Facing the storm at the end of life:

A Buddhism inspired approach to understanding and relieving suffering in end-of-life care

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Abstract

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Conventional medical practice often follows a tried formula that has been successful for many acute medical conditions: identify and isolate the offending disease or condition and eliminate or fix it in order to bring about recovery, and the relief of suffering should follow. However, such a paradigm of care may not work if this simple linearity is erroneously assumed, and it becomes simply untenable in situations where cure is no longer possible, such as in chronic and degenerative conditions and at the end of life. Particularly in end-of-life (EOL) care, the experience of suffering may only be comprehended as a complex, multidimensional and systemic phenomenon. The failure to recognize this may not only result in ineffective care, it may also add to the suffering not only for the patients and their families, but also for care providers. The Buddha had attained enlightenment and developed his teachings with the specific intention of addressing the suffering of all beings. This paper will explore the relevance of the core Buddhist teachings to EOL care, and using the framework of the Four Noble Truths, derive an approach that guides attending to suffering with special reference to end-of-life care. This approach features the importance of attending to the human condition as the primary guiding principle, as well as practices and cultivations that are known to be conducive to a compassionate response to suffering.

Introduction

On biomedicine, suffering and the end of life

Medicine, in tandem with the development of science and technology, has made spectacular advances in the areas of disease treatments. The highly focused approach in identifying specific pathology involved in the disease process and treating or reversing the pathologic element, has been a well-used model. Mortality from acute conditions has generally decreased and people are living longer lives. As such, over the last century, the biomedical approach has become the dominant model in many medical settings (Wade & Halligan, 2004, p.1398). Most people hold biomedicine with considerable regard, to the extent that we seek biomedical solutions for many of the ills that affect our lives. Nowadays, we look towards biomedicine to deal with ageing, to improve how we look aesthetically, to deal with our moods, to improve sexual performances and other problems of living. Dying is also considered an event that requires some form of medical attention, and while many people hope to die at home, the fact is that the majority still die in the hospitals.

But we are now beginning to realize the serious short-comings of the biomedical approach (Wade & Halligan, 2004, p.1398-9). Part of the issues stem from the basic assumptions of this model. Firstly, it has the reductionist belief that an illness has a single linear cause, the elimination of which will result in recovery. The converse is also held as true - that if there is no identifiable disease, then the illness is not present. As a result, the physical and objective aspects of illnesses are generally considered as important or "hard science" while the mental phenomena, such as the emotional and other subjective responses are regarded as "soft" or non-contributory (Wade & Halligan, 2004, p.1399; Cassell EJ, 1982, p. 640). In this context, even if suffering is acknowledged, it tends to be considered extraneous and not part of the "key" medical agenda. At other times, suffering becomes "invisible" because both patients and doctors have been conditioned by biomedicine to assume that suffering is to be expected in an illness and has to be tolerated by the patient (hence the word "patient").

In addition, the over-emphasis on disease-directed treatments has led biomedicine to split-off the work of care from its responsibility. This aspect is usually delegated to other healthcare professionals, such as nurses, social workers, therapists or health aides. Once again, disease-directed activities are accorded higher importance and priority over so-called care issues. A prevailing belief is that once the disease is managed, care is less important. In routine clinical practice, this might be construed as a logical assertion when it comes to say a leg or arm fracture, or appendicitis, or a lung infection, for which the effective intervention is deemed to be medical or surgical treatment. However, what is often unnoticed is the amount of care that patients may require in the background. I consider care in these instances as any action that supports the patient and family in their course of recovery or healing. Hence, the scope of care may involve such activities as feeding, clothing, cleaning, bathing, toileting, transferring, filling out the prescription, serving medication and dressing wounds, as well as paying bills, doing laundry, cooking, and other things that maintains the living spaces, and also the talking, sitting, reading, watching TV, consoling, soothing, doing something or nothing... essentially, all the things that enable the person to pass the time with ease and to support the living of each moment during that period of illness.

The inadequacies of the biomedical model become starker for those whose conditions are not curable, such as those with chronic diseases like diabetes mellitus, psoriasis or rheumatoid arthritis, or chronic organ impairments such as chronic lung, heart, liver, kidney diseases, and neurodegenerative disorders such as Alzheimer's disease or Parkinson's disease. In the setting of modern societies, chronic illnesses are expected to become a major healthcare burden especially with the ageing population. Though people may now to live longer in spite of chronic illnesses, this may come with longer periods of disability (Solomon et al, 2012, p.2157-8). In the early stages, one may still retain some semblance of normalcy through biomedical interventions that temporarily mask, halt or slow the progression or manifestation of the illness. In the later stages however, one grapples with the increased disease burden stemming from progressive organ–system failure, which is often compounded by the burden of treatments. To the family or care givers, the burden of care falls heavily on their shoulders. The needs of the patient shift progressively from those with a treatment focus to those with care focus.

And then we come to the end of life, where there is no known biomedical way to "solve" it. Herein lies the "perfect storm": In most of the developed countries, we are already seeing the impact of an ageing population, where there are increasing numbers of elderly patients who present with multiple chronic comorbidities and disability, and more people are dying each year (Etkind, S.N., Bone, A.E., Gomes, B., Lovell, N., Evans, C.J.,… Murtagh, F. E.M., 2017). As the biomedical approach is still the predominant model, there is an expectation for a biomedically appropriate response from the doctor. Yet biomedicine is now required to contend with disease conditions that cannot be treated, so persisting with the disease-treatment paradigm becomes quite irrelevant and ineffective. Because biomedicine has traditionally not focused on or created the training or structures to address the human experience or the work of care, the doctor is ill-prepared to manage the suffering that may arise at the end of life (Egnew, 2009 p. 170-1).

How do we try to cope?

I have observed that especially when the biomedical options for treatment are limited, some patients and families grasp even more desperately at any available treatment with the attitude that they "must not give up the fight". Others may find the situation too daunting to even consider, and opt to avoid or deny its severity. Yet other may feel abandoned, betrayed and disillusioned, and may in despair, turn their backs on all that mattered, or just lapse into confusion and inaction. The reactions from doctors may be quite analogous. Some doctors continue to treat with biomedical interventions even though they may acknowledge that the outcome is certain death. Such an approach may be justified as the only way to sustain "hope" to the patient and family. Other doctors may simply declare that the situation is "hopeless" and withdraw their role, often citing bioethical grounds of medical futility or even social justice. Yet others feel quite lost in this territory, and though they continue to see their patients and keep up the appointments, there is therapeutic disorganization and incoherence. "Expectant management" may be a euphemism for the lack of clinical direction or treatment plan. Another related strategy is to give "open date" appointments or 3-6 month appointments even when

the prognosis is recorded in terms of weeks. What these clinical responses may represent are various ways of turning away from dying and death.

But are doctors expected to be so different from their patients and families when it comes to the end of life? Interviews with oncologists in Canada showed how more than half of them were hard-struck by their patients' death - struggling with sadness, crying, and loss of sleep, feeling of responsibility for their patients' lives, as well as feelings of powerlessness, self-doubt, guilt, and failure (Granek, Tozer, Mazzotta, Ramjaun & Krzyzanowska, 2012). The impact of such experiences for doctors goes beyond their personal lives and may result in altered treatment decisions, mental distraction, emotional and physical withdrawal from patients (Granek, Tozer, Mazzotta, Ramjaun & Krzyzanowska, 2012; Shanafelt, Adjei & Meyskens, 2003; Meier, Back & Morrison, 2001). The lack of training and competence among doctors with regards to end of life care may be contributory to this state of affairs. In a study of 1455 students, 296 residents and 287 faculty members from 62 accredited US medical schools, while 99% agree that doctors have a responsibility to help patients at the end of life prepare for death, fewer than 18% of students and residents received formal training, and more than 40% of residents felt unprepared to teach end-of-life care (Sullivan, Lakoma, Block, 2003).

Mythology of medicine

But apart from the sheer intensity of having to deal with dying and death both at the personal and professional levels coupled with the lack of training, there is a more insidious aspect which discourages our turning towards dying and death. For a long time in human civilization, religion and spirituality has been the reliable sources of inspiration, meaning and solace for our mortal existence. But in a mere few hundred years, we have developed a new-found confidence in modern science. Our understanding and application of science has drastically changed our living environments. Medical science has indeed averted countless deaths from acute conditions and staved off many serious complications from chronic diseases. In fact, it has taken on a mythical status where selected mortals may now manipulate the knowledge and powers that can change lives dramatically. In this delusion,

it is easy to miss the fine line that separates saving lives and conquering deaths. In its developed form in many modern societies, the myth of medicine is routinely instilled in medical students and regularly promoted among lay persons. We hear about its exploits in all forms of media, at social and public gatherings, at home and work places. The theme generally centers on the prowess of medicine and valiant struggles in fighting and overcoming diseases that threaten life. Death is the personified villain and almost universally perceived as the undesirable and abhorred outcome - a sign that medicine and its agents, have failed. In this paradigm, it becomes understandable why we would rather emphasize medical "successes" and designate much less medical attention and training to dying and death – to dispel the myth would render us totally unprotected against the truth of mortality and impermanence, since many have already forsaken the protection from religion by their faith in the new science.

Objective

With this brief introductory narrative of the clinical landscape, this paper will now explore the Four Noble Truths for its wisdom and inspiration on how to address human suffering, especially in the context of care at the end of life. So far, there is, to my knowledge, no approach that directly utilizes the Four Noble Truths as the basis of ethical practice. Based on the findings, I will try to formulate an approach to suffering, which will hopefully take into consideration the needs as mentioned in the foregoing context:

1. A medical narrative that views dying and death as normative rather than pathological; one that supports turning to suffering, dying and death.

2. An approach that shifts the focus of intervention from disease to person.

3. The non-separation of biomedicine and care; bridging the chasm between what medicine can offer and what people need.

4. A compassionate approach towards the suffering of patients and families but also for healthcare workers who may be vicariously impacted by the suffering as a mortal.

5. An inclusive model that may be applied secularly and can be consistent with a scientific approach to medicine.

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Methods

This essay will bring together and integrate ideas, information and knowledge from three main sources. The first source comes from the current medical literature on issues on medical practice, end-of-life care, and areas of care provision which may be relevant to this discussion. References will also be made on the psychological, behavioral and neurobiological bases for compassionate behavior. The next source comes from Buddhist texts, such as translations from the Pali Canons, and articles on the Buddha's teachings, especially those pertaining to the Four Noble Truths, with particular reference to the Dhammacakkappavatana Sutta; as well as teachings at Upaya Zen Centre. I have also included relevant perspectives and teachings from the Upaya Buddhist Chaplaincy Program, in such areas as systems thinking and conflict resolution. Finally, I also draw on my personal experiences as a palliative medicine doctor and some case illustrations to provide a "bedside" validation of the materials presented.

The general format will comprise a description of the Four Noble Truths, based on translated suttas and authoritative commentaries. This will be kept brief as it is not the intention of this work to be a detailed exposition of the Noble Truths. This will be followed by an exploration on how the Truths relates to the common clinical experience as well as materials from published medical literature. And at the end, I will present how the Truths may advise on an approach to suffering in the medical setting.

Why the Four Noble Truths?

In this chapter, we shall consider the reasons why the Four Noble Truths – a two thousand five hundred-year-old teaching – may still be a relevant resource for an approach to suffering in the modern medical setting.

Suffering as the Big Picture

The Four Noble Truths is well recognized as one of the foundational Buddhists teachings. (Dalai Lama (1997), Ajahn Sumedho) The Dalai Lama has described its understanding as essential for the practice of the Buddha Dharma (p. 1). Comprehending the extent and pervasiveness of suffering in humanity, it was the young Gotama's compassion that compelled him to search for enlightenment in order to address the suffering that invariably plagued all existence.

