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Facilitating an Ideal Death: Tibetan Medical and Buddhist Approaches to Death and Dying in a  
Tibetan Refugee community in south India.

By

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Doctor of Philosophy  
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a dissertation submitted to the Faculty of the  
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## ABSTRACT

Facilitating an Ideal Death: Tibetan Medical and Buddhist Approaches to Death and Dying in a Tibetan Refugee community in south India

By Tenzin Namdul

The Tibetan cultural conceptualization of death and care for the dying are informed and shaped by the intersection of Tibetan medical and Buddhist practice. In Tibetan culture, death is generally seen as a process of transition from one life to another through reincarnation, as well as a critical opportunity for adept practitioners to emerge into full enlightenment. In a Tibetan refugee community in south India, the care for the dying is a culturally orchestrated process involving Tibetan doctors, Tibetan Buddhist monks, and family members of the dying person. While Tibetan doctors assist in promoting a peaceful death through herbal remedies and counseling, Tibetan monks facilitate a smooth transition from one life to the next. Employing a variety of ethnographic methods—participant observations, unstructured and semi-structured interviews, and surveys—this dissertation examines how Tibetan doctors, monks, and family members collaborate in facilitating an ideal death; and how these collaborators understand and negotiate their roles in caring for the dying person. Importantly, through this nexus of cultural actors supporting the dying in this universal existential moment, the dissertation explores the central question: what constitutes an ideal death in Tibetan Buddhist culture?

This dissertation focuses on how the Tibetan medical paradigm, structurally integrated with the Buddhist cultural model, offers family members the freedom to seek medical and spiritual care concurrently and to seek guidance from both Tibetan doctors and monks. My research demonstrates how Tibetan doctors, incorporating philosophical and psychological features of Tibetan Buddhism in their practices, employ personalized care to dying persons based on their “constitutional nature” (Tib. *rang bzhin*). This enables Tibetan doctors to provide more holistic care that addresses not only biophysiological, but also psychological, social, and spiritual aspects of their patients. I propose that the inextricable integration of Tibetan medicine and Buddhism during end-of-life care addresses the overall needs of the patient.

Finally, this work challenges the suitability of a descriptor such as “dying well” based on the binary of a good and a bad death understood in the modern biomedical and palliative/hospice care. Instead, I argue that it would be more fitting to refer to a good death as an “ideal death.” In so doing, any particular way of dying does not have to be labelled as good or bad, rather it could be viewed as an appropriate death in its own context.

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## **Notes on Transliteration**

In the contents of this manuscript, I have retained Wylie transliteration for Tibetan words in the main text as formalized by David Germano and Nicolas Tournadre (2010). For the reader's convenience, I have included the simplified phonetic transcription of standard Tibetan (*ibid*) every time I introduce a new Tibetan word. However, I have chosen to translate Tibetan words in interview excerpts into English, using phonetic transcription, to maintain the flow of the conversation.

## INTRODUCTION: DEATH IS NOT A DEAD-END

*In the past few decades, medical science has rendered obsolete centuries of experience, tradition, and language about our mortality and created a new difficulty for mankind: how to die.*

- Atul Gawande, *Being Mortal*, 2014.

Have we forgotten how to die? If it is true, as argued by medical and academic scholars such as Atul Gawande and others (Warraich 2017; Bishop 2011; Green 2008; Lavi 2005), then it is likely that we have forgotten how to live as well. Morrie Schwartz's famous quote in the celebrated book *Tuesdays with Morrie...*, "The truth is, once you learn how to die, you learn how to live" (2002: 82), speaks volumes about the importance of knowing how to die. Of course, the phrase "Good Life and Good Death" might sound like nothing more than a platitude owing to its ubiquitous usage in the title of course syllabi, conferences, and focus discussion groups. However, it makes sense when we juxtapose the phrase with our experiential lives. All major religious traditions as well as the wisdom of elders of innumerable societies echo this simple association between life and death (Seneca 2018; Nytroe 2013; Dorjee 2007; Alбом 2002; Aries 1974). However, the understanding of death and the ways in which it is related to individuals' lives varies across cultures, as does care for the dying.

Rather than viewing death as something to avoid and prolong life with significant personal and institutional resources, this dissertation shows that Tibetans conceive of death as a necessary life course that aids in motivating morally ethical behavior, and for adept practitioners, a moment of critical spiritual development. Tibetans see death as a philosophical ground to tame humankind's most deceiving emotions—desire and attachment—by embracing the fundamental Buddhist principle of impermanence, animated by the certainty of death. Moreover, death is not viewed as a dead-end; rather, death is a bridge to the next life where the deceased is reborn

depending on how the person has lived. This dissertation examines the importance of death among Tibetans and how their conception of death and dying is strongly influenced by its sociomoral utility and spiritual opportunity.

