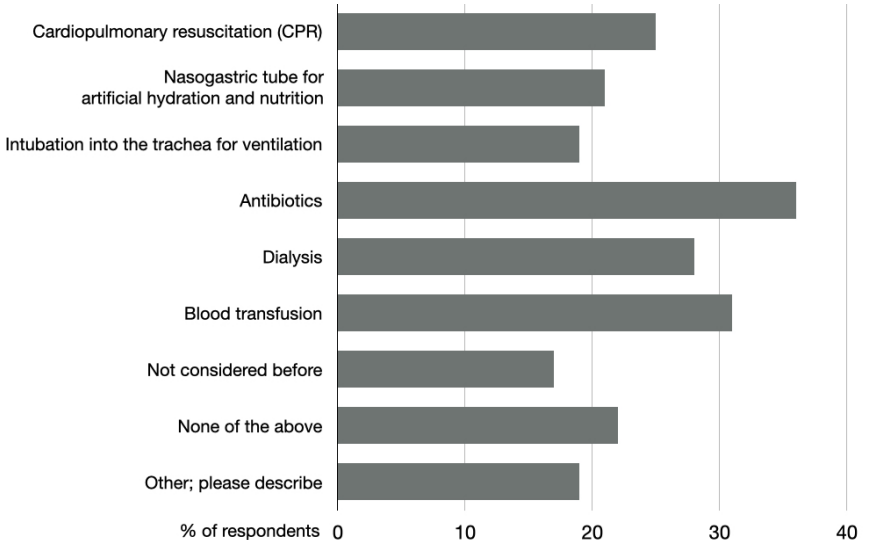

FIGURE 19. Responses of Jain medical professionals ($n = 36$) to the question "Which of the following life-sustaining treatments would you be willing to accept as part of your end-of-life care?"

(28%), feeding tube (19%), and intubation (19%). A similar minority would accept none of the available treatments (22%). Those who selected "Other" offered the following remarks:

> "Depends on the situation; but in advanced age or poor baseline health I would choose DNR; prior to this such interventions may be acceptable."
>
> "Depends on the situation."
>
> "It will depend upon the circumstances as I may consider many options if I know it is for short term."
>
> "If I know that I am dying, I do not want treatment of any kind."
>
> "Die with dignity [through] *sallekhanā*."
>
> "None of the above [treatments] contradict with Jain principles."

The Quinlan and Cruzan cases established that patients could forgo life-sustaining treatment and that third-party surrogates could also refuse this care so long as they could produce a living will, another advance directive, or convincing evidence of a patient's wishes before becoming incapacitated. In a clinical setting, the hierarchy of decision making revolves around a patient's autonomous choice, ideally expressed through informed consent or in a detailed advance directive for those who lack capacity. If no such document exists, the hierarchy of decision making falls to a surrogate decision maker who has some knowledge of the patient's wishes or values, as in the case of Nancy Cruzan's parents. Absent that

knowledge, physicians and family members exercise substitutionary judgment using the "best interests" standard for the patient's well-being.

Euthanasia and Physician Aid-in-Dying

The term *euthanasia* is derived from the Greek *eu-* and *thanatos*, meaning a good, happy, or easy death. Akin to the many types of death discussed in the Jain tradition, the good death of euthanasia can be active or passive, as well as voluntary or involuntary.

"Passive euthanasia" refers to an indirect action, typically a removal or withholding of care, rather than direct action. An example of *voluntary* passive euthanasia is when a competent patient exercises informed decision-making capacity to refuse life-sustaining treatment, which may include refusing food and fluids, as in the Quinlan and Cruzan cases above. What is morally and legally salient in voluntary passive euthanasia is that it constitutes a patient's *act of omission* in which an additional treatment is refused or removed, thereby "allowing" an underlying disease or condition to take its course, rather than a direct *act of commission* in which the act itself causes the death. *Involuntary* passive euthanasia, on the other hand, occurs when a physician withdraws a treatment without a patient's request or consent, such as unplugging a dialysis machine for a patient with kidney disease. Advance directives, including DNR and/or POLST forms, are intended to clarify a patient's wishes for precisely these times, so that surrogate decision makers and care staff can rely on those wishes to guide the maintaining, stoppage, or withdrawal of life-sustaining treatment.