> *"Monks, before my enlightenment, while I was still a bodhisatta, not yet fully enlightened, it occurred to me: 'Alas, this world has fallen into trouble, in that it is born, ages, and dies, it passes away and is reborn, yet it does not understand the escape from this suffering headed by ageing-and-death. When now will an escape be discerned from this suffering headed by aging-and-death?"* (Samyutta Nikaya (SN) 12:65)

But when he became enlightened, the Buddha initially reflected that the Truths he had discovered was so profound that the people of his times, who were described as delighting and rejoicing in attachment, may not be able to comprehend them. He therefore hesitated to teach the Dhamma. But upon pleading by Brahma and "out of compassion for beings", he surveyed the world with the eye of a Buddha, and he saw that there were also "beings with little dust in their eyes", and so decided to open for them the "doors to the Deathless" (Majjhima Nikaya (MK) 26; i 167-173).

> *"Monks, there is one person who arises in the world for the welfare of the multitude, for the happiness of the multitude,* ***out of compassion*** *for the world, for the food, welfare, and*

> *happiness of devas and humans. Who is that one person? It is the Tathagata, the Arahant, the Perfectly Enlightened One. That is that one person"* (AN (Anguttara Nikaya 1; i 22-23)(author's emphasis)

It was therefore not coincidental that the Buddha's First Sermon was the Four Noble Truths on suffering and the cessation of suffering. (Although on the way to Baranasi in the Deer Park at Isipatana, where the discourse was said to take place, he encountered Ajivaka Upaka to whom the Buddha revealed his enlightenment. Ajivaka Upaka replied "'May it be so friend.' Shaking his head, he took a bypath and departed." – confirming the Buddha's assertion that not all were ready to receive the Dhamma teaching.)

It is easy to forget that the development of medicine has also originated from the desire to relief human suffering, though there is a clear slant towards the suffering from illnesses. Suffering is however a human experience that extends beyond bodily, mental or medical terms – Cassell (1982) described suffering as occurring when the sense of one's personhood is threatened by disintegration (p. 640); the entire person is what experiences suffering. In the modern hospice movement, Dame Cicely Saunders has also coined the term Total Pain, to denote how the experience of "pain" encompasses physical symptoms, mental distress, social problems and emotional difficulties (Mehta & Chan, 2008, p. 27). In the International Association of Hospice and Palliative Care Manual of Palliative Care (3rd Ed), Doyle and Woodruff (2013) introduced the analogous term Total Suffering which was described as the equation of "pain + other physical symptoms + psychological problems + social difficulties + cultural issues + spiritual/existential concerns" (p. 11). But in spite of these attempts to broaden our understanding of suffering, the key frame of reference is still the medical context, and to some doctors, the medical agenda still hold the centre-stage. I therefore assert that the teaching of the Four Noble Truths, by way of addressing the very roots of human suffering, may reframe suffering in a broad enough manner such that it is the **universal human condition** of suffering that becomes the centre stage. There are several important implications of grounding the practice of medicine in our common humanity, which will be discussed in subsequent sections. But at this juncture, recognizing the common human condition reminds us that the core doctor's role is not

just treating or eradicating diseases but has always been to respond to suffering. In the words of Eric Cassell (1982), "the obligation of doctors to relieve human suffering stretches back into antiquity." (p. 639)

The Middle Way

The first exposition of the Four Noble Truths appeared in the Dhammacakkappavattana Sutta, literally, the "Setting in Motion the Wheel of the Dhamma" (SN 56:11; V 420-24). The audience to the first discourse were the five ascetics who had by now, thought that Gotama had forsaken the ascetic practices for a life of luxury. Foreseeing their skepticism, the Buddha first explained the concept of the Middle Way as one that avoids the extremes of wanton indulgence in sensual pleasures and the unnecessary and unproductive torment of austere practices to the point of self-mortification:

> *"Monks, these two extremes should not be followed by one who has gone forth into homelessness. What two? The pursuit of sensual happiness in sensual pleasures, which is low, vulgar, the way of worldlings, ignoble, unbeneficial; and the pursuit of self-mortification, which is painful, ignoble, unbeneficial. Without veering towards either of these extremes, the Tathagata has awakened to the middle way, which gives rise to vision, which gives rise to knowledge, and leads to peace, to direct knowledge, to enlightenment, to Nibbana.*
>
> *"And what, monks is the middle way awakened to by the Tathagata? It is this Noble Eightfold Path; that is, right view, right intention, right speech, right action, right livelihood, right effort, right mindfulness, right concentration. This, monks, is that middle way awakened to by the Tathagata, which gives rise to vision, which gives rise to knowledge, and leads to peace, to direct knowledge, to enlightenment, to Nibbana."* (SN 56:11: Dhammacakkappavattana Sutta)

Having assured the Five Ascetics, he then revealed the Noble Truth of Suffering, the Noble Truth of the Origin of Suffering, the Noble Truth of the Cessation of Suffering, and the Noble Truth of the Way Leading to the Cessation of Suffering.

To introduce a "middle way" is similarly significant in end-of-life care. In the setting where there is often a lack of support for doctors to deal with the grief of losing their patients, one way that doctors seek to protect their own integrity in the face of seemingly unsurmountable and repeated challenges at work is by emotional distancing and depersonalization (Granek, Tozer, Mazzotta, Ramjaun & Krzyzanowska, 2012). Often, such behavior may be justified by invoking professional objectivity, professional boundaries, ethics and even "palliative care"! Yet, without appreciating what that suffering is really about, care would at best be a hit-or-miss project. On the other hand, we can still find some doctors compulsively taking on more pain and suffering that they can bear, to the point of emotional fatigue and even psychological traumatization. Finding that "middle way" of practice is therefore vital – doctors are useless if they behave like unfeeling and robotic technicians, or if they become burnt out martyrs. But the "middle way" is NOT about being semi-robots or half-martyrs either. Rather, as described in the sutta, it is a path that permits **new** vision and knowledge that leads to experience of peace, even in states of turmoil, which shall be described later.

The nature of medical practice

It is also notable that the sequential pattern of the Four Noble Truths has a resemblance with the traditional medical approach of diagnosing the disease, elucidating the cause or mechanism of the disease, eradicating the disease and intervention to the eradication of the disease. This may encourage doctors to also use the same approach to recognize and address suffering, but then again, it may also lead to the same corruption by the linear mindset about disease and treatment, such that suffering becomes similarly over-simplified and inadequately addressed. Fortunately, the resemblance to the biomedical approach goes no further than this. As will be illustrated when the Four Noble Truths are discussed individually, the methodology of the Four Noble Truths comprise

three aspects or "turnings of the wheel of the Dhamma" (Ajahn Sumedho, p. 10) - a clarity of the nature of each truth, a prescribed task that goes with each truth and the attainment upon completion of the task. Hence, for the First Noble Truth, it is the truth of suffering, the task of which is to be understood, and the completion is to fully understand it; the Second Noble Truth is about the origin of suffering or craving, which is to be abandoned, and is completed when craving is abandoned; the Third Noble Truth is about the cessation of suffering, which is to be realized, and is completed when it has been realized, and the Four Noble Truth is the truth of the path, which is to be developed, and is completed when it has been developed. This formulation also points to a basic principle that in order for the attainment (*pativedha*), there is a need for the theory (*pariyatti*) but it must necessarily include the practice (*paripatti*).

We have to relearn that the practice in medicine does not just pertain to the technical aspects, the data or evidence, clinical examination, and how to diagnose and prescribe. These are not the only components that define an experienced practitioner. What has probably been forgotten are the less conscious and subjective parts of our processes that are constantly calibrating and adjusting to the actual situation that is in front of us – attending to the diverse types of personalities and situations, dealing with clinical uncertainty, discerning the lived experience of the patient and the family, perceiving human qualities and foibles, the moral dilemmas and our moral position and such inferences as whether you are in sync with the patient or family member or they are on board with your suggestion. These often contribute to the clinical "hunch" but they may also determine if one is clinically "astute". I see the format of the Four Noble Truths resembling this aspect of clinical practice. Just as the aspirants of Four Noble Truths attains through knowing and practicing the Dhamma time and again, the clinician accumulates clinical insight and becomes "experienced" by gaining knowledge (*pariyatti*), practicing/application (*paripatti*) and reflection (*pativedha*) from numerous clinical encounters.

The First Noble Truth

> *"Now this, monks, is the noble truth of suffering: birth is suffering, aging is suffering, illness is suffering, death is suffering; union with what is displeasing is suffering; separation from what is pleasing is suffering; not to get what one wants is suffering; in brief, the five aggregates subject to clinging are suffering….*
>
> *"'This is the noble truth of suffering': thus, monks, in regard to things unheard before, there arose in me vision, knowledge, wisdom, penetration, and light.*
>
> *'This noble truth of suffering is to be fully understood': thus, monks, in regard to things unheard before, there arose in me vision, knowledge, wisdom, penetration, and light.*
>
> *'This noble truth of suffering has been fully understood': thus, monks, in regard to things unheard before, there arose in me vision, knowledge, wisdom, penetration, and light."*
>
> (SN 56:11: Dhammacakkappavattana Sutta; V 420-24)

The noble truth of suffering or dukkha states the inherent unsatisfactoriness of all conditioned existence and phenomenon. This relates to their fundamental nature of impermanence of all things conditioned:

> *"And while this discourse was being spoken, there arose in the Venerable Kondanna the dustfree, stainless vision of the Dhamma: 'Whatever is subject to origination is all subject to cessation.'"* (SN 56:11: V423)

The Buddha however has not intended the noble truth of suffering as a metaphysical statement, but rather a conclusion verifiable by direct observation. All mundane experience, whether they are pleasant, unpleasant or neutral experience, and indeed our very existence come to an end. And struggling with the idea of impermanence and not seeing the conditionality behind the phenomenon, we react with a sense of dissatisfaction or dis-ease – we suffer.

Some may baulk at the pessimistic notion that their existence is suffering. In response, some authors have attempted to clarify the translation of "dukkha" as "unsatisfactoriness" or "stress" or "badness". But I believe there is distinct value in keeping "suffering", particularly in the context of this discussion:

- Firstly, the formulation is not an absolute or metaphysical declaration of the nature of existence but rather a simple statement of fact – "there is suffering and this is the truth of suffering". As an observation, we may be able to identify that some extent of suffering occurs even when we are relatively well, such as bodily aches after exertion, displeasure when we hear things that we don't agree with, and so on. We seldom consider it "real" suffering because we still maintain the capacity to adapt and find relief from such situations, as part of our inherent resilience and survival instincts. But suffering in the common sense of the word becomes more stark and irrefutable when one is physically impaired from illness, and certainly at the end of life. In the latter situation, the physical form that had been the support for our "selfness" disintegrates literally before our eyes. Pain is understandably common at this time as pain is the key neurobiological signal of threats to bodily integrity. Roles and functions stop applying in its old ways, and measures to maintain status quo no longer work. Change is real, undeniably and irreversibly so. And just as elaborated in the sutta, suffering unfolds from the unwellness that accompanies sickness; the declining capacities and functional reserves attributable to ageing; dissolution of form and function that comes with impending and final death; and we fret and despair over how things do not happen the way we would like, or how things happen in ways we do not want; in other words, all components of our existence, which in Buddhist terms comprise form, sensations, perceptions, mental formations and consciousness, become bases from which suffering arises. There is even suffering from birth, which many may associate as a joyous occasion even if it is not necessarily a pleasant experience – the birthing process can be painful. But from a Buddhist perspective, birth leads to ageing and death, and is therefore the basis for existential suffering and a manifestation of samsaric process.

