

The Development of Indigenous Hospice Care and Clinical Buddhism in Taiwan

Jonathan Watts & Rev. Yoshiharu Tomatsu

*Published in Buddhist Care for the Dying and Bereaved. Edited by
Jonathan S. Watts and Yoshiharu Tomatsu (Boston: Wisdom Publications, 2012) in
collaboration with the Jodo Shu Research Institute (JSRI)*

Introduction

As we have seen in the opening chapters of this volume, although Japan is considered a predominantly Buddhist country with a long and deep tradition dating back to the 6th century, Buddhism has been in decline in the modern era. The advance of modern, secular culture has driven it out of most public places and facilities. Taiwan, on the other hand, presents us with an interesting comparative case in that it too has inherited a deep Buddhist tradition from Mainland China as well as developing a strong modern, secular culture from both the west and Japan. Taiwan, as a relatively new nation, however, exhibits some fascinating trends in the development of Buddhism in the social sphere.

With the weight of ancient Chinese traditions being somewhat lighter in this new nation state and little influence from communist China's strong anti-religious sentiment, Taiwanese Buddhism has been able to recreate itself and its role in society. Since the 1960s, a number of large and prominent, new Buddhist denominations have arisen in Taiwan, most conspicuously the "Four Mountains" of Fo Guang Shan, Tzu Chi, Dharma Drum, and Zhongtai Temple. They have revived a rigorous monastic study and practice that has been largely lost in Mainland China and given birth to the strongest movement of fully ordained women (*bhikkhuni*) in the Buddhist world. At the same time, these groups have developed very robust lay memberships. In general, this revival movement has paralleled Taiwan's rise as one of the Asia's economic tigers. In this way, many Taiwanese, monastic and lay together, find no apparent separation or alienation between their Buddhist faith and practice and their daily lives and work. Indeed, many of these new Buddhist organizations have promoted civic participation and volunteerism as a core value to their monastics and lay followers. These trends are in great contrast to the wide chasm between the Japanese Buddhist world and mainstream Japanese society.

In this chapter, we will look at one of the most compelling forms of this integration of Taiwanese Buddhist practice and modern, secular culture in the Clinical Buddhism movement. It is fair to call this an actual movement as the training and dispatch of Buddhist monks and nuns in hospice and end of life care has spread throughout the country and is being sponsored by numerous different medical and Buddhist organizations. In this chapter, we will focus on the most prominent and compelling example of this work based out of Taiwan's largest and most prestigious hospital, the National Taiwan University Hospice and Palliative Care Unit.

Preparing the Ground

The National Taiwan University Hospice (NTUH) and Palliative Care Unit was the first public unit established in Taiwan in 1995, after private hospices had been established at the Christian Mackay Memorial Hospital in Tamsui in 1990 and the Catholic Cardinal Tien's Hospital in Hsindian in 1994. At this time, Prof. Rong-chi Chen was the Vice Superintendent of NTU hospital and had become aware of the need for Buddhist monastics to be involved in patient care. He explains, "Although spirituality doesn't necessarily pertain to religion, if religious representatives can become fully involved, the spiritual care that they could provide would be much more effective."¹ Prof. Chen also notes that Christian denominations have had specific training for chaplains to serve in hospitals and other places yet Buddhist groups have not. As 70-80% of Taiwanese are Buddhist, he and his colleagues thought it would be good to identify some enthusiastic monks and nuns to begin such training. The major obstacle they discovered, however, was that Buddhist monastics were not used to working in such intensive medical environments. Eventually, everyone in this first training group of candidates dropped out. From this experience, Prof. Chen and his colleagues realized they needed a systematic form of chaplain training.

In the previous year, 1994, a group of people from Buddhist universities, both ordained and lay, created the Buddhist Lotus Hospice Care Foundation (BLHCF) to promote hospice and palliative care and Life & Death Education. Prof. Chen was serving as the President of the BLHCF and together they began a systematic plan for a full-fledged clinical Buddhist monastic, hospice training program. They asked Dr.

¹ *The Lotus Blossom: The Clinical Buddhist Monastics Practicing in Hospital Sites*, DVD (Taipei, Taiwan: Buddhist Lotus Hospice Care Foundation, August, 2009).