Based on an ethnographic study in a Tibetan refugee community in Mundgod, south India, the dissertation asks how medical, monastic and lay understandings of death and care for dying people are informed and shaped by the intersection of Tibetan medical and Buddhist practice. Likewise, the research examines the ways in which Tibetan medical doctors (trained in traditional Tibetan medicine) and Tibetan Buddhist monks collaborate with family members in caring for dying people. In Tibetan culture, care for the dying is a culturally orchestrated process involving Tibetan Medical Doctors, Tibetan Buddhist Monks, and family members. While Tibetan doctors<sup>1</sup> assist in promoting a peaceful and desirable death through Tibetan pharmaceutical drugs and counseling, Tibetan monks<sup>2</sup> have the task of aiding the smooth spiritual transition between two lives. The research explores the mechanism of how the Tibetan cultural concept of reincarnation informs both the living and the dying members of that society. Furthermore, the dissertation illustrates the complex relationships across the conception of death, the behavior of dying individuals, and the care provided for the dying. Most importantly, this research investigates: what constitutes an ideal death in Tibetan Buddhist culture?

## **CENTRAL QUESTIONS**

Examining my central question—what constitutes an ideal death in Tibetan Buddhist culture—led to several other sub-questions that provided structure in obtaining my ethnographic

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<sup>1</sup> I will use the term “Tibetan doctor” henceforth as a short hand for Tibetan Medical Doctors. Tibetan medical doctors, one of my collaborators for my doctoral research, are doctors trained in traditional Tibetan medicine.

<sup>2</sup> I will use the term “Tibetan monks” henceforth as a short hand for Tibetan Buddhist Monks. Tibetan Buddhist monks, other collaborators along with family members of dying people for my research, are trained in Tibetan Buddhist philosophy and psychology.



data. There are three analytical subjects to which my investigation of an ideal death applies: the association between the Tibetan Buddhist conceptual framework of death and the care for dying people, the intersection of Tibetan medicine and Buddhism, and the collaboration between Tibetan doctors, Tibetan monks, and family members of dying people: (1) What does death mean to someone who believes in reincarnation? (2) How do Tibetan Medical doctors, Tibetan Monks, and family members collaborate in assisting a dying person to die well? and (3) How do these actors understand and negotiate their roles in taking care of a dying person? And what happens if a conflict arises among these collaborators?

## **RELATIONSHIP BETWEEN LIFE AND DEATH**

An important question in assessing the relationship between life and death is how an age-old conceptual wisdom might be applied when the moment of death arrives; and how do we gauge our preparedness? Understandably, the utility of death with regard to an individual and social wellbeing seems much easier to grasp as long as we stick to the physical aspects of death. To illustrate how death informs life, Cardiologist Haider Warraich, for example, focuses on the connection between life and death from a cellular perspective. Warraich affirms that even though cells might not show any emotions or manifest conscious thought about ethics or morality, “the ecology and mechanisms of death among cells denote how truly linked life is to death.” “When cells *forget* to die,” he argues, “it ends up becoming something that threatens to bring the entire organism down. Those are cells that cause cancer” (2017: 15, author’s emphasis). On the other hand, the intimacy between life and death and its utility at a metaphysical level, might sound a bit too mechanical and abstractly inhumane.

To illuminate the relationship between life and death, let me share my own experiences with death and the circumstances that inspired and motivated me to dedicate myself to the study of death and dying. I was not a stranger to death when I began my graduate study at Emory University. I mean I have seen death, quite a few deaths when I practiced Tibetan medicine in India, and that too in different forms and situations. Three deaths that I have observed closely, however, stand out. These three deaths made me think about death, question my pre-existing notions of death and life, and most of all, they increased my curiosity to know more about death and dying in Tibetan Buddhist culture, my own culture. As is the case with many of my friends and my generation of Tibetans in exile, I knew little about this aspect of our culture. During these three deaths, I was in different situations and had different responsibilities.