- But equally important, beyond the statement of an observable and verifiable reality, the First Noble Truth actually does not preclude positive states such as happiness or peace. In fact, the flow of the Noble Truths leads to the possibility of cessation of suffering and the way to its cessation. What it does however is to point out the ubiquity of suffering, as the common human condition. It brings to the foreground what plagues the existence of conditioned beings, and then offers it a path out of the suffering.
- The direct value of the truth of suffering therefore is to bring to awareness the experience of suffering that goes on often in the background among patients and their families. As mentioned in the introduction, suffering is sometimes considered as an expectation in patient-hood, something which patients should bear with and not complain about. Doctors may also downplay the extent of suffering as they feel quite helpless in dealing with it. And as discussed earlier, the medical profession had somehow forgotten that suffering, instead of disease, is the primary target. Patients and sometimes their families too believe that suffering is a necessary part of the end of life. Some patients feel the need to suffer, to the extent of declining any treatment to relieve pain or other symptoms, because this is somehow their "kamma", and to receive punishment now would arrest the kammic consequences; or that suffering is their way of demonstrating the strength of their faith, while awaiting for the ultimate miracle or to demonstrate their worthiness to be saved by the divine; or that willingly suffering now beats suffering in purgatory. All these contribute to the invisibility of suffering, which only adds to the apprehension and torment at the end of life.
- Another very important value of directing our attention to the presence of suffering is the critical practice of seeing things as they are. To see things clearly, not to be clouded or deluded, to penetrate, "not having dust in eyes" are commonly encountered Buddhist instructions. The truth of suffering directs us to look clearly at the nature of existence. As mentioned, the first truth of suffering is "to be understood". What of? I interpret the First Noble Truth as pointing to the basic human condition. The understanding beyond the simple fact of "suffering" that defines our common existence is the solidarity in our common humanity of suffering - that we can always know what it is like to suffer; and because of that,

> that we can empathise with others and be compassionate to those who are suffering; and we too, like everyone else, are deserving of compassion. This, I believe, is an element that had somehow been lost in the development of modern medical practice. In healthcare, patients are frequently separated from their families, staying in sanitized environments and engaged more often by machines than by people; and even healthcare workers are trained to keep their distance, under the guise of professional boundaries and objectivity. The truth of suffering therefore compels us to see what is often ignored, to see we are no different from our patients. In end-of-life care, knowing that we will one day also go through what happens to our patients changes the way we give care – they become the experts and we are the novice, and we shouldn't do anything that we don't want ourselves to go through. To be sure, it does not tell us not ignore happiness and joy either, but this is already what most people want to see. It implores that we see them all.

An additional angle to the practice of seeing things clearly comes from Ajahn Sumedha's commentary on "understanding" as the second turning of the first truth (p. 10):

> "We can look at the word 'understanding' as 'standing under'. It is a common enough word but, in Pali, 'understanding' means to really accept the suffering, stand under or embrace it rather than just react to it. With any form of suffering – physical or mental – we usually just react, but with understanding we can really look at suffering; really accept it, really hold it and embrace it. So that is the second aspect 'We should understand suffering'."

Presently, the clinical situation so abhors suffering that we either deny that it is going on or we imagine that it doesn't, or we spend all efforts to cover or patch it up. The former was discussed earlier. As the situation cannot be ignored any further, we still use various means to turn away from the suffering – treating laboratory abnormalities, such as low blood sodium, potassium, oxygen…etc, is a common way of doing something to assuage the doctor or family members' helplessness and anxiety, although such assurances have little value beyond temporary reprieve. Even palliative care may be subverted for this purpose: not infrequently, I was asked by oncologists and surgeons to "just

sedate the patient" since they are dying already. In the haste to band-aid the situation, we fail to address what is needed. What can we possibly do to "fix" someone dying or the sorrows of their lives; it tends to be our delusion that we can just approach someone close to death and neutralize what might have happened in their lives or even across generations. And sometimes, all that can be, or needed to be done is to bear witness and to be present with the person and the suffering. In modelling how to bear witness without reactivity, without the compulsive need to invoke some medical labelling and intervention, we also model for the patient and family how they can hold and process the suffering without turning away.

At an even deeper level, the value of the Noble Truths may be appreciated a series of progression steps that guides us to the ultimate goal. Here, there is concurrence with an excellent discussion by Sangharakshita (2001) on how the Noble Truths are more akin to Methodology than a Doctrine (p. 147-157). The structure and sequence of the Noble Truths makes more sense as a systematic device to experience the Dhamma and for cultivation than just as a simple pronouncement on unavoidable universal suffering. Simply knowing the experience of suffering in life is therefore NOT the end-game or desired outcome. This is similar to many contemplative exercises used in Buddhism, such as meditation on death or the "foulness of body" – they are not doctrines on these "facts", but methodologies to appreciate attachments and craving. In the similar ways, reflecting on the extent to which our lives are dependent on the tolls and labors of numerous people, such as impoverished farmers and factory workers, is not an exercise to demonstrate that we are no better than parasitic leeches. The Noble Truth of suffering is therefore best understood as a skillful means (Upaya) to access and experience the Dhamma as a step in our development. In the same way, acknowledging the presence of suffering and our preoccupation about turning towards it is not about some morbid fetish to sadden people or to enjoy the stormy drama – it is only by turning towards, even by just leaning into the suffering that we may begin to hold and process what has happened in a sober enough way… and then we may discover the meaning of that suffering for each of us.

Case Study – "What storm?": Leo

Leo (not his real name) was a 57 year old scientist with a defense science company who had been diagnosed with an aggressive rare tumor known as GIST – gastro-intestinal stromal tumor. By the time he saw me, he had exhausted all avenues for medical treatment and had 2 major abdominal surgeries to remove the large masses in the abdomen. Towards the last part of his admission at another hospital, there were serious concerns about his use of opioid and he was accused of attempting to overdose and kill himself. Yet he complained of severe pain, which could only be transiently relieved. It was his sister who initiated the consultation. She was the wealthy one in the family, and she was footing the medical bills. She goes straight to the point – she wanted me to treat the pain so that he can have a chance with another treatment option, even though she knows he was very ill. Beware, he is quite irritable – she warned.

I saw Leo in his house where he was hooked to a fentanyl infusion. He was feisty as stated. "They don't believe me" he said. I assessed him as earnestly as possible and told him that I agree that he was in severe pain. The tumor was literally eating right through the intestines; much of the abdomen was tumor. The pain eventually settled, but only after using large doses of pain medications. But it did give him an opportunity to meet his buddies and fly his hobby drone, if only for one last time.

But there was always this tension in the midst. It was the stereotypically "Chinese family" squabble between his wife and the in-laws. It also did not help that his siblings were Buddhists and his wife was Christian, not that there was any obvious disagreement between the religions but rather it was an excuse to see each other on opposite sides. But a battleground was his treatment plan – they all have their own ideas about what he should be receiving. And they suffer too, from their desire to have him treated in their ways. Notwithstanding, both sides loved him dearly.

Leo was quite remarkable in that he was probably taking all these struggles in, and he knew he was epicenter of the situation. As his condition declined, he literally realized that he did not have to take this crap anymore, and he was letting it show in his irritability and burst of anger. I offered to facilitate a family meeting if he wanted to tell the family about how he felt. That evening, we spoke

about his experience. It didn't take long before the frustration, anger to God (abundantly punctuated with expletives) and disappointments (mostly with himself) surfaced. Finally, he yelled "Please let me die… I am suffering so much!" and then he sobbed in the arms of his wife. The family was clearly dumbstruck. Mother then broke the silence and tearfully agreed. His siblings fell silent.

Leo's condition deteriorated quickly thereafter. The animosity in the family went underground. There were still misgivings but now, it was not in the open. Leo had episodes of breakthroughs pain together with bleeding, as the tumor grew in size by the day. He died less than 2 weeks after the family meeting, the morning after his 14 year old daughter's birthday.

For Leo, what is worse than suffering was suffering unheard and unattended…

The Second Noble Truth

> *"Now this, monks, is the noble truth of the origin of suffering: it is this craving that leads to renewed existence, accompanied by delight and lust, seeking delight here and there; that is, craving for sensual pleasures, craving for existence, craving for extermination.*
>
> *"This is the noble truth of the origin of suffering': thus, monks, in regard to things unheard before, there arose in me vision, knowledge, wisdom, penetration, and light.*
>
> *'This noble truth of the origin of suffering is to be abandoned': thus, monks, in regard to things unheard before, there arose in me vision, knowledge, wisdom, penetration, and light.*
>
> *This noble truth of the origin of suffering has been abandoned': thus, monks, in regard to things unheard before, there arose in me vision, knowledge, wisdom, penetration, and light."*
>
> (SN 56: 11; V420-24)

In the Dhammacakkapavattana Sutta, the Buddha described the root cause of suffering as craving, and the task associated with this noble truth is to let go of craving. Here, craving is classified into 3 kinds: *kama tanha*, which is the craving for sensual desires; *bhava tanha* which is the craving for becoming; and *abhava tanha*, which is the desire to get rid of or unbecoming. Once again, the clinical experience at the end-of-life verifies what has been described. Some patients desire for food, ability to eat, see or talk with their families or friends; some want to be able to walk again, some want to return to work, or simply to become well again; and then there are those who want the cancer or disease to disappear, or not be bed bound, or simply to not be dying or to die sooner. An important distinction in this noble truth is that it is not so much the object of desire that matters, such the pleasurable or painful feeling, or capacity to walk or even dying, that are the causes of suffering, but rather the craving for them that is the real cause of suffering. It is the craving to have experiences and possessions, to hang on to the pleasant ones, or to stop the unpleasant ones that causes suffering. In

end-of-life care, it is certainly common to see patients with the same disease and symptoms but totally different experiences of suffering. Those who die peacefully seem to take the physical changes in their stride, riding the vicissitudes with gentle surrender, if not grace. Yet others may feel distressed and unsettled by the appearance of each change, and there is unceasing and hard striving to find comfort, seeking here and there for pleasant experiences or treatments and many times, painfully overwhelmed by the fact that things could not be fixed "once and for all".

A direct offering of the Second Truth is therefore to shift away from the fixation (attachment) to circumstances and events around the end of life, which are often out of the control of patient, family or care workers anyway. Presently, there is a lot of compulsive busyness and striving to eradicate symptoms and circumstances in order to fix the dying experience. One reason for this comes from our fear of facing dying and death. Unfortunately, such an approach would only lead to almost certain failure, since many of the issues, for example "I want to walk/work again", "I want to live longer", "I want to die faster" are unlikely to be solvable or achieved with resultant ease or peace. On the other hand, feeling cared, held, loved, connected, forgiven and healed are all possible outcomes independent of the mundane realities of dying and death. To get there however would require more than just this recognition. With the dominance of the clinical setting by biomedicine, there are undoubtedly many challenges to overcome before we can ensure such an environment of care. A primary hurdle however might be a matter of 'not knowing what we don't know' – being molded by biomedicine, it is difficult to even believe that other ways can be more useful in attending to the suffering at the end-of-life.

Dependent Origination (Paticca-samuppada-vibhanga Sutta)

The Buddha's treatise on the origin of suffering is primarily explained by the teachings on Dependent Origination. In this schema, the Buddha articulated a detailed chain of factors that lead to suffering, originally with reference to the endless cyclical existence that characterizes samsara. This is described as Paticca Samuppada or Dependent Origination, which is so central to the teachings that

the Buddha had declared that "One who sees dependent origination sees the Dhamma, and one who sees the Dhamma sees dependent origination" (MN I 190,37-191,2). The fundamental Buddhist principle that is embedded is that all phenomena happen causally:

> *"When there is this, there is that,*
> *When there is not this, there is not that.*
> *When this arises, that arises.*
> *When this ceases, that ceases. "*
> (Samyutta Nikaya 12.37)

A deep dive into Dependent Origination or Paticca Samuppada would be beyond the scope of this author and paper. The concept will be presented briefly and then the discussion will focus on the implications to medical practice. A brief version of the Dependent Origination that is adapted from Thanissaro (2008) is as follows:

1. *Ignorance*: not seeing things in terms of the four noble truths
2. *Fabrication*: bodily, verbal, mental fabrications
3. *Consciousness* at the six sense media: the eye, ear, nose, tongue, body, and intellect.
4. *Name-and-form*: mental (feeling, perception, intention, contact, attention) and physical (earth, water, wind, fire) phenomena.
5. The *six internal sense media*: the eye, ear, nose, tongue, body, and intellect.
6. *Contact* at the six sense media. (when a sense organ meets with a sense object)
7. *Feeling* based on contact at the six sense media.
8. *Craving* for the objects of the six sense media: *Sensuality-craving* (craving for sensual plans and resolves); *Becoming-craving* (craving to assume an identity in a world of experience); *Non-becoming-craving* (craving for the end of an identity in a world of experience)
9. *Clinging:* clinging to sensuality, view, habit/practice, doctrine-of-self
10. *Becoming* on any of three levels: sensuality, form, formlessness

11. *Birth*: the actual assumption of an identity on any of these three levels.
12. The *aging-and-death* of that identity, with its attendant sorrow, lamentation, pain, distress, and despair (p. 8-9).