Ching-yu Chen, the Head of the Department of Family Medicine at NTU Hospital who oversees the NTU Hospice, to design, coordinate, and run this training program. Dr. Chen sees himself as a mediator helping to merge Buddhism and medical science and to provide monastics with proper clinical training. He remarks that 10% of the Taiwan population is now elderly but that this will climb to 20% in the next twenty years. In this way, the issue of death is becoming increasingly important, yet education about life should also be developed. Thus, Dr. Chen feels monastic clinicians with their grounding in a traditional and deep understanding of life based on Buddhism can offer Taiwan's industrialized society something very important in these coming years.²

Finally, Ven. Huimin, the President of Dharma Drum Buddhist College, was brought in as Dr. Chen's spiritual, clinical counterpart. With the support of the Buddhist Lotus Hospice Care Foundation (BLHCF), they began an initial three-year period of preparatory work in 1995 that focused on developing doctrinal and teaching standpoints from Buddhism for hospice and palliative care. Besides training and supporting Buddhist clinical chaplains, BLHCF also works to educate the larger public through seminars on death and dying issues. This education of the general public is equally as important as some Taiwanese, like Japanese, fear the site of religious professionals in the hospital as harbingers of death. Eventually, this collaboration between NTUH, the Buddhist Lotus Hospice Care Foundation, and Ven. Huimin and other Buddhist monastics led to a national program for training monks and nuns in hospice and terminal care through the establishment of the Association of Clinical Buddhist Studies in 2007. The mission of this association is:

1. To integrate medicine with Buddhist studies, develop a spiritual care model indigenous to the culture of Taiwan, and enhance the quality of palliative care for terminally ill patients.
2. Plan and host research activities, education programs, and training courses with a focus on clinical Buddhist studies.
3. Incorporate hospice/palliative care and life education as integral components of health promotion activities and courses.
4. Assist in the professional education of clinical Buddhist chaplains and expedite

² *The Lotus Blossom.*

ongoing development and research.

Developing an Indigenous Spiritual Care Model

The senior doctors at NTU who established this hospice, specifically Dr. Chen, received a strong influence from the hospice tradition of the United Kingdom after visiting and studying at St. Christopher's hospice with Cecily Saunders. They have also been influenced by hospice care in Hong Kong and Singapore, which has also been influenced by the U.K. hospice movement. The deputy superintendent of NTUH, Prof. Rong-Chi Chen who established this hospice, received a strong influence from the hospice traditions of Japan after visiting several hospice and palliative units in Japan in 1994. On the other hand, Ven. Huimin has been one of the leaders in the group to develop an indigenous spiritual care model that better suits the style of Taiwanese culture that is predominantly Buddhist. At the same time that NTUH was set up in 1995, Ven. Huimin and his colleagues began to look for a pattern and vocabulary that would fit the cultural background of Taiwan and the needs of this region. Defining "Clinical Buddhism" was an important first step, and they eventually developed the following one: Clinical Buddhology is the contemporary excellence of integrated medicine with the Buddha's teachings for end of life care. This work covers six areas: 1) end of life suffering, 2) death preparation, 3) life meanings and affirmation, 4) clinical practice of the Buddha Dharma, 5) fear of death, and 6) spiritual and life education.³

Another important task was addressing the differences in the occidental and East Asian view of the person and the self. Ven Humin explains that when the idea of "whole person care" was introduced to Taiwan, medical care was developed that addressed "physicality, mind, and spirit." This type of occidental thought, which typically sees the human as consisting of body, mind, and spirit, puts a greater focus on "spiritual care." For example, in cases regarding the administering euthanasia, Ven. Huimin remarks that we often find two emphases: one that separates the person into body and mind; and a second that focuses on a "spirit" that transcends the body and exists separately. If we follow the explanation that the essence of life is nothing but the body and mind, then curative medical care that prolongs life will be emphasized, for example, in the case of a patient with terminal cancer.

³ Ching-Yu Chen, "End of Life Indigenous Spiritual Care in Taiwan: Foundation for Clinical Buddhology" (lecture, National Taiwan University Hospital, Taipei, September 28, 2009).