The first death was the death of my father. He died in the spring of 2007 at his home while I sat at his bedside after months of debilitating health resulting primarily from his affinity for alcohol. I remember sitting next to him as he lay in the motionless; eyes fixed at the ceiling with his mouth wide open. He did not seem to be in much pain but every now and then he struggled to breathe. As his body started to shut down, his breathing became increasingly laborious and the pause between breaths longer. Sometimes the gap was so long that I thought he was dead but then, he would breath again, but with more force and effort. He stayed in that condition for almost two days. He looked like he was trying to fight against his death, perhaps he wanted to say something to me. I did not have a clear idea what to say at that time and felt inadequately prepared.

A few months after my father's death, I attended to an elderly Tibetan woman with multiple health complications who was in the last stage before death. I saw her every day during her last few days, and we developed a close relationship. She amazed me with the calmness and

resilience she maintained until her last breath despite frequent bouts of pain and discomfort and the chaotic environment created by her anxious family members. Imminent to her death, though completely immobile, she kept her fingers busy counting her prayer beads and died peacefully, listening to a monk reciting a Buddhist text. Her neighbors later described her an extremely kind and spiritual person.

Then, a little more than a year after my father's death in fall 2008, I had an opportunity to observe a Tibetan Buddhist practitioner, a monk, who was in the state of advanced meditation called *thugs dam* (pronounced *tukdam*). It was a fascinating experience for me because I had never seen anyone in such a condition. The monk had been clinically dead (cessation of cardiopulmonary and brain functions) for nine days when I first saw him but for his caretakers and other monks, he was very much alive because his consciousness had not yet left his body. The monk's body did not show even a single sign of decomposition; his body remained warm, and his face literally glowed. He went on to stay in that state for eighteen days which I will discuss in detail in chapter 2. Learning more about the intention, motivation, and purpose behind the monk's "post-death" meditation completely re-framed the way I had seen and related death to my life. And over the course of years, it has influenced the way I attend to terminal patients or dying people and their family members both as a Tibetan physician and a researcher.

My aforementioned experiences with death also inspired and motivated me to move to the United States for further study in order to prepare myself to engage in intellectual study of death and dying. During my initial years of study in the U.S., I took two classes on death and dying from public health and anthropological perspectives. In these courses, I learned a great deal about the different perceptions people have of death as well as the varying degrees to which people are impacted by death. I was amazed to see how, in contemporary American culture,

death is avoided, medicalized, feared, and viewed as something completely negative. Similarly, I learned about the economic burden of this view due to an unrealistic emphasis on prolonging life through staggeringly expensive medical interventions. I remember watching '60 Minutes' on CBS in August 2010 where they reported that Medicare pays 55 billion dollars annually for doctors and hospital bills providing care for patients during the last two months of their lives. That economic cost and the cultural priorities it reflects quickly reaffirmed my own academic purpose to examine how it is different in Tibetan Buddhist culture.

My education—or re-education—of understanding death from an anthropological perspective and preparing for my doctoral research has helped me immensely in acquiring a deeper understanding of death and dying across cultures. During the last six to seven years, I spent most of my time reading and talking to people from different disciplines with diverse cultural backgrounds about death and dying and conducted an expansive pilot study in India before the doctoral fieldwork. Nevertheless, everything I have learned about death and dying, specifically, the lived-experience of dying and the connection between life and death has been from a third person perspective. I wondered how directly experiencing the dying process, which some of my informants would talk about in great detail, would impact the exploration of the relationship between death and life.

### **Close Encounter with Death**

Fortunately, or unfortunately, I had my first close-up encounter with my own death in a severe road accident on July 22, 2016, two days before I was scheduled to depart for India to conduct my fieldwork. For people who witnessed the collision, it was a miracle I survived. However, the rapid sequence of moments I experienced during the accident comprised one of the most liberating experiences of my life.

It was a typical Midwest summer day with a deep, expansive blue sky, and temperatures reaching up into the high 80s. Everything across the landscape looked fresh and colorful. I was driving west on I-94, one of the last legs of highway on my way from Atlanta to Minnesota. I was listening to an audio recording biography of Albert Einstein as the reader spoke enthusiastically about Einstein's theory of relativity. I passed through the small Wisconsin town of Menomonie and the highway location marker indicated seventy miles to Minneapolis as I entered onto I-95 West. It was close to 4 pm, and I was getting excited about the thought of arriving in Minneapolis in another hour or so. I recall thinking to myself that everyone must have decided to leave for vacation at the same time since I could see a long line of vehicles penetrating into the horizon moving steadily across the very flat Midwest land.