By explicating how each of the elements link to eventuate in suffering, the Buddha also shows the way to interrupt the cyclical progression and extricate oneself from the tangle that only spells suffering. More on this will be described in the Third Noble Truth of Cessation.

When understood in a psychological sense, these twelve links may represent fleeting internal states that are experienced within moments. Yet, the same causation sequences might also be taken in a more expansive way that spans past, present and future lifetimes (AN: Nidanavagga; p. 520). In his teachings of Dependent Origination, the links had been presented, often with ignorance at the beginning, which conditions the arising of fabrications, which conditions the arising of consciousness… and which conditions the arising of ageing and death, with the attendant sorrow, lamentation, pain, distress and despair as the last link. In the "reverse order ", it similarly begins with ignorance: the cessation of ignorance conditions the cessation of fabrications, which conditions the cessation of consciousness… which conditions the cessation of ageing and death, and the attendant sorrow, lamentation, pain, distress and despair. It is also well documented in the suttas that the Buddha discourages theorizing on ideas of cosmological beginnings or endings, preferring to speak of beginningless and endless flow of cause and effect. However, starting with ignorance may be reasonable as delusion, arising from ignorance is one of the roots of unwholesomeness, but in reality, ignorance is in a constant state of flux, just like all the other links.

In the application of Dependent Origination to real life situations, one will be able to appreciate that the classical interpretation of Dependent Origination as a circle fails in many ways. Firstly, the actual flow can be "bidirectional" (at the risk of misconstruing it too linearly). In fact, it is conceivable that the flow may go back and forth, depending on what happens at each link. A less mechanical and organic way of looking these links is to conceive of them as multiple feedback loops of variable sizes, each link somehow having an effect of each other, in a more interdependent manner. As such, some

Buddhist scholars have refined the translation of Paticca samuppada as Interdependent Origination or Dependent Co-arising to better reflect these characteristics.

But to carry this application further, one may realize that so far, Paticcasamuppada has only been applied to what might be called an "individual" thread (there is no same "self" to speak of in Buddhist teachings and in the literal crossing of ageing and death to the next birth, the conditioning for new name-form would have resulted in another "individual"). When we include the interaction between threads, and even the natural rhythms of environments, what can be perceived is an infinite mass of interconnecting threads – more of a web of causations and cessations, and perhaps more accurately, systems of feedback loops. The ground of suffering therefore exists in this beginningless and endless, complex web of internal or external relationships, that may span moments or across lifetimes. It is interesting to note that in various suttas on causation, the Buddha is usually quoted as wrapping up the series of links with either "such is the origin of the whole mass of suffering" or "such is the cessation of the whole mass of suffering". The use of "mass of suffering" would more accurately describe a non-linear, complex system of infinite feedback loops. This perspective evokes a systems conceptualization of Dependent Origination.

But to return to the purpose of this paper, what implications might the Second Noble Truth of the Origin of Suffering have on clinical care?

1. We need to perceive suffering as a personal experience AND a systemic issue. It originates from complex interplay of internal processes that has its roots or conditions long embedded in the lives of the person and his family and environment. The conventional reductionist approach of isolating a cause and treating it is likely to fall short when dealing with suffering. This is analogous to the hospice concept of total pain or total suffering – there is often no one single cause but a web of interrelated causes involving physical, psychological, emotional, social and spiritual domains.

2. The systemic nature of suffering (The "mass of suffering") touches everyone, including the doctors. The traditional approach to stand out of the situation, in the name of clinical objectivity or professionalism, is unreal as it ignores the impact of suffering to care professionals, much to their

detriment. There are many such examples in routine clinical practice: the suffering of a patient who is screaming in pain, or a family member wailing in bereavement, affects all penetratingly, except perhaps the most defended of individuals (or those most able to deny). But even for those who appear blasé, the energy in the defending or denying may manifest as clinical over-reactivity or detachment. The sense of helplessness often distresses many care providers in end-of-life care. From a systems angle, the feeling of helplessness may come from the failure to recognize or accept that we are a responsible and accountable part of the system, i.e. we cannot find the place and role that we want in the situation. It is conceivable that in this state of helplessness, we also contribute to the suffering of those in our care as we leave them without care.

3. Some may find the complexity of having a systemic view of suffering daunting, especially the part where we are all participants and potentially contributing and being affected by it. It is therefore useful to note that in Dependent Origination, the same factors that are involved in the origin of suffering are also the factors involved in its cessation. Moreover, just as the condition for the next link is determined by what arises or cease in the prior link, our action AND non-action matters all the same. In the systems view, we are all therefore the points of leverage in the Buddhist formulation of suffering. Though we cannot control every aspect of the system and therefore the eventual outcome, we can still induce a feedback loop to start a cascade that lead to a more favorable outcome. In the Second Noble Truth, the point of best leverage to nudge the system was identified by the Buddha as craving. In the field of conflict transformation, John Paul Lederach (2018) has used the phrase "a nudge of calm to shift the storm", which describes this possibility of our efficacy even in apparently difficult systemic situations.

4. From the systemic complexity of suffering that is implied by the Second Noble Truth, we can appreciate the value of a larger and more realistic perspective, in contrast to a moralistic one, about suffering, its causes and resolution. Firstly, we can be more humble about what we really actually know about the patient or family's suffering. Doctors often get fixated about knowing and may be too quick to attribute suffering to medical reasons. Blame and judgment are the related behaviors that occur with this approach and it may be directed at diseases, treatments as well as the patient, family or

healthcare team. Doing so not only distracts the work that is needed to address the suffering, it also makes it more difficult for the other parts of the system to work together to respond to the suffering. A related insight for any care worker might be the sobering realization that the suffering has arisen from many years (even lifetimes) of conditions involving a web of complex causes, and so it would be quite delusional if we believe that the suffering should go away simply from our interventions weeks or even months before the person dies. This implores us to tread non-judgmentally, with humility and equanimity. In the Zen Buddhist teachings, this is embedded in the practice of Not Knowing. With this perspective on suffering, care workers may not feel compelled and hold themselves accountable to solve all of the patient/families problems, which can arise as a form of "idiot compassion" and pathologic altruism.

5. Hope and hopelessness

The associated task of the Second Noble Truth is to abandon the craving that is the described as the root cause of the suffering. But for the dying patient or the family members who are caught in the midst of the emotional storm of dying, giving up what they desire, or what they have so dearly clung on to, is often misperceived as giving up hope. Here, the systems approach of adopting multiple perspectives may be valuable guidance. This is to see things clearly and at multiple levels and time frames in the system (Lederach, 2003, p. 48-50) in particular, developing the presence to look beyond the symptoms and " noise" for the higher levels of the action models such as the patterns, structure, world views or mind-sets, and vision or purpose of what is transpiring. In situation where patients and families struggle with treatment decisions, dealing with these higher levels of perspective may be more productive than confronting the demand for specific situations, treatments or objects on the supposition of "hope". A common end-of-life example might be the desperate grasping and craving for any available treatment while the goal of care remains unaddressed; but if what really matters in a bigger scheme of things and time are clarified, the goal is usually established as comfort, at which many of these burdensome interventions become irrelevant.

Often, in the turmoil, perspectives are often constricted around the problematic issues, which can in turn lead to a sense of hopelessness. As Sullivan (2003) explains:

> "We think of hopelessness as the absence of hope. But if we remember the wider range of hope possible, another understanding emerges: Hopelessness is not the absence of hope, but an attachment to a form of hope that is lost. If we are tied to a hope for survival that is "sinking into the deep blue sea", we will be unable to see the other forms of hope floating before us. This possible diversity of hope suggests the challenge at the end of life is not so much protecting or restoring hope as diversifying and redirecting hope." (p. 393-405)

6. Calming down

In situations with high levels of emotionality and expressivity, there is a tendency to request the participants to "calm down". In actual practice, requiring the patient and family members to do this is often unproductive; telling them to calm down (though I note this is commonly recommended in training for care providers) are at best ineffective, and worst, leads to emphatic failure and the perception of insensitivity. The first step is perhaps to consider how we may be contributing to the situation, as we are inevitably part of the system and the system is designed to produce exactly this outcome that is experienced (Joshin 2018). Anything that directly involves us would theoretically be easier to control than if the loci of control lie with others.

Apart from staying close and connected, against our habitual instincts, John Paul Lederach (2018) also recommends being the "non-anxious presence". Being in the system means that we are in a position to shift it. Here, providing the experience and model of calmness (e.g. curbing our own reactivity), the patient and family may pause from their habitual patterns. For them, the possibility of calm and composure treats the notion that "things will only get worse". This experience may be the doorway to finding the hope to live through the storm.

Case Study – "Nudging the storm": Chong

A 44-year old mother of 2 young children who had very advanced and metastatic breast cancer, asked her primary oncologist to provide terminal sedation as she could see no meaning in life. He actually sedated her but after 3 days, the patient somehow asked for it to be reversed. I was later asked to see her for "depression" by a covering oncologist as she spoke to him of the desire for suicide. She was quite alert and rather asymptomatic, though weaker than her usual. There was something that was discordant about the scene at the bedside. This young mother, still alert and composed in the same room as her 2 young children, and yet she wanted to die. I posed a question about how she may want to use the time with her children. Almost automatically, she replied: "I have already done the will; they will be taken care of" We continue to speak about her impending death as an expectation, her suffering but also about how she can "live" this time - I clarified that I was interested to hear what she wants to do while she is alive. She paused. We continued the conversation with what others may want to do. Her interest seemed somewhat piqued. Before we stopped, I asked if she could find a place of peace within her body. She pointed to her chest, and we practiced how she may access that place of peace. I offered that I will come by if that's what she wanted, knowing that there is an obvious reluctance of the primary oncologist for a palliative referral – she had by then been staying in the ward for more than a month. I was mindful that they had probably a longer relationship and that can be a source of support, even though we may differ in our approaches. After that session, she (or the primary oncologist) did not ask for another consultation again. I was later informed that she continued to receive care in the ward, and died 3 weeks later due to natural progression of the disease.

The outcomes of such consultations are always uncertain; how it ends does not necessarily predict what may follow. It is a reflection of the complexity of the real life interactions between what goes on in the present as well as the conditions of the past, and the unknown event of the future. It is the practice of Not Knowing and riding the waves. There must have been a lot that happened such that this mother had "forgotten" her role as mother, even in

front of her kids. I cannot barge in and fix her, just as I cannot change the oncologist, or any parts of the system that had led to this outcome. Perhaps it was a "nudge" that reminded her there may still be reason to live, no matter how short it might be? I guess I will never know.