In contrast, Buddhism sees the person as consisting of body, feeling, mind, and dharma (i.e. the Four Foundations of Mindfulness 四念住 as taught in the *Satipatana Sutta*). This approach focuses more on “awareness care” than “spiritual care.” The two core Buddhist teachings of Not-self and Dependent Origination offer a different view of life from the ones that posit the separate existence of a “true self” or a “spirit” that eternally never changes, or the idea that the body and mind both totally extinguish at death. From the viewpoint of Buddhism, the essence of life comes down to a middle way of seeing the reality of life as neither total extinction nor everlasting eternity. Following this middle way of thinking, besides the body and mind, there is an object (not a “spirit”) that can experience absolute illumination of the dharmas of reality, law, and duty. Further, the necessary condition for the arising of “mind” is “feeling,” which changes in suffering and happiness and in life and death. In terms of hospice care, euthanasia and assisted death can be performed in accord with the concern for the person whose feeling and mind are experiencing unsuitable symptoms and levels of pain. Through deeply recognizing the four aspects of a patient, their own body, feeling, mind, and dharma, they can develop a keen awareness and equanimity. By practicing this kind of “awareness care,” we can help the dying person to purify their mind and at the same time enter the dharma of the fundamental practice of Buddhism.⁴

Ven. Huimin and this Clinical Buddhist working group have developed a process for engaging in such “awareness care” based on the Buddha’s Four Noble Truths as follows:

1) Suffering: Because of the comprehensive suffering of a terminally ill patient, clinicians must engage in “truth telling,” that is, inform the patient and their family of the patient’s terminal prognosis. At NTU Hospital, they push doctors to engage in such practice, and approximately 50-60% of patients do know their prognosis. In Taiwanese culture, however, 80% of families tend to not want to have this information communicated to the patient.⁵ Since they feel this is essential at NTUH, they communicate such news through a family conference with the patient, family, and the entire clinical team assigned to that

⁴ Huimin, “The Cultivation of Buddhist Chaplains Concerning Hospice Care: A Case Study of Medical Centers in Taiwan,” trans. Jonathan Watts (lecture, Dharma Drum Buddhist College, Taiwan, September 29, 2009).

⁵ Chen, “End of Life Indigenous Spiritual Care in Taiwan.”

patient.

2) The Cause of Suffering: If a patient's health continues to deteriorate, they are encouraged to accept death. On a passive level, this means that in working with a patient's physical and mental pain and suffering helping them come to an acceptance of death can help relieve this pain. On a more active level, such an acceptance of death can lead into seeing death as part of the continual learning process of the journey of life. In this way, the team tries to fulfill the patient's final wishes and to affirm the meaning and value of their life (strength from inside), and to affirm the care of the medical team (strength from outside)

3) Nirvana: The end of suffering happens in the development of a sense of spirituality, which in passive terms means achieving relief of physical pain and tranquility of mind, and in active terms means a change in one's behavioral patterns through cultivating Buddha nature, nurturing compassion, and letting go of possessions. In the following chapter on Thailand, we will see a similar emphasis on the potentiality of the person to continue to grow spiritually in their final days even as their bodies completely deteriorate.

4) The Path to Nirvana: The path involves the practice of Buddha Dharma, which in passive terms means the feeling of being guided towards salvation, and in active terms means one's own attainment of salvation. The result is a "good death," which includes awareness of death, accepting it peacefully, preparing properly including arranging one's will, and timing the death appropriately.

Dr. Ching-yu Chen recalls one patient suffering from terminal oral cancer as a good illustration of this above process. The primary care Buddhist chaplain in this case designed many survey methods to communicate with the patient and to evaluate his physical and mental conditions everyday. The patient had his first contact with Buddhism upon arriving for palliative care at NTUH, but quite shortly he became a very active practitioner, either reciting Amitabha Buddha's name or listening to the dharma talks on tape everyday. He developed great confidence in Buddhist chaplain's care and dreamed one night that the chaplain led him to Amitabha's Pure Land. On the day before his death, he took formal refuge in Triple Gem of Buddha, Dharma, and Sangha, even managing to chant out loud through his severely damaged throat. On the day of his death, his consciousness was very clear. About an hour and half before his death, he knew his time was coming and under the guidance of the Buddhist chaplain, he lied on his bed and

peacefully passed away. Dr. Chen notes that this patient re-affirmed their belief that palliative care provides one of the best chances for spiritual cultivation not only for patients and families but also care staff. For the care staff, the patient becomes a teacher for them in how practice dying. Dr. Chen concludes that the Palliative Care Unit “is a *vihara* or practice hall (道場) that encourages the patients, the relatives, and the team members to grow together.”⁶