"Active euthanasia" refers to a direct action that causes a patient's death. Sometimes referred to as a "gentle death" or "mercy killing," *voluntary* active euthanasia (VAE) requires a physician to act directly upon a patient who has requested that action—for instance, directly administering a lethal dose of medication to a patient who no longer wants to live. This form of euthanasia was brought into the public eye by Jack Kevorkian, a Michigan-based pathologist who claimed to have helped over a hundred patients end their lives in the 1990s. In the majority of these cases, Kevorkian utilized a machine he had built in which a patient would press a button to initiate the administration of a lethal drug, thereby "assisting" a patient in ending their own life. Because Michigan had no laws against assisted death on record, attempts to charge Kevorkian with illegal wrongdoing failed.

However, in 1998, Kevorkian released a video in which he removed the artifice of the machine and directly administered a lethal injection to Thomas Youk, a fifty-two-year-old man in the final stages of Lou Gehrig's disease. The video depicts Youk stating his informed consent, followed by Kevorkian giving a series of injections that swiftly stop Youk's heart. With this act, Kevorkian crossed an already murky legal line between aid-in-dying and the perceived killing of VAE. He was convicted of second degree murder in 1999, subsequently serving over eight years

in prison. *Involuntary* active euthanasia takes place when a fatal action is intentionally initiated without a patient's request and consent. A common example of this kind of death is when a veterinarian euthanizes a companion pet without that animal's voluntary participation or consent in the decision.

Physician aid-in-dying (PAD), also sometimes called "physician-assisted suicide," does not fit neatly into the above euthanasia paradigm. It involves a physician making lethal means available that patients must administer to themselves at a time of their own choosing. Some have referred to it as "passive-assisted death," since the physician is not actively engaging in a direct fatal act. Kevorkian's machine—which required the patient to press a button—is an example of PAD.

Dying Well as an Ongoing Moral and Legal Debate. Every living being will undergo a death of some kind. The speculations of bioethicists and judges emerge from actual situations in which there is no clear guidance. In spite of considerable consensus on the value of autonomy in making individual end-of-life decisions, there is little agreement across or within cultures—legally or morally—about the accepted ways in which individuals can end their own life. At the same time, the ongoing advancement of life-sustaining technologies and treatments confronts us with longer lives characterized by ever-greater medical interventions that can obstruct our ability to die in accordance with our desires and values.

A select group of countries have laws that permit voluntary active euthanasia as a legally acceptable mode of dying for those experiencing unbearable pain or suffering. As of 2020, these countries include Belgium, Colombia, Japan, Luxembourg, and the Netherlands. The Netherlands, considered to have the most permissive laws regarding assisted death in the world, ruled in 1986 that "psychic suffering" be included in criteria for euthanasia, resulting in the sanctioned deaths of individuals with mental illness and depressive disorders. In 2014, Belgium expanded its euthanasia statute to include children undergoing unbearable suffering, and in 2016–17, three Belgian children were euthanized after a process involving their written request and psychological evaluation: a seventeen-year-old with muscular dystrophy, an eleven-year-old with cystic fibrosis, and a nine-year-old with a brain tumor (Embury-Dennis 2018). In all other countries, it is illegal for a physician to directly administer a lethal dose of medication to a competent patient who has requested and consented to the action. As in the Kevorkian case, such an act would be deemed murder, even though the same act, when it is done to companion animals, is frequently understood to provide a "merciful" death.

Contemporary Jain Views on Euthanasia. As we discussed in chapter 6, Jainism rejects the ultimate value of mercy killing for people and animals. The possible consequences of euthanasia within the orthodox Jain view are twofold: first, the one performing, causing another to perform, or approving of the performance of death would incur negative karma, inhibiting their own path toward liberation;