The Third Noble Truth

> *"Now this, monks, is the noble truth of the cessation of suffering: it is the remainderless fading away and cessation of that same craving, the giving up and relinquishing of it, freedom from it, nonattachment.*
>
> *"This is the noble truth of the cessation of suffering': thus, monks, in regard to things unheard before, there arose in me vision, knowledge, wisdom, penetration, and light.*
>
> *This noble truth of the cessation of suffering is to be realized': thus, monks, in regard to things unheard before, there arose in me vision, knowledge, wisdom, penetration, and light.*
>
> *This noble truth of the cessation of suffering has been realized': thus, monks, in regard to things unheard before, there arose in me vision, knowledge, wisdom, penetration, and light".*
>
> (SN 56:11V420-24)

As quoted earlier, the Buddha had discovered the Noble Truths with the specific intention of ending suffering, especially from the endless cycle of rebirths. It was significant that the Buddha' enlightenment had always been described as following his realization of the cessation of suffering and not just upon the discovery of the origin of suffering.

> *"It occurred to me: 'When what does not exist does consciousness not come to be? With the cessation of what does the cessation of consciousness come about?' Then, monks, through careful attention, there took place in me a breakthrough by wisdom: 'When there is no name-and-form, consciousness does not come to be; with the cessation of name-and-form comes cessation of consciousness.'*
>
> *"Then, monks, it occurred to me: T have discovered this path to enlightenment, that is, with the cessation of name-and-form comes cessation of consciousness; with the cessation of consciousness comes cessation of name-and-form; with the cessation of name-and-form,*

> *cessation of the six sense bases; with the cessation of the six sense bases, cessation of contact.... Such is the cessation of this whole mass of suffering.*
>
> (SN 12:65)

We shall see how this can relate to clinical work later.

And while the cessation of suffering has been described basically in terms of the extinguishing of craving, elsewhere in Buddhist literature would describe this state as the attainment of Nibbana. Defining Nibbana is tricky, as a non-conditioned state is said to be indescribable with conditioned terms. Hence, Nibbana has been described commonly with negative descriptors, i.e. as what it is not. And with regards to our topic of discussion, recommending Nibbana to patients at the end of life and their families can be quite awkward as Nibbana commonly brings forth ideas of extinction and fading away. Nevertheless, there are sections in the Buddhist Pali literature that provides some useful and more positive features of Nibbana:

> *"This is peace, this is exquisite — the resolution of all fabrications, the relinquishment of all acquisitions, the ending of craving; dispassion; cessation; Nibbana."* (AN 3.32)

> *"There's no fire like passion,*
> *no loss like anger,*
> *no pain like the aggregates,*
> *no ease other than peace.*
>
> *Hunger: the foremost illness.*
> *Fabrications: the foremost pain.*
> *For one knowing this truth as it actually is,*
> *Unbinding is the foremost ease.*

Freedom from illness: the foremost good fortune.

Contentment: the foremost wealth.

Trust: the foremost kinship.

Unbinding: the foremost ease." (Dhp 202-205)

Cessation of suffering and end-of-life care

While it is quite unlikely that recommending Nibbana will catch on as a therapeutic approach in clinical practice, the experience of not responding to triggers in a habitual manner can itself be liberating. Almost anyone would have experienced the relief of letting go of an object that is causing pain, for example, when we let go of a very hot glass of water. The experience of the heat dissipating from the fingers, the relaxation of the tightened muscles, the sigh of relief and the arrest of escalating anxiety and mental catastrophizing, can probably offer a glimpse of a moment of letting go. But such letting go is unlikely to be good enough as a once-off attempt, especially with reference to the end-of-life experience. In the dying process, symptoms can arise depending on the progression of the illness and how the body eventually shuts down. Emotions like anxiety or fear, or anger may also arise or re-surface, even though the issues that were thought to have provoked them may apparently have been addressed. Confusion is also commonly observed as one gets closer to dying. It seems, then that the process of dying necessitates a series of letting go, which eventually culminates in the often involuntary "letting go" of the physical body. So realistically, to just be present for each moment of letting go, and not craving for more or grasping and clinging for the moment seem more appropriate for dying patients and their families instead of suggesting of a state of "happily ever after".

Seeing a little more of dying and death

But even to state the Third Noble Truth is extremely significant. It dispels the assumption that knowing what caused the suffering automatically implies having the way to solve it. This point could

not be emphasized enough in the medical setting. The fact that we know the causes of the diseases, even if it had led directly to the suffering does not mean we know how to relieve the suffering. The gap between biomedical treatment and the eventual recovery of the person, which is to be filled by care, has been highlighted earlier. But even when there is a direct link between a state of disease and suffering, many of the conditions at the end of life, such as grief or the physicality of dying, the way to relieve suffering has little to do with simply reversing the causes, many of which are not reversible.

Knowing what cessation is about also has another parallel in end-of-life care. To most people in modern societies, the process of dying has become unfamiliar, since for most of them, dying very often takes place in the sanitized place of the hospital. Even to the care providers, many are more aware (and comfortable) with wellness, sickness and even death, but the period between sickness and death often appears as a blur. The more senior the clinicians, the less likely they will be sitting by the bedside with the patient till the last breath. Even the ward nurses are nowadays too busy to be doing that. Death sometimes become "discovered" in the ward rather than observed. As a result, most have become unsure about how to respond to the moment-to-moment changes as life comes to a close. Often, they may be knee-jerk responses that tend to cause more commotion than needed, or on the other hand, there could be neglect, when care is most needed. The current medical literature about what is observed at the end of life focusses on the common symptoms (Hui et al, 2014, Hui, et al, 2015). These are useful guideposts for the physical trajectory, but to conclude that is all to note would have missed out a great deal that continue to change and may carry significant meaning at the end of life.

Case Study - Cessation: Shan

> *Shan (not her real name) was a lady in her late forties who was dying from metastatic breast cancer. In the early course of her terminal illness, pain from metastatic lesions to the mediastinum and right femur were at the foreground of her experience, but fortunately, these symptoms abated with treatment. At times, we sensed her fear and anxiety about dying though she was reserved about going deeper on these issues. Towards the end, Shan chose to*

be at home, cared for by her mother. The last days were marked by confusion and delirium, contributed by hepatic encephalopathy secondary to extensive hepatic metastases.

One morning, mother called to say that Shan was not responsive though seemingly comfortable. Medically, she had come to the final stage of her life, and will probably die while in coma. But perhaps sensing the neediness in her mother's tone, I decided to make a home visit anyway.

When I arrived, she was deeply jaundiced, gasping and lying quite motionlessly. Blood pressure was no longer recordable and her pupils were dilating. Probably short hours to her death, I thought. And while her eyes remained closed, she still managed quite surprisingly to shake her head just barely perceptibly when I asked if she had pain, and nodded when I asked if she was comfortable. I then proceeded to prepare the family for her impending demise. Then suddenly, her eyes opened widely, to the astonishment of her family who had gathered in her room. Was I wrong about her prognosis? In all medical likelihood, she was on the brink of finality! I paused to consider what this situation is about. Then just guided by the flow, I asked the family to go the side of the bed on her left. Her eyes drifted to the left where most of her family was, and mother emotionally reaffirmed her commitment to look after Shan's young children after her death, and bade her to die in peace. Then Shan's eyes drifted towards the right. I looked around, and saw that her father, a rather reserved person in the family, was standing as usual in the fringes. He was always in the background. I showed him the way to Shan's right, where he too, offered his consoling and brief words. After a while, the eyes drifted back to the midline with the same slow but measured and clearly deliberate pace. She closed her eyes, and within minutes, took her last breath.

All too frequently, we assume that the process of cessation is all negative and nihilistic. But if we pay more attention and stay open to what may unfold beyond standard "vital signs" parameters, then we may discover much more that is going on, continuing, evolving, and perhaps even transforming.

These signs are usually subtle and less visible, though some are more dramatic, some obvious only if we look out for them, but they all have the potential to offer new meanings and solace to the patient or the family, and to the care providers about suffering.

But to be at the bedside to observe without contaminating with our personal and clinical agenda requires presence, openness, willingness to turn towards the suffering that unfolds, skills that are seldom provided in the training of doctors. The next chapter will discuss the Fourth Noble Truth - the path of cultivation towards the end of suffering, where we will also consider the cultivation of those who care for others at the end of life.

The Fourth Noble Truth

> *"Now this, monks, is the noble truth of the way leading to the cessation of suffering: it is this Noble Eightfold Path; that is, right view, right intention, right speech, right action, right livelihood, right effort, right mindfulness and right concentration.*
>
> *"This is the noble truth of the way leading to the cessation of suffering': thus, monks, in regard to things unheard before, there arose in me vision, knowledge, wisdom, penetration, and light.*
>
> *"This noble truth of the way leading to the cessation of suffering is to be developed': thus, monks, in regard to things unheard before, there arose in me vision, knowledge, wisdom, penetration, and light.*
>
> *"This noble truth of the way leading to the cessation of suffering has been developed': thus, monks, in regard to things unheard before, there arose in me vision, knowledge, wisdom, penetration, and light."*
>
> (SN 56: 11 V420-24)

The Fourth Noble Truth concludes the "complete package" of teaching offered by the Buddha: the elucidation of suffering, the mechanisms leading to its arising and cessation, what happens upon its cessation and finally the road map, which is proclaimed as the Noble Eightfold Path, to get there. The assertion that this Path has to be developed is significant – cultivation is to be expected, and as with many Buddhist teachings, deep insight (what is often referred to in Buddhist literature as "penetration") emerges from the depth of practice rather than direct instruction.

Changing the relationship with suffering

Earlier sections of this paper alluded to the uneasy relationship between biomedicine and suffering. The contributory causes to this relationship is multidimensional: the evolving world views or

perspectives on suffering in the age where science is buoyantly regarded (at times to the point of infatuation) and waning influence of religion; the disproportionate medical focus on disease rather than person; the economic incentives that shifts parameters of care to impersonal metrics such as efficiency and productivity; the financial rewards of prescribing and lack of it for care; the personal burden of meeting suffering among care staff, and the lack of institutional support to deal with suffering. Given this backdrop, one might even wonder if this relationship may be changed.

As illuminated by the Paticcasamuppada, the moment of contact with stimuli (a sense object with one of the six corresponding sense doors) elicits a patterned response, which may be determined by how we have been conditioned: by our present life habits, by our interaction with others and the environment, by significant events in our life, and even by our past lives. Understanding the conditions for a compassionate response to suffering may therefore pave the way for a more congruous relationship.