Clinical Monastic Training Program

In 1998 the training program for clinical Buddhist chaplains began. The Buddhist Lotus Hospice Care Foundation sponsored this initial training. They continue to support these students and the already certified chaplains with small stipends for transportation, since it is considered that monks and nuns should not receive salaries. Monastics ranging in age from 28-40 participate in nurse medical training and receive academic credentials. The program lasts of over five years with more than sixty hours of hospice and palliative care study. Candidates are first interviewed about their motivation and education level and then are selected for the program. The training consists of four stages:

1. General Education: a twenty-eight hour course delivered by the experts in the hospice care team on the meaning of hospice and palliative care and the roles played by each and every one of the care team, which includes physicians, nurses, psychologists, social workers, monastics, and volunteers.
2. Shared Courses: a 16-hour course open to Buddhist monastics and also to clinical professionals, which communicates the definition and meaning of spiritual care developed in their research system and how it works.
3. Profession 1: a 14-hour course for only monastics who have undergone the first two courses. It covers key issues for working in hospice and palliative care environments, such as “How does spiritual care work?”; learning how to read, understand, and make use of a patient’s medical record; how to use Buddha Dharma to care for the patient and what dharmas are frequently used.
4. Clinical Internship: a 4-week course in which the monastic must be involved in one

⁶ Ching-Yu Chen, “Clinical Buddhist Chaplain based Spiritual Care in Taiwan” (lecture, International Association of Buddhist Studies Conference, Dharma Drum College, Taiwan, June 25, 2011).

complete case. They must keep records of their dialogues with patients that are then given critical comments and suggestions by the instructors and professors. There is then an assessment of the student's qualities as to whether they are fit for the work. After passing this assessment, they may proceed to clinical training in which the monastic participates in fuller practice as a member of the care team. The clinical experience follows a self-learning, problem oriented model. The trainee should continuously assess what problems need to be solved and evaluate carefully problem-solving priorities. During the process, they observe and determine themselves whether they have to go further. They are supported in this process through small group discussion and sessions focused on the integration of clinical medicine and Buddha Dharma with leading staff at NTUH.

Over the last ten years, seventy-three monastics have been involved in the training program, beginning with just two in the initial year of 1999 but quickly growing to seventeen by 2002. By 2009, twenty-nine had completed the full internship, all of whom are now working as clinical monastics in hospice and palliative care wards across the country, such as at Chungshan Medical University Hospital, Chinese Medical University Hospital, and Veterans General Hospital Taichung.

Bhikkhuni Tsung-Teung was the first monastic to be trained in this program, under the guidance of Dr. Ching-yu Chen, and is now the Secretary General of the Association of Clinical Buddhist Studies. She has been a nun since 1987 and has been involved in this training since 1999. She recounts that she had a hard time adjusting from a monastic environment to a hospital one. She had to learn how to interact and communicate with people in a way very different from interactions at the temple. At first, this is a big challenge for monastics. The monastic clinician must learn to refer to the physicians and nurses to find out about the patient's family and about their needs as well. By developing a relationship with the family, they can better make a connection with the patient. The monastic clinician also develops a care plan, which is re-evaluated and altered as needed before continuing on. Despite these challenges and new skills that must be learned, Ven. Tsung-Teung says that the role of religious professionals in a hospital is an ordinary thing. She notes that patients will usually ask more from a religious professional than from a nurse or social worker and that 71% of patients will ask for

spiritual care from monk or nun.⁷

Bhikkhuni Der Chia completed the training in 2005 and became chief instructor responsible for training and assisting Ven. Tsung-Teung at NTUH. Ven. Der Chia also speaks of the difficulties for monks and nuns to learn how to do this kind of work. She says that many monastics, even high level ones, may just offer the dying very standard phrases like, “Just think positive.”; “You have to let go.”; “You cannot do anything now.”; “Just try to clear your mind for Birth in the Pure Land of the West.” She says that, “Before I came to the training program, that was the method I used to treat a patient. Even though I knew that at that time and situation this method was incorrect, I was at a loss for what was the correct thing to say and consequently had a lot of apprehension ... When speaking those phrases, I feel like I’m walking upon clouds with a large sense of disconnection. Even to the point that when I finish those phrases, I feel very sad deep down.” This way of dealing with a patient may often neglect their needed emotional support and recognition. Thus, in the training program they learn how to listen and to empathize with the patient’s predicament and then guide them through a more realistic process of their eventual death.⁸