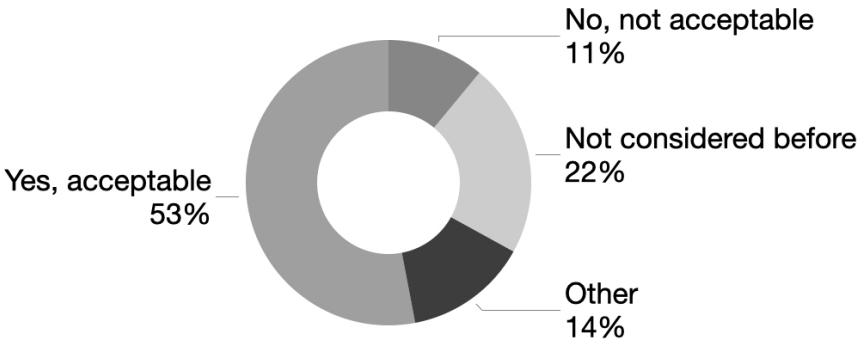

FIGURE 20. Responses of Jain medical professionals (n = 36) to the question "Certain forms of palliative care (pain relief) can potentially shorten life by depressing respiration, among other side effects. Do you feel that such pain management techniques are acceptable if they may shorten life?"

and second, it would interfere in the path of another living being, who is considered to deserve the opportunity to work through their karmic burden in their own way and time. The consequences of this Jain perspective may strike some readers as callous or cruel, whereas many Jains see active euthanasia—whether voluntary or involuntary and whether of an animal or person—as a costly act of harm to another being's ongoing existence.

However, a majority (53%, n = 36) of the Jain medical professionals we surveyed felt that palliative care, or aggressive pain medication to relieve suffering, is acceptable even if it might shorten a patient's life through depressed respiration or other side effects (figure 20). The other responses were divided among those who selected "No, it is not acceptable" (11%), those who had not considered it before (22%), and those who selected "Other" (11%). The latter included the following responses:

> "Only for terminal illness."
>
> "Acceptable if patient has consented."
>
> "Treatment depends on what the patient desires who is suffering."
>
> "If the intent of pain medication is patient comfort then I would discuss with the patient the possible consequences of shortening life and prescribe pain medication if the patient wishes."

Even more significant, a considerable number of respondents felt that a patient can make a morally correct decision to end their life in certain circumstances—for example, if that person (a) "is suffering a great deal with no hope of improvement" (47%, n = 36) or (b) "has an incurable disease" (45%). A significant minority also felt that it is morally justified to end one's life if a person (c) "is ready to die (living has become a burden)" (25%). Relatively few felt that terminating one's life is

justified if a person (d) "is an extremely heavy burden on his/her family" (6%). Still, nearly a third (27%) felt that none of the above reasons was sufficient to morally justify ending one's existence.

From the textual Jain view of the unwise death, euthanasia is more likely to prevent one's dying well than to enable it. However, not all Jain medical professionals in our survey agreed with this view. When asked if they felt that VAE of a consenting, terminally ill adult constitutes a form of violence, slightly more respondents agreed (39%, $n = 36$) than disagreed (33%). Those who added comments wrote, for example, that "it depends on the will of the person," while another stated that "intention is important." Modern Jains who integrate Jain values with the demands of clinical medicine are not of one voice regarding active euthanasia.

Contemporary Jain Views on Physician Aid-in-Dying. A larger number of countries have legalized PAD than euthanasia. Worldwide, as of 2020, PAD is permitted under certain conditions in Belgium, Canada, Colombia, Germany, Japan, Luxembourg, the Netherlands, Switzerland, and certain states in Australia and the United States. As with VAE, advocates disagree on whom these laws should apply to. In Canada, for example, legislation is currently being debated that would open PAD to patients who have only mental illness and no underlying physical malady. In the United States, PAD is not legal at the federal level, though growing public support has enabled several states to successfully introduce so-called "death with dignity" laws permitting PAD under certain guidelines. As of 2020, California, Colorado, Hawaii, Maine, Montana, New Jersey, Oregon, Vermont, Washington, and the District of Columbia permit regulated forms of PAD, and advocates are committed to pursuing similar statutes in every state.

Opponents of PAD in the United States—including the Catholic Church and other religious organizations, some disability-rights groups, and certain medical ethicists, among others—raise legitimate concerns about assisted dying that state-based initiatives have tried to address. Chief among these issues is the contention that PAD is not a truly autonomous act because it requires the participation of a physician and pharmacy staff who must involve themselves in another's death, and thus contributes to a pervasive cheapening of human life at a social level, beyond mere personal decision making. Critics also see PAD as a "slippery slope" to sanctioning euthanasia for those who are depressed or lonely, for individuals with mental illness or physical disability, and for the elderly, the homeless, or anyone else society deems undesirable or useless. While advocates insist that only those who are truly suffering would pursue this avenue, it is worth considering whether a person who fails to have a "meaningful life" in the normative sense of regular happiness, family, friendships, meaningful work, being able-bodied, or being distress-free might be more inclined to explore assisted death if it were available, rather than the creative challenge and therapeutic interventions involved in coping and thriving with non-normative experiences that are not acknowledged

or welcomed in media and society. Finally, critics argue that PAD contradicts the physician's oath to "do no harm" by enabling others to actively end life.