Evolutionary beginnings

From the perspective of evolutionary psychology, Paul Gilbert (proposed that we have evolved three distinct functional emotional systems to respond to different scenarios that had basic survival significance (Figure 1), raising the possibility that we are biologically hardwired to care for others:

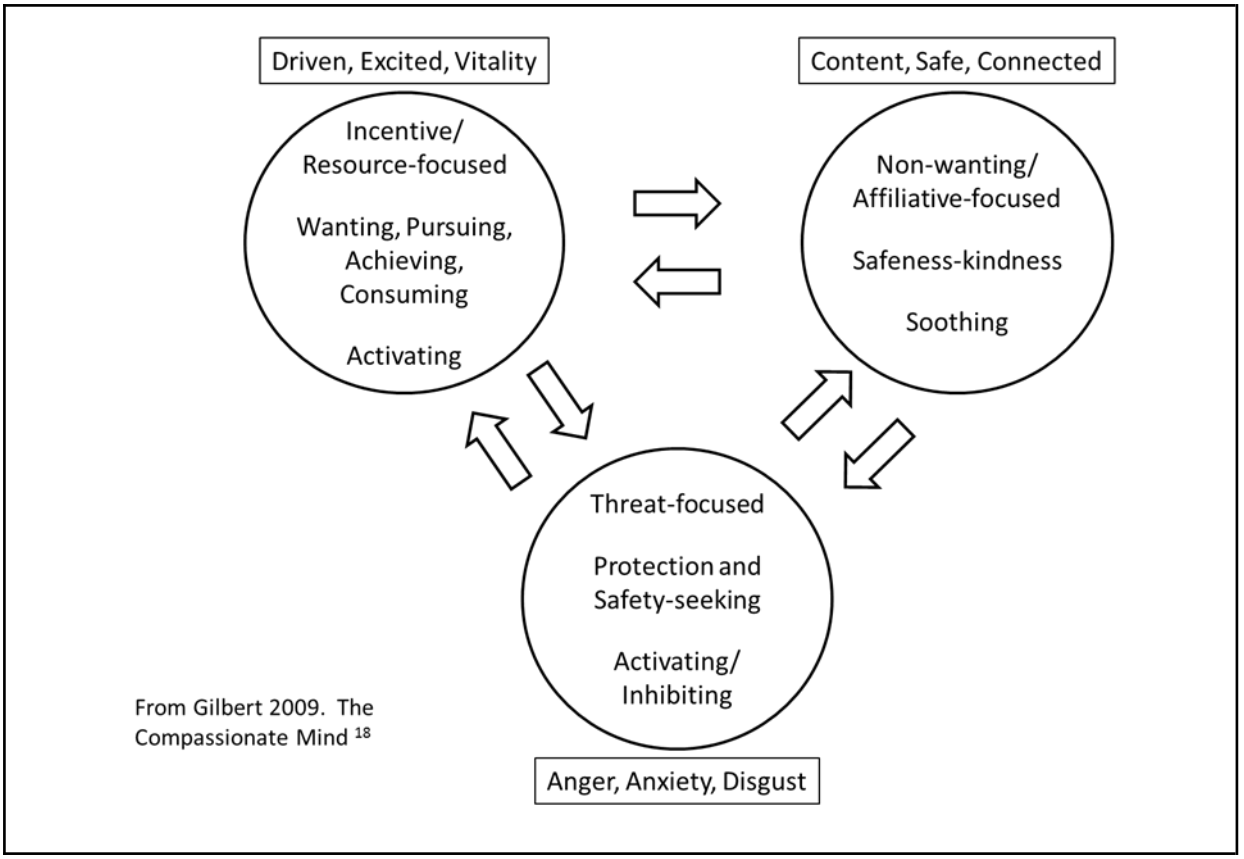

Figure 1. The interaction between three major emotion regulation systems

- **Threat and self-protection focused system** – which enable the individual to detect, attend, process and respond to perceived threats or danger. The emotions involved include anger, anxiety and disgust and behaviors elicited from this system include the preparation to fight or confront, to run away to safety and to play dead or submit (fight-flight-freeze).

- **Drive, seeking and acquisition focused system** – which enable seeking and securing resources that enhances the social position and the perhaps the chances of passing on the genes through procreation. The experience of the activation of this system includes the excitement and pleasure in pursuing and securing resources and the positive feelings of achieving and winning.

- **Contentment, soothing and affiliative focused system** – which enable the state of peacefulness, openness and satisfaction when the individual is no longer focused on threats or seeking resources. This system is associated with caring and soothing, as well as trust and bonding behaviors. It imparts the experience of warmth and comfort in belonging and

> connectedness, and has been found to be mediated by the neurotransmitters oxytocin and vasopressin. This is the system from which compassion emanates. Given the prolonged period that the human child remains vulnerable before maturity, the presence of a mother who can attend to the child in distress is absolutely vital for survival of the human race. It is postulated that the same system is also adapted to ensure that humans can live harmoniously in communities, developing positive feelings of safety and trust in belonging and caring for each other, instead of becoming territorial. Prosocial behaviors, which include actions that ensure the well-being of others in a community such as the capacity to recognize and extend help to those who are in distress, are related to the activation of this system. Conversely, the lack of attachment or belonging can induce significant distress in the individual. In this model, compassion is therefore not only hard-wired and innate in everyone, it is an essential component for our sense of security and well-being.

It is also postulated that these three primitive systems tend to work exclusively of each other, with some exceptions mentioned below. For example, when we are responding to danger, it would be unlikely that we engage in the excitement and pleasure of seeking. Similarly, when we are competitively engaged in seeking and achieving, it is difficult to focus on settle down enough to build bonds and attend to others.

But beyond these three primitive emotional systems, the evolutionary leap in humans that differentiates them from animals comes from the marked development of the neocortex or new brain. The capacity to think, reason, imagine and create meant that we can potentially override the primitive systems. Hence, our imagination and creativity may result in our continuation to perceive threats even in their absence, thereby leading to continued anxiety and hypervigilance. Importantly, it also meant that we can choose to be less reactive and even focus on others in the midst of our pain and danger. This raises the possibility that we can train to be more compassionate.

Mirror Neurons and Empathy

Another indication of our innate capacity to feel what others are feeling comes from the discovery of "mirror neurons". Mirror neurons are a type of brain cell that increase their activity during the execution of certain actions and while hearing or seeing corresponding actions being performed by others (Winerman, L. 2005, p. 48). Initially identified in the ventral premotor areas, they are now found in other regions in what may be termed as putative mirror neuron system (Keysers, C. 2009, p R71-73; Hayes, C., 2010, p. 575-83). While their exact roles in helping humans understand others may still be controversial, it is generally agreed that they contribute to our ability to empathise with others when we see or listen to them. So when we observe someone in pain, we may be actually able to appreciate this same pain in a tactile way.

The relevance to our discussion here is how one may be able to empathise with others through an appreciation or awareness of his or her own bodily sensations. The ability to be aware of one's bodily sensations, also termed interoceptivity, was noted to be associated with the capacity for empathy. It is observed that those with an innate inability for interoception, such as those with a condition known as alexithymia, also have difficulty in empathy (Bird & Viding, 2014; Halifax, J. 2012).

From empathy to compassion

But empathy by itself does not always lead to compassionate acts. While the empathic sharing of happiness may be encouraged by the pleasant and enjoyable relationship, the empathic sharing of suffering can deter one from further relating with the sufferer. Studies by workers such as Batson and Eisenberg indicate that an empathic response to suffering can result in two reactions – *empathic distress* which is a self-oriented, reactive aversion that leads to the classic threat responses (i.e. fight/flight/freeze) or selfish prosocial actions (e.g. protection of own kind); and *empathic concern*, which leads to an other-oriented, selfless prosocial action (compassion) (Eisenberg, N., 2002; Singer, T. & Klimecki, O.M., 2004; Lamm, C., Batson, D., Decety, J. 2007; Halifax, J., 2011; Rushton, C.,Kaszniak, A.W., Halifax, J., 2013), In a situation of encountering the suffering of others, the following factors are believed to determine one's emotional responses (Figure 2):

- perspective taking (self or other differentiation)
- the ability to regulate one's emotions to the arousal
- past experiences

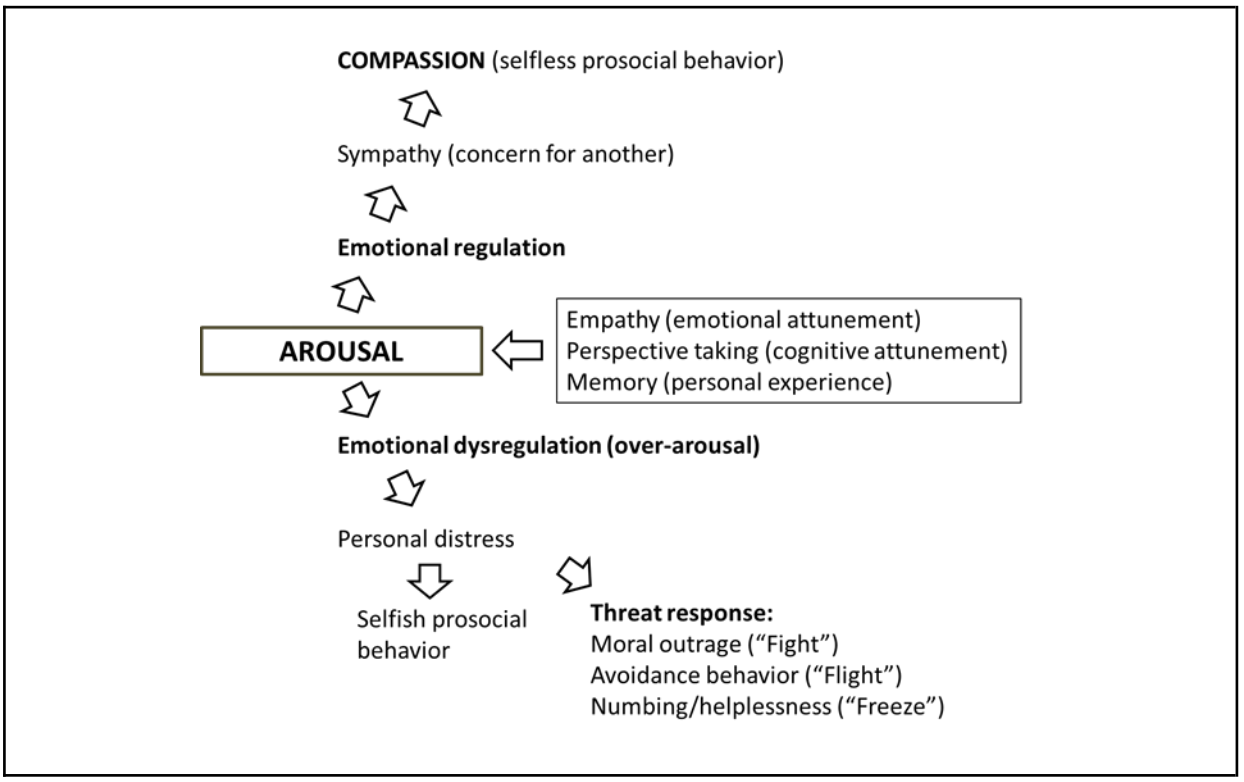

Figure 2. Empathic concern versus empathic distress

It is believed that those who develop distress in such situations may be unable to shift from a self-oriented to an other-oriented perspective. This may in turn be the result of past experiences and the difficulties in staying in the present [27, 29]. In other words, those who become emotionally over-aroused are likely to become distressed and withdraw in self-protection (Halifax, J. 2011; Jazaieri, H., Lee, I.A., McGonigal, K., Jinpa, T, Doty, J.R.,… Goldin, P.R., 2015), while those who could avoid over-arousal to the suffering of the other are more likely to follow with compassionate action.

With this background on the ingredients that conduce or thwart compassionate responses to suffering, we will now explore how the Noble Eightfold Path may provide guidance with regards to the developing a more compassionate paradigm of care.

The Noble Eightfold Path and the cultivation of compassionate care

I shall employ the concise factorial analysis by Bhikkhu Bodhi (1999) as a framework to discuss the specific elements of the Noble Eightfold Path (Table 1).