In this way, the program has the stated goal that every fully trained monastic clinician must have the following qualities:

- ✧ Possesses a full understanding of hospice and palliative care
- ✧ Respects medical teamwork and the need to develop various clinical skills
- ✧ Capable of rendering care as a listener, supporter, and provider of new ideas
- ✧ Enthusiastic and eager to serve people as a life-death explorer

These competencies, especially the shift from the method of preaching for a temple minister to the method of listening for a hospital chaplain, are fundamental points for the training of chaplains, which we have seen across cultures in the chapters presented in this volume.

Building a Team Care System

At NTUH, there are seventeen beds, which are almost always full and are predominantly for cancer patients who are at or after stage four. Liver cancer and lung cancer are the

⁷ *The Lotus Blossom.*

⁸ *The Lotus Blossom.*

most common forms. ALS patients are also admitted, though these cases represent only a very small rate of 1%. Taiwan's national insurance system limited public hospice care to these two diseases until September 2009 when it expanded care to cover almost all terminal illnesses, such as the terminal stages of organ failure to the brain, heart, lung, liver, or kidney. Seventeen days is the average stay at the hospice, and this short period is partly because of the misconception by people of what palliative care means. There is still fear and stigma among Taiwanese behind being admitted to a hospice, so many do not want to come any earlier. At NTUH, they do not perform resuscitation, and the patient's family must sign a waiver upon their entry. In Taiwan, such decisions are still usually the role of the family, since many Taiwanese, like Japanese, do not believe in "truth telling" to the patient. In this way, the patient may not really know they are dying when they are first admitted to the hospice. Dr. Rong-chi Chen and the NTUH team have thus been promoting the Do Not Resuscitate (DNR) advance directive in order to change both the modern medical culture of heroism and the traditional Chinese culture of filial piety that chooses saving a person's life at all costs over compassionately guiding them to death.⁹

NTU Hospice has two senior doctors on call out of a pool of fourteen. There are two to three 3rd year residents, who do a two-month residency and a one-month home care residency. There are seventeen nurses, one per bed as by national regulation. There are also three to four clinical psychologists who are still in training and shift every six months. They do psychological assessments, give advice to the team on care, and deal with patient depression and anxiety, etc. They will also seek help from their supervisor who may come to the hospice to assist. There are two art therapists who do bereavement support and help for the families as well as the patients; for example, supporting an elder sister who was feeling neglected by her parents because they were attending to the younger sister who was dying. The art therapists may guide patients in copying pictures of Kannon Bodhisattva, and the patients may add their thoughts to these pictures or actually speak to Kannon through them. There is also the sense of traditional Buddhist making merit from copying such pictures. There is a pool of seventeen to twenty monastic chaplains with two to three on call in the ward at any one time. The team is rounded out by a base of fifty volunteers who work in shifts of five in the morning and five in the afternoon. They assist the medical professionals, cook food that may include Chinese medicinal herbs, read the

⁹ Rong-Chi Chen, "The Spirit of Humanism in Terminal Care: Taiwan Experience," *The Open Area Studies Journal* 2 (2009): 7-11.

patients books, help organize special events at the hospice like concerts and birthday parties, and help patients with special requests like facilitating a visit by a particular person or taking the patient on a final visit somewhere.