The 1994 Oregon Death with Dignity Act has served as a model for several states (and countries) attempting to address these concerns by permitting physicians or institutions to refuse participation, allowing only adults eighteen years and older with a terminal diagnosis of less than six months and demonstrated decision-making capacity to initiate PAD. The process also requires an oral and written letter of request from the patient, an evaluation by two physicians, referring the patient to counseling or psychiatric services if needed, and a mandatory waiting period between the request and the writing of a prescription.

Still, considerable controversy persists. Advocates note issues of access. Even if a state legalizes PAD, the ability of doctors, pharmacists, and institutions to opt out makes the "right" to PAD an empty one that many patients cannot actualize. In the Coachella Valley region of Southern California, for instance, three of the largest healthcare systems have opted out, making it difficult for patients to find a doctor who will write the prescription or a pharmacy to fill it (Aleccia 2017). Additionally, federal funds cannot be used for PAD, so patients on Medicare as well as patients of the Department of Veterans Affairs cannot have these costs covered. Opponents note examples of abuse. One 2008 study showed that one in six patients who sought and received prescriptions for lethal medication was clinically depressed (Ganzini et al. 2008).

Jain medical professionals in our survey had varied opinions on PAD. When asked if aid-in-dying is a form of violence, respondents diverged, with equal numbers of agreement and dispute (33% each). When asked, "Have you ever provided physician aid-in-dying (PAD) services or counseling at the end of someone's life in your medical/healthcare career?," a small minority answered affirmatively (11%, $n = 36$). The majority had not (64%), while the remainder chose "Not applicable" (25%).

Sallekhanā *and US Policy: PAD versus VRFF and Terminal Sedation*

The Jain practice of *sallekhanā* does not fit into the category of aid-in-dying, though it rests on a similar commitment to autonomy and has a detailed set of regulations to ensure its responsible practice. Because it involves the gradual refusal of treatment, as well as solid food and liquid nourishment, *sallekhanā* could be described as a form of voluntary passive euthanasia in which a person is "allowed to die." Dilip Bobra, in his brief analysis of Jain bioethics, writes that "Jainism tries to answer the questions of physician-assisted suicide and 'death with dignity' by voluntarily making the decision to plan *sallekhanā*." He continues: "This is very similar to a non-written directive, after the opinion of [a] physician that there are no possible options of treatment" (2008).

This comparison opens an especially rich arena for Jains to engage with end-of-life practices and policy in India, the United States, and other diaspora countries

that limit legal options for voluntary euthanasia. If we look to the United States as a case study, only two modes of voluntary euthanasia are legal at the federal level. The first form is the voluntary refusal of food and fluids (VRFF), also called voluntary stopping of eating and drinking (VSED). The second is terminal sedation.

The US Supreme Court has been unwilling to make PAD the law of the land, in part, because VRFF already exists as an alternative (Bernat et al. 1993; Quill and Byock 2000). According to the Court, VRFF is a preferable legal alternative to PAD because it is already enshrined in law under the right of competent patients to refuse or withdraw treatment. In one influential study of Oregon hospice nurses who cared for a patient who undertook VRFF, the majority of nurses rated their patient as having a "good death" using a provided scale, while only a small minority described the patient's experience as a "bad death" (Ganzini et al. 2003). Such studies suggest that patients can exercise their principled self-determination while medical staff can focus on providing palliative care rather than a lethal dose of medication. Per the court, VRFF is potentially less likely to be abused and is also seen to be reversible, in that patients can resume food and fluids at any time (Quill et al. 1997).