Table 1. Factorial Analysis of the Noble Eightfold Path (Bikkhu Bodhi 1999)

	Pali	English
I	**Samma ditthi** ● Dukkhe ñana ● Dukkhasamudaye ñana ● Dukkhanirodhe ñana ● Dukkhanirodhagaminipatipadaya ñana	**Right view** ● Understanding suffering ● Understanding its origin ● Understanding its cessation ● Understanding the way leading to its cessation
II	**Samma sankappa** ● Nekkhamma-sankappa ● Abyapada-sankappa ● Avihimsa-sankappa	**Right intention** ● Intention of renunciation ● Intention of goodwill ● Intention of harmlessness
III	**Samma vaca** ● Musavada veramani ● Pisunaya vacaya veramani ● Pharusaya vacaya veramani ● Samphappalapa veramani	**Right speech** ● Abstaining from false speech ● Abstaining from slanderous speech ● Abstaining from harsh speech ● Abstaining from idle chatter
IV	**Samma kammanta** ● Panatipata veramani ● Adinnadana veramani ● Kamesu micchacara veramani	**Right action** ● Abstaining from taking life ● Abstaining from stealing ● Abstaining from sexual misconduct
V	**Samma ajiva** ● Miccha ajivam pahaya ● Samma ajivena jivitam kappeti	**Right livelihood** ● Giving up wrong livelihood ● One earns one's living by a right form of livelihood
VI	**Samma vayama** ● Samvarappadhana ● Pahanappadhana ● Bhavanappadhana ● Anurakkhanappadhana	**Right effort** ● The effort to restrain defilements ● The effort to abandon defilements ● The effort to develop wholesome states ● The effort to maintain wholesome states
VII	**Samma sati** ● Kayanupassana ● Vedananupassana ● Cittanupassana ● Dhammanupassana	**Right mindfulness** ● Mindful contemplation of the body ● Mindful contemplation of feelings ● Mindful contemplation of the mind ● Mindful contemplation of phenomena
VIII	**Samma samadhi** ● Pathamajjhana ● Dutiyajjhana ● Tatiyajjhana ● Catutthajjhana	**Right concentration** ● The first jhana ● The second jhana ● The third jhana ● The fourth jhana

Organization of the Noble Eightfold Path

As a path of spiritual development, the path factors are organized into three aspects of training: the path may begin with moral discipline (right speech, action and livelihood) as the foundation for concentration (right effort, mindfulness and concentration), which in turn becomes the foundation for penetrating wisdom (right view and intention), which in turn becomes the device for attaining liberation through the elimination of all ignorance. This differs from the usual articulation of the path, which begins with right view and right intention. Bhikkhu Bodhi (1999) explained that the presence of some wisdom is essential to set the right direction and context for proceeding with the other paths, much like having an idea of where we want to go before we start driving and reaching there. In the same way, I concur that the same preliminary sense of perspectives and motives behind the provision of care is similarly important for an approach to suffering at the end of life.

In the schema presented by Bikkhu Bodhi (1999), this is followed by Moral Discipline and then Concentration, by which time, the deeper meanings in the Wisdom division may be more comprehensible.

However, in the practice of socially engaged Buddhism, the ultimate goal of cultivation is compassionate service. In the Zen paradigm, what emerges from the practice of wisdom and cultivation of concentration is compassionate action to others. And since the focus of this paper pertains to an approach to serve others, I believe that this order of organization may be also provide some measure of coherence. Here, I will also invoke the Three Tenets as taught in Upaya Zen Center, and juxtapose them with the more traditional discussion of the factors. The intention is not so much to contrast the differences as to see how they may be complementary.

But ultimately, just as it was earlier discussed about the organization of the Four Noble Truths, these factors are by no means linear in their relationships and it is with the collective practice that the attainment of each factor progressively deepens, and eventually leads finally to enlightenment.

Division of Wisdom (Panna); Three Tenets: Not Knowing

The **Right View** (Samma Ditthi) refers essentially to the Four Noble Truths, which establishes the universality of suffering, its origins, cessation and path to cessation. To summarize some of the ideas that had been described in the earlier sections:

- The concept of the pervasiveness of suffering for all beings puts into perspective that suffering is not just a personal experience but a collective experience that affects all humankind and even all beings. Thus, this helps to shift one from "my" suffering (a "self" orientation) towards "our" suffering (an "other" orientation) (Noble Truth (NT)1).
- Bringing suffering into forefront of the discussion, it highlights what many would rather not address - the 'elephant in the room' about human suffering. But once we acknowledge suffering in our midst, it also invites the empathic process and the compassionate response (NT1).
- The dispassionate constructs of suffering in the Noble Truths and the related law of Kamma are probably significant in inducing compassion to suffering, rather than shame and avoidance that one may expect if suffering is proclaimed to be the result of some fundamental human defects or deficiencies (NT2).
- It encourages a Middle Way approach, neither being detached nor enmeshed (Dhammacakkapavattana Sutta)
- It advocates for a systems approach rather than a linear formulation of suffering (NT2)
- Articulating the cessation of suffering as a separate Noble Truth worthy of understanding, practice and attainment, it illuminates what end-of-life care might look like (NT3).
- The behaviors that conduces the application of this approach includes: seeing deeply and clearly, staying present and open (turning towards suffering and death), letting go/non-striving, and finding a place of rest. We shall discuss these further (NT4).

The Right View therefore plays an instrumental role in providing what researchers and scholars have termed perspective on self and others (Bomemann & Singer, 2013) and perspective taking and insight

(Halifax, J. 2012; Halifax, J. 2011). This also supports selfless prosocial motivation, which in the Batson-Eisenberg models, are more likely to result in compassionate behavior (as opposed to selfish prosocial behavior, or compassion only limited to related persons) (See Figure 2). Hence, Right View provides the ideation that will subsequently invite the intent and motivation for compassion to all. But beyond its initiation, it can be conceived that the returning to, or not wavering from such a view is crucial to maintain one on course for the fruition of compassionate behavior. This particular aspect shall be discussed further in the paper.

Right Intention (Samma Sankappa) elaborates the intention of renunciation, goodwill and harmlessness, which address the wrong intentions of craving/desire, ill-will and harmfulness respectively. It can be easily noted that these intentions all move one to loosen self-directed intentions (by renunciation of craving) and to attune to others with an altruistic intent (through goodwill and harmlessness).

More pertinently, intent intimately determines the nature of actions that may follow. Compassion is often described as a mental state that comprises not just an empathic emotional element but also involves the intent to alleviate suffering. The corruption of intent often results in unwholesome actions performed in the name of compassion. For example, compassion may be subverted for the egoistic pursuits of name, glory and status in charitable or volunteer activities (Batson, Ahmad & Tsang, 2002). "Compassionate killing" or involuntary euthanasia represents another corrupted process. Likewise, there are numerous reports of "compassion fatigue", where compassion is erroneously attributed as the cause of detachment, avoidance and helplessness of workers in the people helping industry, which in reality, are essentially facets of the threat response. It may be observed that the emotional systems that are activated in these examples pertain to either the drive, seeking and acquisition focused system or the threat and self-protection focused system in Gilbert's model (Gilbert, P. 2013, p 126-149).

In Right Intention, the intention of renunciation may therefore weaken the seeking or competitive attitude which is based on craving, particularly with regards to objects that we have traditionally

associated with the preservation or enhancement of the concept of "self". So long there is craving for sensual gratification, it will be difficult to open to the suffering of others (it may even deny our own suffering as well). Without the interference from personal craving which may subvert the feeling of compassion, one is also in a better position to respond appropriately to the suffering of others. Likewise, the intentions of goodwill and harmlessness address the aversive aspects of experience. It is the aversion to suffering that usually shifts us to the threat responses of fight, flight and freeze, all of which turns us away from suffering.

From the Zen tradition, between the two factors, Right View and Right Intention, a certain common quality of being can be further discerned – the tenet of **Not Knowing**. Not Knowing relinquishes any fixed ideas about any situation and thereby permits one to stay present and be open to all possibilities. In doing so, we withhold our judgment and suspend our reactivity and so give ourselves the time and space to see things as they are, avoiding any premature or habitual responses, and neither pushing away suffering nor grasping or clinging to happiness. It is notable that many acts of cruelty and harm comes about from the attitude of Knowing, even if it were "unintentional". When we believe we already know, we do not see the need to learn more. Revenge, defensiveness and aggression may also be justified by what we want to believe about the situation, which is often about how we have been harmed, cheated, betrayed, taken advantage of, or hurt. In the medical setting, labelling patients as non-compliant, uncooperative, recalcitrant are common examples of Knowing. The mechanical adherence to "evidence-based medicine", protocols or other medical dogmas on the basis of "knowing" is another example that can lead to harmful practices. In the pharmaceutical industry, there are many examples where drugs known to be "safe" had to be eventually withdrawn because of their harmfulness. A recent email notified me of the controversial approval of sublingual sufentanil, which is not only a highly addictive opioid, but also in a form that invites misuse. Clearly, those who had approved it and learned people who "knew" why it was should be approved.

But in the medical setting, doctors are expected to "know" and they often also feel proud about the depth of their expertise. Not Knowing may therefore appear antithetic to the preferred "doctor" demeanor. To resolve this dilemma, one might find comfort that Not Knowing actually creates the

pause and space for "new" knowing. More pertinently, it avoids the compulsive pressure to know, or the discomfort of not knowing or worse of deceiving that we know. This might be extremely useful when coping with the inevitable uncertainty of the dying process, and indeed the great unknown in death.

Division of Concentration (Samadhi); Three Tenets: Bearing Witness

The next three path factors, Right Effort, Right Mindfulness and Right Concentration, constitute the division of concentration (Samadhikkhanda), which focuses on the mental training to develop the concentrated mind. In the Theravadan tradition, this is the mind with which one attains penetrative wisdom. The cultivation of a mental disposition is also pertinent for compassion as it is not an effortless endeavor. It requires one to stay with the experience of other's suffering, which is understandably not what the conditioned mind may naturally opt to respond by. This division is akin to the tenet of Bearing Witness in the Zen Peacemaker tradition.

The first path factor of this division, **Right Effort** (Samma Vayama), comprises these four key tasks:

1. to prevent the arising of unarisen unwholesome states;
2. to abandon unwholesome states that have already arisen;
3. to arouse wholesome states that have not yet arisen;
4. to maintain and perfect wholesome states already arisen.

The unwholesome states (akusala dhamma) are the defilements of mind, which may be described by the set of "five hindrances", namely: sensual desire, ill-will, dullness and drowsiness, restlessness and worry, and doubt. The impact of sensual desire and ill-will in hindering compassion has been described earlier. The other three may arise from the failure to perceive the importance of compassion (i.e. earlier discussed as perspectives), and may also be related to the presence of a deluded mind.

The wholesome states (kusala dhamma) are described in various ways, one of which is the set of "seven enlightenment factors" (satta bojjhanga): mindfulness, investigation of phenomenon, energy, rapture, tranquility, concentration, and equanimity. Again, such factors are just as important in the development of compassion. *Mindfulness* brings insight to the experience in the here and now, which is necessary for one to appreciate another's suffering as it is without adulteration or censorship. To respond with compassion, it is also vital to stay in the present, lest our efforts become thwarted by imagined concerns or past memories. *Mindfulness* also prepares the mind to utilize a spirit of *investigation* in order to fully engage with the sufferer's experience, instead of using conditioned responses. The *energy* (viriya), with which one strives towards enlightenment, is similarly applicable to compassion. One may be enthused by the situation to be compassionate, but the energy to persevere will be called upon as compassionate work may require unrelenting efforts, until the stage where one can derive *energy* from an absorbed state of compassion to sustain the work itself. By that time, there may also be *rapture*, which in this case, may arise from the joy of compassionate service. This may equate to the state of "flow" or "second wind" which is not uncommonly described among artists or athletes, as a state of increased energy and sense of ease when one enters this state.

In the schema of the seven enlightenment factors on the path to liberation, further practice results in *tranquility*, which then leads to *concentration*, the deepening of which results in *equanimity*. Such a sequence harkens to the activation of the affiliative emotional system described by Gilbert (2013). For one to be able to provide unconditional compassion, the state of mind is one of ease, calm and equipoised, and necessarily extricated from the seeking/ competitive state and the threatened states. The analogy that often comes to mind is the imagery of the nursing mother providing unconditional love and attention to her child: contented, present, absorbed and remaining unfazed by the environment or the possible fretfulness of the child.

The next factor in this division is **Right Mindfulness**. In the presence of suffering, the practice of mindfulness enables one to stay open, present, and engaged, suspending judgment, and be undistracted by thoughts or emotions. The core psychological process operating is that of attentional focus. Beyond merely staying present with the other's suffering, the association between

mind-wandering and lower levels of care has been described (Jazaieri, H., et al, 2015). Interestingly, the mindfulness methods advocated by the Buddha have been demonstrated to be relevant to developing attentional focus and compassion. For example, the simple practice of returning attention to the breath or a specific part of the body is known to calm the mind, in addition to other physical benefits (Halifx, J., 2011). Open-field awareness, which teaches the noticing of phenomena arising without reactivity, trains the mind to deal with upheavals with calm and equanimity. These practices can therefore help one to avoid being so overwhelmed by suffering that the possibility of any compassionate response is thwarted.