The core principle of the NTU hospice is “team care” amongst the doctors, nurses, social workers, psychiatrists, and clinical chaplains. Every Tuesday morning for two hours the entire team goes on rounds together to all seventeen beds. Dr. Chien-An Yao, the Head Doctor and Director of the NTU Hospice, relates that, “Our team does an assessment of good death after each patient’s death, usually every week, to audit the quality outcome of the patients’ dying process. At that time, clinical Buddhist chaplains often give important information about spiritual well-being. They also help the palliative team learn how to approach a good death by spiritual care.”¹⁰

Dr. Yao also notes that it has not been easy to build this team care model. He says in order to introduce this system, they had to prove that spiritual care is effective. He says that NTU medical students are the top in the country, and they have a high level of pride. They think education is very important, so it was very important to make an impression on them concerning spiritual care. Therefore, this was another one of the key areas of research in which they engaged during the formational period of 1995-98. Dr. Ching-yu Chen notes that no medical education in Taiwan has tried to incorporate these four aspects of holistic care: the physical, social, psychological, and spiritual. Taiwanese medical doctors generally do not learn about spirituality at all in their medical training. Therefore, they have difficulty facing death and talking to the dying. Palliative care training exposes them to these issues. Dr. Yao notes that mutual respect for the rest of the team by the doctor is a key element, and now every doctor at NTU hospital must study end of life care. However, in other hospice units around the country, the lack of a complete care team that includes chaplains and doctors trained in engaged in holistic care means that an inordinate amount of the emotional and spiritual care of patients falls on the nurses. In this way, some hospices, like the Buddhist Tzu Chi Heart Lotus Palliative Care Unit at Tzu Chi General Hospital in Taipei, cannot operate at full capacity due to a shortage of nurses who are reluctant to enter such a demanding field.

Indeed, stress and burnout are common problems among clinicians working in

¹⁰ Chien-An Yao, “Spiritual Care in Palliative Care Team” (lecture, 24th General Conference of the World Fellowship of Buddhists, Tokyo, Japan, November 15, 2008).

this field. Priests and doctors, especially, tend to neglect their own health. They work hard for their patients but neglect their own well being and development and in turn the well being of the team. Dr. Yao says that, “Ongoing involvement with dying and bereaved persons may cause a severe drain of energy and uncover old and new spiritual issues for the caregiver. As such, spiritual education, growth, and renewal should be part of a staff support program as well.”¹¹ In this way, NTUH feels it is important to teach and develop such self-care. NTUH team members will often consult the monastic chaplains when they have their own personal problems. Nurses attend spiritual care programs for their own well being. However, since doctors tend to avoid such issues, they have started to include such issues and study as part of the training for medical students. 6th year medical students take courses in spiritual studies, ethics, and counseling as basic knowledge in their education, while also studying outside of class in the NTUH ward. Concerning self-care for the monastic clinicians themselves, Ven. Tsung-Teung says there is training for chaplains to control and deal with the strong emotions that come up in hospice work. The Lotus Foundation and the Association of Clinical Buddhist Studies have also created their own internal counseling sessions. As an extension of the team care building work, the NTUH team participates in an internet video conference every two weeks with palliative care units around the country at which they present case reports like truth telling and informed consent, symptom control, spiritual care, and success and failure stories. These conferences began twelve years ago with only four hospitals but have now grown to include forty.

Medical Ethics and the Final Moment of Death

As in the Tibetan Buddhist tradition, Chinese Buddhists believe that moving the deceased’s body or causing any abrupt environmental change will disturb the deceased subtle consciousness. Thus, the body should not be disturbed (in some cases even not touched or moved) for at least another eight hours after it has gone cold. The part of the body where warmth lingers until the rest of the body has become cold is called the Gate of Death in the sense that the consciousness finally leaves the body through this spot. Its relative position on the body is believed to indicate to which realm the consciousness has

¹¹ Yao, “Spiritual Care in Palliative Care Team”.

migrated. In general, higher spots on the body such as the crown of the head indicate heavenly realms while lower ones such as the feet indicate unfortunate realms.¹²

In this way, it is ideal for a person to die in a sitting posture so that the consciousness may more easily leave the body from a higher place. In contrast, dying in sleep, in unconsciousness, under the influence of drugs, or in other such abnormal or violent ways is dangerous to the migrating consciousness. The state of mind of the dying person is considered most crucial to their transcendence or rebirth. Therefore, the family should withhold expressions of grief that will disturb the dying and offer them encouragement. As done in the Japanese Pure Land tradition, many Chinese practice the Death Bed Ceremony (臨終行儀) in which a monk and groups of laypeople come to chant the name of Amitabha Buddha for the benefit of the dying person. In East Asia, there is a strong popular belief that says Amitabha Buddha will arrive at the moment of death to guide the deceased towards rebirth in his Pure Land. However, since the dying person may be too lost in the pain of death or their own delusion, all persons involved in the moment of death should chant Amitabha Buddha's name to assist the dying's transcendence. Voluntary groups, usually called "Help Chant Group," and even audio tapes may be used to continue with the chanting of the Buddha's name.¹³