Terminal sedation is closely related to VRFF. When patients experience extreme pain that cannot be relieved by high doses of common pain medications, it is legal for a medical professional to continuously sedate the patient into an unconscious state; this is typically followed by the withdrawal of artificial nutrition and hydration, until the patient dies. From a legal perspective, terminal sedation acknowledges that the cause of death is the underlying disease rather than an active intervention of the doctor.

Some critics, however, claim that VRFF and terminal sedation are actually more problematic than either PAD or active euthanasia. VRFF opponents assert that physicians must still collaborate with patients in an act that is not altogether different from suicide (Jansen 2015; Jansen and Sulmasy 2002). Although many "death with dignity" advocates acknowledge that VRFF can be an effective and meaningful end-of-life choice for some patients, many emphasize the challenges and ambivalence of dying through dehydration for patients and families. In an influential public opinion piece, California physician Christopher Stookey described his own father's death by VRFF after seven days, documenting arm movements and accelerated breathing that seemed to indicate prolonged distress until his father lost consciousness on the sixth day. Stookey reasons, "The moment we'd decided to withhold fluids, my father was on a sure path to death. . . . Why did we have to wait 6 days to reach this point?" (2015).

Critics of terminal sedation claim that there are insufficient data on the suffering that patients undergo in an unconscious state (Rady and Verheijde 2012). Others also assert that terminal sedation poses greater risks of abuse than either PAD or active euthanasia, since it does not have the extensive consent process, and also results in a patient who will likely be incapacitated for several days prior to death (Orentlicher 2010). According to physician and attorney David Orentlicher,

the approval of terminal sedation reflects the "Court's deference to symbolic considerations" that privilege the appearance of "allowing to die" over a treatment that is essentially active euthanasia (2010, 417). The informed consent process of PAD, Orentlicher argues, better exemplifies a physician's duty to relieve pain, in that it is preferable for patients for whom death is imminent and who do not wish to linger in an unconscious state in which pain and suffering may be undetectable to outside observers.

How might the Jain community weigh in on these end-of-life debates? The practice of *sallekhanā* is, at the surface, most similar to VRFF, which is legal in many countries under the right to refuse treatment. Indeed, the Supreme Court of India passed such a law in March 2018, permitting patients to refuse life-sustaining treatment through advance directives. Upon the announcement, a well-known Digambara monk, Taruṇ Sāgar, publicly praised the Court's decision, even as the nation's Catholic bishop denounced it. Taruṇ Sāgar, whose response was reported across national media outlets, stated: "Today, the Supreme Court has given a historical ruling, which has been a law in Jainism for ages. I thank the Supreme Court [for the verdict]" ("Passive Euthanasia Legalised" 2018).

Jain medical professionals, however, had diverse opinions on the modes of dying that should be available to patients at the end of life. Among respondents, 28 percent ($n = 36$) affirmed that "PAD should be available to any consenting, competent adult when terminal illness has been clinically diagnosed." A significant minority felt that PAD is never justified because of the karmic burden it places upon the physician (22%) or upon the patient (19%). Only 11 percent of participants believed that "PAD is completely different than *sallekhanā*," which suggests that most respondents see some overlap between the two processes (figure 21).

Interestingly, over half of respondents (53%, $n = 36$) agreed that *sallekhanā* "is a better alternative to PAD for Jains," while 36 percent felt that it is also a better alternative to PAD for *non-Jains*. The fact that Jains see *sallekhanā* as having value outside the Jain community suggests that voluntary fasting unto death can be appreciated by those who do not share the overall Jain worldview. US bioethicist Dena Davis asserted this very point over twenty-five years ago, stating that *sallekhanā* could help Western medical practitioners and patients "break our automatic association of starvation with moral evil" and offer "an image of food refusal that is associated with voluntariness, with the fulfillment of a life span, with the last chapter of a completed narrative" (1990). Likewise, Chapple asserts that the paradigm of legal "rights" related to death might be enriched by encountering Jain "rites" that reflect a unique understanding of the self in relation to the body, to other beings, and to an existence that extends beyond one lifetime (2016a). In the final section of this chapter, we reflect on five principles of application for dying and death. Some are unique to the Jain worldview, and others—primarily derived from the insights of *sallekhanā*—may offer common ground to support a Jain engagement with contemporary bioethical debates related to the end of life.