In **Right Mindfulness**, the Buddha recommended as objects for mindful contemplation the body, feelings, states of mind and phenomena. It is fascinating that such practices are also known to enhance the capacities for introspection and interoceptivity, both of which have been identified as important elements for the empathic aspect of compassion.

In **Right Concentration**, one ventures into increasingly sublimed mind states – the four jhanas. With each progressive jhana, the deepening concentration is associated with continuous and concentrated one-pointedness, neither pleasant nor unpleasant, devoid of emotion, experienced with the neutrality of equanimity.

But the ultimate purpose of concentration is not so much in the attainment of jhanic states as the development of the mental capacity to derive deep Wisdom. Contemplating deeply on the many aspects of existence with clear and sustained concentration, one may go beyond the intellectual knowing, to experience the truth about the nature of existence, in particular, the innate mirage of the self, and the fundamental futility of craving and aversion. It may be conjectured that at such a point of spiritual development, one would be fully open to the experience of suffering, understanding its roots and consequences, appreciating its scale and proportions, but yet not perturbed to respond in any conditioned way. Perhaps this represents a glimpse of what is construed as Maha Karuna, or Great Compassion of the Buddha.

Bearing Witness to suffering is not the same as being a passive bystander. The elements involved in bearing witness to suffering includes accepting without attachment or judgment, permitting whatever arises or cease in that situation, listening, being present, holding mentally and physically all the joys and pains without selection, turning away or compulsively trying to fix, pathologies or change things. It conveys kindness instead of coldness; connection instead of isolation or abandonment; and solidarity instead of discordance. It therefore creates a compassionate space to help sufferers process what needs to arise or cease. It is in this way that Bearing Witness is also about "doing good". But for the doer, Bearing Witness is also about learning to let go of striving and patterned reactivity, and to maintain the internal spaciousness through emotional and physical regulation.

It may be obvious now that together with Not Knowing, Bearing Witness addresses all the conditions identified by the Bateson and Eisenberg model to produce an appropriate compassionate response to suffering.

Division of Moral Discipline (Sila); Three Tenets: Compassionate Action

The next three factors collectively form the aspect of the Eightfold Path that pertains to moral discipline (silakkhanda). A cursory inspection of these factors may lead to the conclusion that they constitute a personal code of moral conduct. Interestingly, examination of the content reveals that all the items specified in these factors relate to interpersonal conduct, in particular, conduct that ensures non-harming to others and preservation of social harmony.

In **Right Speech**, one abstains from false speech, slanderous speech, harsh speech and idle chatter. In **Right Action**, one abstains from taking life, stealing, and sexual misconduct. In **Right Livelihood**, one abandons a wrong mode of livelihood and earns a living by a right form of livelihood. Five trades had been singled out by the Buddha which a lay-follower should avoid: trading in weapons, living beings, meat, intoxicants and poisons (AN 177; iii 209).

It is easy to understand that engaging in such wrong speech, action or livelihood is not consistent with compassionate behavior, but what is less obvious is how abstaining from them may support compassion? The following may be postulated:

Firstly, it is possible that just by specifying what to abstain from, not only does one become more sensitive to how their physical actions and existence may harm or hurt other beings; it may also invoke mental surveillance of their compliance with these abstinences. As an actual practice, abstinence involves the processes of self-awareness, empathy, self-restraint and the regulation of personal desires and emotional impulses. It is notable that all these processes reiterate the findings from studies by Batson and Eisenberg on what needs to take place for compassion to occur (as depicted in Figure 2).

Secondly, while the prescribed abstinence may appear simply as a code of conduct, when interpreted as part of the path factors, this moral discipline becomes the foundation on which one builds concentration. This is underpinned by the notion that it would be immensely difficult for one to develop the necessary concentration while committing immoral actions. In the same way, the lack of moral conduct precludes one from compassion; abstaining from immoral conduct prepares the ground for compassion. One can also notice that all the conduct (speech, actions and livelihood) which the Buddha caution against are fundamentally antisocial in nature – they can disrupt interpersonal relations, sow unrest and discord, and can even lead to harm on other beings. The continuation of antisocial behavior would not be consistent with the prosocial nature of compassion.

Thirdly, some may argue that not doing antisocial actions does not mean that one becomes prosocial. Notwithstanding, it may be possible that this program of moral discipline is only the pre-requisite "entry" position (hence the foundation). Such an ideation would be in keeping with the descriptions of Right Effort (see later) where one begins with the discontinuation of harmful behaviors. However, it may also be possible that the Buddha is cognizant of how prevalent and ingrained these behaviors are to the common man, and this warranted a direct and clear reminder to avoid lapsing into such situations.

From another angle, the prescription of moral discipline also accords with the idea of the evolutionary design for humans to survive and flourish in compassionate communities. The sense of interdependence embedded in moral discipline is an important concept that underscores the basic necessity of compassion for "common good", instead of an expectation of a specific personal outcome or gratification. This once again reinforces the other-directed behaviors, which we have noted earlier is required for the emergence of compassion.

As mentioned in the earlier section, what emerges from Not Knowing and Bearing Witness, when given the space to do so spontaneously, would become compassionate action or "Doing Good to Others" as the Third Tenet of the Zen tradition is worded. The accompanying statement that goes with the Third Tenet as taught in Upaya Chaplaincy Training Program is worth mentioning:

> "I vow to invite all hungry spirits into my life, and commit my energy and love to the healing of the earth, humanity and all beings"

The vow, establishes the intention of practice. Within it, we can see the effort in committing to love and healing, both of which are positive frames of mind directed to the wellness and non-harming of others. And the scope, once again is humanity, all beings and even the earth – this reinforces once again the "big picture" mindset that may extricate one from the prison of the narrowness or obsession with the self-saturated or problem-saturated views. The phrase "invite all hungry spirits into my life" is a voluntary and courageous acceptance of what most people would be averse to - that we can become big enough to do that. It is also a statement of non-separateness and harmony (solidarity) with all beings, and it acknowledges what was discussed earlier as an insight from the systems perspective and the Second Noble Truth: we all co-create the world that we live in, and therein lies our compassionate obligation to ourselves and all afflictive states. This unique statement also shows the need for the combination of "soft" elements (inviting, love and healing, humanity and all beings) as well as the "hard" elements (vow, hungry spirits, energy, the earth) in the work to relieve suffering – something which Roshi Joan has experientially termed "soft front, strong back".

In summary, while the traditional interpretation of the Noble Eightfold Path in the Pali canon resembles a path for personal cultivation, there is much that it can inform as an approach of cultivating our capacity to attend to suffering in the medical setting. And clearly, the Zen Tenets are by design meant for the arising of compassion and therefore has much to offer to the paradigm of care. Moreover, it is conceivable that by addressing those issues that are associated with cognitive and emotional dissonance for the care providers, it may also become a kinder approach for care staff. The Noble Eightfold Path factors and the corresponding derived elements of an approach to suffering may be presented as follows:

		Elements of approach to suffering	
	Noble Eightfold Path factors	**Derivation from Noble Eightfold Path text**	**Derivation from Three Tenets**
I	**Right view** ● Understanding suffering ● Understanding its origin ● Understanding its cessation ● Understanding the way leading to its cessation	● Suffering as universal human condition, hence a more compassionate attitude towards all beings, including care staff. ● Attending to suffering as core expectation (NT1) ● Destigmatizing suffering (NT1) ● Middle way for care staff (NT2) ● A systems approach (NT2) ● Experiencing cessation and the EOL (NT3) ● Understanding the way to attending to suffering (NT4)	**Not knowing** ● Acknowledging complexity of systems, bias and uncertainty ● Allowing "new" knowledge ● Humility ● Accepting all possibilities ● Questioning assumptions and habitual responses ● Not harming
II	**Right intention** ● Intention of renunciation ● Intention of goodwill ● Intention of harmlessness	● weakening self-directed intentions, such as greed, gain, gratification ● intention to let go and not strive ● Enhancing altruistic aspects of experience rather than focus on aversive aspects	
VI	**Right effort** ● The effort to restrain defilements ● The effort to abandon defilements ● The effort to develop wholesome states ● The effort to maintain wholesome states	● Developing the capacity of restraint; strategies to stay present and open ● Dealing with doubt and self- conflicts ● Maintaining calm and equipoised state through meditative and reflective practices ● Developing joy and equanimity	**Bearing Witness** ● Staying present ● Listening ● Holding emotionally others and self ● Withholding judging, criticism, labelling ● Accepting whatever arises or falls ● Concerned
VII	**Right mindfulness** ● Mindful contemplation of the body	● Attentional focus – staying open, present, engaged, non-judgmental ● Open-field awareness	

	● Mindful contemplation of feelings ● Mindful contemplation of the mind ● Mindful contemplation of phenomena	● Introspection, interoceptivity ● Reflective practices	● Conveying kindness, connection, solidarity, non-abandonment
VIII	**Right concentration** ● The first jhana ● The second jhana ● The third jhana ● The fourth jhana	● Stability through meditative practices ● Developing joy and equanimity ● Fostering Great Compassion	
III	**Right speech** ● Abstaining from false speech ● Abstaining from slanderous speech ● Abstaining from harsh speech ● Abstaining from idle chatter	● Developing moral discipline/ conduct or encouraging patterns of behavior that ability to tend to others; avoiding immoral conduct/behaviors that impairs tending to others ● Non-violent communication ● Attending skills	**Compassionate action** ● Non-separateness; touching into suffering ● Intent to love and heal ● Allowing suffering to break our hearts ● Softening and not hardening to challenge ● Soft front, strong back
IV	**Right action** ● Abstaining from taking life ● Abstaining from stealing ● Abstaining from sexual misconduct	● Practice of self-awareness, empathy, self-restraint, regulation of personal desires and emotional impulses ● Non-striving ● Awareness of interpersonal boundaries and transgression	
V	**Right livelihood** ● Giving up wrong livelihood ● One earns one's living by a right form of livelihood	● Moral and ethical means of living ● Avoiding conflict of interest; moral distress ● Examining institutional goals and purpose	

It cannot be over-emphasized that in this model which seeks to address some very fundamental issues in our present biomedical model, the first step of acknowledging the common humanity is vital. This step grounds the entire endeavor of medicine to what it was originally meant for – to relief human suffering. Without the step of turning towards and seeing clearly suffering, we have the potential to misuse any of these processes above, not unlike the situation in biomedicine, to do everything but to relieve suffering. Worst, they can potentially lead to more suffering.

Conclusion

At the beginning, this paper considered the deficiencies in the conventional medical response to suffering with special reference to the end-of-life situation. The causes behind this state of affairs are multidimensional and complex. In spite of this and the fact that the Four Noble Truths was proclaimed more than two thousand five hundred years ago and clearly intended for spiritual teaching, it is fascinating to find that many of the elements in the Buddha's teaching are not only relevant, they can be validated by modern scientific research. At the end, it was possible to derive a care approach based on the Noble Truths that considers the needs of those suffering as well as doctors attending to the sufferers.

However, it is necessary to state the obvious limitations of this paper. Firstly, the author is clearly not a Buddhist scholar and there are probably many aspects with subtle nuances and depth of the text that had not been perceived. Secondly, the author comes primarily from the angle of a clinician, and therefore many of the systemic, administrative and policy issues may be largely under-appreciated. Also, the resulting approach was essentially produced from a purely descriptive and theoretical exercise that has not received any proper validation. It is therefore obvious that much more work will be required if this approach can eventually translate to anything useful.

But for now, I am only grateful for the people and conditions that had made this paper possible. May the merits of this paper (if any at all) benefit all beings.

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