In this regard, one of the distinctive innovations of the Buddhist terminal care movement in Taiwan is the spiritualization of dying rooms in hospices in both private and public hospitals. Regulations in Taiwan require that hospices and palliative care units have a special room to move patients for their final moments. However, it was a Buddhist chaplain at the NTUH who came up with the idea for putting up a large painted image of the Amitabha Buddha to assist in the special deathbed practice outlined above¹⁴. These rooms are also used for special counseling and for housing religious images for people of different faiths to pray. NTU hospital also developed special rooms in the basement called literally "Room for Rebirth in the Pure Land" (往生室), which have become common in

¹² Yutang Lin, "Crossing the Gate of Death in Chinese Buddhist Culture," in *Living and Dying in Buddhist Cultures*, eds. David W. Chappell & Karma Lekshe Tsomo (Honolulu: School of Hawaiian, Asian, and Pacific Studies, University of Hawaii, 1997) 94.

¹³ Lin, "Crossing the Gate of Death in Chinese Buddhist Culture", 97.

¹⁴ For more on the use of Buddha images and paintings in Pure Land Buddhist deathbed practices, see *Never Die Alone: Birth as Death in Pure Land Buddhism*, eds. Jonathan Watts and Yoshiharu Tomatsu (Tokyo: Jodo Shu Press, 2008).

hospitals across Taiwan. Here the deceased's body may remain undistributed for the traditional period of eight hours during which Buddhist priests, family, and also members of the care team may join together in the chanting of Amitabha Buddha's name. There is also a room for observances by families who are not Buddhist. For westerners used to morgues that are nothing more than a room of drawers for dead bodies or for Japanese who's Buddhist sectarianism and general social secularism have led to the elimination all vestiges of religion from hospitals, this spiritualization of death is incomprehensible in a public medical facility.

Organ Transplants & Grief Care

Unfortunately, this belief and practice of not disturbing the body after death has also been an impediment in Japan and Taiwan to the modern medical practice of organ transplants and of donating organs at death by common citizens. In Japan, organ donation by common citizens is not a common practice and can be problematic. In general, Japanese Buddhist organizations and priests have been very slow to develop adopt more modern views on such practices. It was this way in Taiwan until recently when certain Buddhist institutions and teachers, such as Master Cheng Yen and the Tzu Chi Buddhist denomination, began promoting organ donations and transplants as a bodhisattva act of compassion and self-sacrifice. Indeed, numerous well-known Tibetan Buddhist masters, who share the same tradition of leaving the dead body undisturbed, have commented that the power of a person's intention to help others with their leftover organs will protect and override the negative influences of disturbing their body in order to harvest the organs.¹⁵ In this way, many Taiwanese Buddhist organizations have begun to support and promote organ donation by their followers. NTUH supports this movement as well through holding an annual, large memorial service for all patients who have donated their bodies for research or organ transplants. The families and monks are invited to attend as well.

The Tzu Chi Buddhist denomination has taken this movement a step further by encouraging whole body donation to their new medical school through their Silent Mentors program that began in 1996. Because of the Chinese and Taiwanese traditions of "maintaining a whole body" and "being buried," there has always been a lack of cadavers for medical study in Taiwan. The founder of Tzu Chi, Master Cheng Yen, responded by

¹⁵ This view is expressed by the great Tibetan Buddhist master, Dilgo Khyentse Rinpoche, in Sogyal Rinpoche, *The Tibetan Book of Living and Dying* (San Francisco: HarperSanFrancisco, 1994): 383-84.

trying to shift this traditional culture to a new one grounded in the Buddhist ethics of compassion and self-sacrifice. She notes that, “We do not own our lives. We only have the right to make use of them.... Turning the useless corpse into teaching materials is a liberating experience from life and death as well as the wisdom of knowing how to teach selflessly.”¹⁶

Tzu Chi Medical College does not simply collect these bodies and use them in the typical way that most hospitals and medical schools use cadavers. They have instituted a highly creative and systematic method of putting teachers, students, bereaved families, and the bodies of the donors in intimate contact to encourage the development of what they call “humane doctors.” Using the cadaver as a basis for not only imparting medical learning but also emotional and spiritual learning, Tzu Chi has coined the phrase “Silent Mentors.”