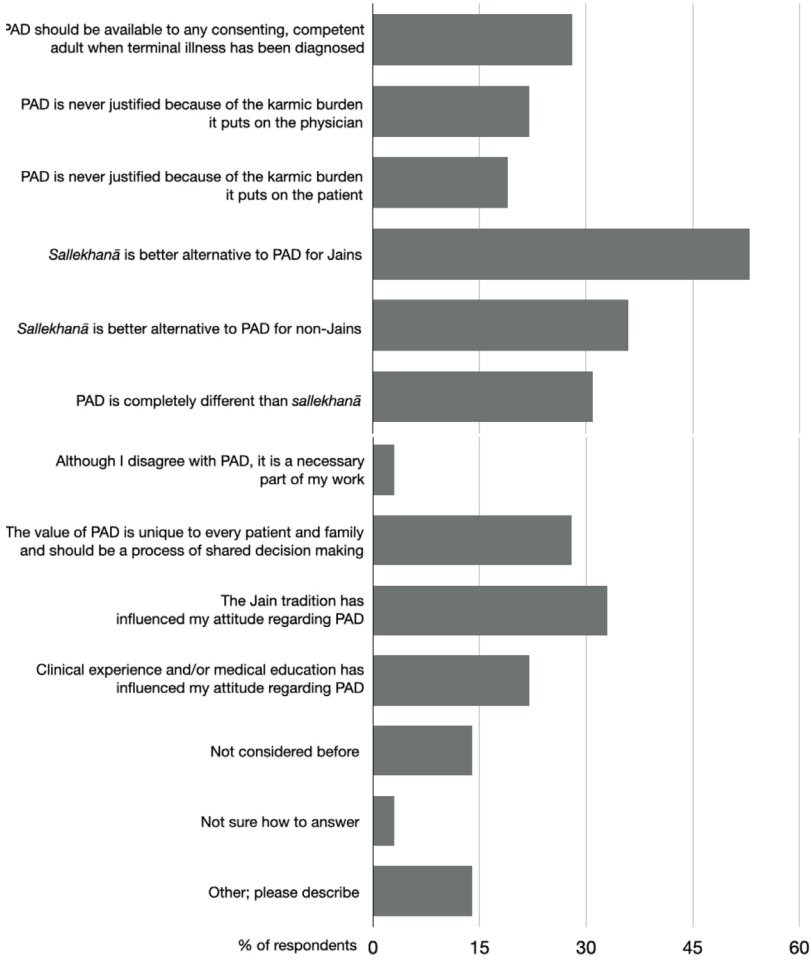

FIGURE 21. Responses of Jain medical professionals ($n = 36$) to the question "Which of the following statements [regarding physician aid-in-dying (PAD)] is/are most true for you? Choose all that apply."

JAIN PRINCIPLES OF APPLICATION FOR DYING AND DEATH

Jains understand death, like rebirth, as a transition point within one's overall karmic journey, which may span innumerable lifetimes. The inevitability of old age and death provides motivation to strive for right worldview, knowledge, and conduct in order to shed karmic attachments and advance oneself toward a better rebirth, a possibility open to mendicants, laypeople, and even animals. While most of the Jain medical professionals in our survey identified with the currently prevailing medical definitions of death—namely heart-lung criteria,

whole-brain death, or brainstem death—their overall support for organ donation as a Jain-inspired act of merit, their support of advance directives (for themselves and others) that enable them to forgo medical care, and their ambivalence with accepting certain life-sustaining treatments are suggestive of a keen awareness about dying wisely.

The wise and voluntary death of *sallekhanā* is widely seen as the ideal means by which a Jain can die well. The practice of *sallekhanā* looms large in the Jain imagination, defended in both historical and modern times as a value-laden mode of dying that is counter to the violent impulses of suicide. At the same time, while "mercy killing" is not accepted in the textual tradition, about one-third of Jain medical professionals in our survey viewed active euthanasia as well as physician aid-in-dying as morally and medically acceptable, demonstrating a departure from orthodox belief. Drawing upon the insights of *sallekhanā*, we identify five additional Jain principles of death and dying.

First, autonomy is a critical, but insufficient, criterion for end-of-life decisions. The act of *sallekhanā* always takes place within the bodily, environmental, and cognitive constraints of a given life. It requires a process of preparation and ideally takes place in a community that understands the person's wishes and supports their values. The practice of fasting is a way to expand autonomy by enlarging one's experience and understanding of the self through one's relationship to others.