Before beginning the Gross Anatomy course at Tzu Chi Medical College, students will visit the families of the donors on whom they will operate to learn more about their lives. They look at photos and listen to stories by the family members. Afterwards, the family members provide a photo of the donor, and the student writes a short biography of the donor, both of which are posted on the program’s website, in the hall outside of the dissection room, and in front of the dissection table itself. At the beginning of the course, an opening ceremony of gratitude is held that includes the families of the donors. A Buddhist funeral rite is conducted at this time in order for the bereaved family to have peace of mind and for the donors to rest in peace. The ceremony is then moved to the medical operating classroom for surgical simulation, where the donor’s bodies are uncovered, and the bereaved family members may face their departed loved ones for the last time. The medical students are actively involved in this moment, learning to be present and to comfort these families. In turn, the family members may also ease the nerves of the young students by reminding them of the vow of their loved ones to be used for this very purpose. This personal connection with the donor’s bodies and their families is meant to emotionally move and thus encourage the students to develop themselves as more humane doctors.

The students will use this one personalized cadaver for the whole semester. Then, at the end of the semester, the students sew up the bodies, redress them in clothes

¹⁶ *Silent Mentor*. DVD (Hua Lien, Taiwan: Tzu Chi University, 2009).

and shoes, and place them in coffins. A public funeral ceremony with the coffins is held in front of the medical school attended by Buddhist nuns, the school president, faculty, students, volunteers, and the bereaved families. After cremation, the students and the families attend an internment ceremony for each individual's ashes at a special shrine called the Great Giving Hall housed within the medical college itself.

The comprehensive nature of this program shows the great meaning that can be created from building not just Buddhist but general spiritual mechanisms into the often alienating, secular culture of modern medicine. The program clearly has a powerful effect on the students who are deeply exposed to the emotionality and spirituality connected with medical work—an aspect that is usually totally neglected in modern medical education. The effects span out further in: 1) providing the dying with a sense of meaning to their deaths and personal value that will extend beyond their deaths; and 2) providing bereaved families a sense of continuing value to their loved one's lives as well as offering them a very profound form of extended grief care through participating in the program.

Conclusions and Future Directions

The NTUH, Buddhist Lotus Hospice Care Foundation, and Association of Buddhist Clinical Studies program has developed monastic clinicians who are serving all over the country. This work has now been expanded to include another hospital besides NTUH where monastic candidates can train. The Jinshan Hospital, located on the northern coast near Dharma Drum Temple and Buddhist College where Ven. Huimin serves as the Dean, became an official branch hospital to NTUH in 2010. They have one hundred beds in a rural setting, which contrasts NTUH's downtown Taipei setting. With a more natural setting and fresh air, this hospital will specialize in patients with chronic diseases as well as supporting a hospice and palliative care unit. With its location within eyesight of Dharma Drum Buddhist College, it will also be tied into the educational program for monastics at the college.

This is a development of which Prof. Rong-Chi Chen would like to see more. He says that in recent years there are many freelance monastics engaging in this issue of terminal care but that there are no systematic programs being run by the large monasteries and denominations, like Tzu Chi, Dharma Drum, Fo Guang Shan, and Zhongtai Temple. He feels that as these temples have major Buddhist universities, chaplaincy and clinical studies should be incorporated into the curriculums. Such curriculums would encourage

and guide some students into the profession since after their university training they could directly proceed to internship. Prof. Chen feels that this role should be provided by these major Buddhist universities and not the Buddhist Lotus Hospice Care Foundation, which struggles to fund this work. BLHCF has an assembly of different Buddhists who appeal to society for donations, and the new reductions on income tax for making such donations have made doing so more popular, especially at the end of the fiscal year. However, without the generous donors behind the Foundation who come from the laity and general public, this work could not continue as hospital insurance does not pay for chaplains.