Second, life-sustaining treatments are a meaningful aspect of end-of-life care. Dying is not an all-or-nothing process; the vow of *sallekhanā* contains many steps, prior to the final vow of unlimited fasting, in which one can weigh the costs and benefits of a specific treatment.

Third, maintaining awareness and agency is a valuable part of the dying process. The vow of fasting is an attempt to consciously approach death with awareness and determination, applying the values of one's life to the experience of dying. Efforts to enshrine POLST forms, as well as the "Five Wishes," resonate with this aspect of *sallekhanā* by creating a framework that requires discussion between patient, loved ones, and caregivers and involves a more holistic framework to think through the medical, emotional, and spiritual significance of death, especially as one advances in age or illness. The significant support of PAD by Jain medical professionals in our survey suggests that the required steps of informed decision making may be compatible with certain aspects of *sallekhanā*, insofar as they allow a patient to maintain awareness up to the moment of death. It is not clear whether terminal sedation would be theoretically welcomed by Jains, since it forces one into an unconscious state.

Fourth, limiting one's use of material resources at the end of life has personal and social benefits beyond "allocation" debates. The practice of *sallekhanā* reflects the real costs of living in a dynamic universe where life requires life. Forgoing food and water is an act of compassion for other life-forms that benefits oneself during life and at its end. Healthcare debates regarding the "allocation of resources" between those at the end of life and those who have a longer life ahead

of them give way to a relational understanding of responsibility and care for self and others.

Fifth, and finally, it is a meaningful goal to approach death without fear. Meeting death with a calm state of mind is paramount in *sallekhanā*. Cultivating this state requires practice and community dialogue about our common experiences of aversions and attachments, which shape our attitudes toward identity, body, daily life, and death, and which perpetuate anxiety rather than equanimity.

Articulating these and other possible principles may be just as important within the Jain community as outside it. While Braun claims that "*sallekhanā* is being practiced in the United States," only a very few cases have been documented (2008, 923). In 1997, Vijay Bhade, a forty-three-year-old Jain mother and wife from West Virginia, undertook a final fast after six months of unsuccessful treatment for sarcoma (Chapple 2010, 206). Bhagwati Gada, a retired physician in Texas, undertook a short-term fast in 2013, after her colon cancer progressed to stage 4 and she declined further treatment (Eplett 2015). The "Guidelines for Healthcare Providers Interacting with Patients of the Jain Religion and Their Families" (2002), created by the Jain Society of Metropolitan Chicago in conjunction with the Council for the World Parliament of Religions, mention the practice of *sallekhanā* (called *santharo* in the guide), stating that it is a "personal choice done with the advice of a spiritual leader . . . generally done away from the hospital" ("Guidelines" 2002, 6). This view suggests that *sallekhanā* is a private practice that has little bearing on the clinical context.

Yet, with the recent litigation in Rajasthan regarding *sallekhanā*, the global Jain community may be poised to deepen their engagement with modern medicine regarding end-of-life care. Jains mobilized around the world to protest and overturn the High Court's 2015 ban and continue to lobby to safeguard the practice ("JAINA President's Message" 2017, 8). Videos and articles by Jain laypeople and mendicants have proliferated on the internet, offering detailed support for the end-of-life fast, which has also been featured in documentaries and a *National Geographic* special on unique death rituals.[29] It remains to be seen whether Jains will bring the traditional insights of a wise voluntary death into modern biomedical debates or maintain it as a religious ritual that takes place in the private sphere.

Among legal options for death in the United States, *sallekhanā* is most parallel to the voluntary refusal of food and fluids. Given that a significant number of respondents felt that *sallekhanā* could offer a meaningful alternative to physician aid-in-dying for Jains as well as non-Jains, Jains might have unique contributions to public discourses on end-of-life care. There is similar overlap with initiatives such as POLST or Five Wishes, which articulate and support holistic dying initiatives that understand medical decisions in light of one's physical, emotional, and spiritual fears, hopes, and aspirations. Uniquely, Jains also extend these conversations into wider consideration of the many one- through five-sensed beings in existence who are affirmed when use of medicines, food, fluids, and water is dialed back.