I was driving in the right lane and I noticed that our lane was slowed down by two oversized trucks. As vehicles in front of me changed lanes to speed up, I followed behind the trucks for a few more minutes. I flipped on my left indicator blinker and changed into the left lane, speeding up to do so. My speedometer read close to 75 miles per hour as I passed the trucks. Just as I was preparing to move back into the right lane, I saw a Ford SUV truck on the opposite side of the road—I-95 East—losing control. For a split second, I thought, "That's no good," and then, in the next 2 to 3 seconds, the SUV spun, rolled, and flew straight toward my car. With a little time to think coherently, I knew I could not turn toward my right side or hit the brake pedal because that could result in multiple accidents. So, I turned the steering wheel left toward the median as the SUV collided with the front end of my car. I felt a huge jolt from the impact, resulting in an instant release of the airbag. As I turned toward the median on my left, my car spun like a toy top. At that instant, it was as if time stood still.

There was no correlation between things happening in my immediate environment and my perceptual awareness. Everything slowed down. I could see and experience everything with surprising clarity despite the intensity of what was happening: the car spinning, the global positioning system (GPS) device placed on the dashboard floating around, and the cloud of dust that erupted everywhere around my car. I vividly remember telling myself, “Oh man, this will be a lot of work before I fly to India.” And then, as my car spun intensely over a low gorge that separated the two sides of the highway, my car continued to fly right into the side of a huge semi wheeler truck driving at full speed on the opposite side of the highway. As I saw my car slam head on into the cargo space of the semi, I thought to myself that this is it, “I will probably die today.”

Surprisingly, I did not experience any fear or anxiety. I saw everything clearly, distinctly and thought of the possible repercussions. I remember thinking, “This is the time to implement anything I have ever read, heard, and learned from all the Tibetan Buddhist practitioners I have spoken to over the years.” My mind was clear, and I was able to process the situation. That short moment of 5 to 6 seconds of my life felt much longer; and while my car flew toward the truck, I even had time to talk to myself and think about the process of dying that I had read and heard so many times. I recall thinking to myself that I deeply wished to experience the stages of dying that Buddhist practitioners endeavor to be mindful about in the process of dying.

The impact of the front of my car T-boning the semi wheeler’s large expansive truck bed, instantaneously split the entire cargo bed in two. My car landed in the lane of oncoming traffic where three more vehicles hit my car and ricocheted me to the road shoulder where I finally came to a standstill. I sat in my demolished car for a few seconds before I saw smoke coming out of the fully smashed engine and started kicking the crumpled door to get myself out. Other than a

minor cut on my upper right shin, I miraculously came out of the accident without any physical injury. Once I got out of my car, I remember checking on the Ford SUV driver who hit me and others involved in the crash and their amazed faces staring back at me in disbelief that I had survived. It took me a while to process what had happened, and needless to say, my departure to India to begin fieldwork was slightly delayed as I took care of the accident aftermath with my trauma.

When I reached the field a week later, I thought about the accident frequently but without any insightful realization. However, in June 2017, while I was teaching a class on Tibetan medicine for the Emory-Tibet Mind-Body Summer Abroad Program at Drepung Monastery Science Center, a student asked a question that instantly made me think about the accident a little differently. Knowing my field of research, she asked: How can the Tibetan Buddhist approach to death help someone die well? I thought for a moment and told the student that I still need to analyze my data, however, one thing I could say personally was it helped me to have more options about how I want to die. I said I happened to be mindful enough to think through those options in the midst of a road accident that nearly killed me. It dawned on me that day, while responding to the student's question, that thinking about different ways of dying—scared and terrified, or peaceful and confident—and making an attempt to be aware of them actually might have helped me to stay focused without panicking.

Nevertheless, I think it is critical to understand that the need to engage in conversations related to death and dying is not only about motivating oneself to live an ethical life, but also to prepare for one's individual death. In addition, the current dismal social reality, specifically, with regard to end-of-life care in the West, demands a dedicated collective discourse across disciplines.

## WHY TALK ABOUT DEATH?

“Why did you choose death [out of all others] as your research topic?” is one of the common questions I get from people when I tell them about my research. With some, as the conversation went a little further, they would ask: “Why should we remind ourselves of our own mortality when there are too many other things to worry about?” Such questions might sound odd to members of the (Tibetan) community studied for this dissertation, but unfortunately, such questions are common in contemporary western culture. In our pursuit of avoiding death and prolonging life at any cost, reverence and attention toward the other end of life has diminished. Death is now a hushed topic and dying is controlled and secluded at best (Aries 1974; Green 2008; Neumann 2016). However, it is hard to ignore the recent collective call for the reassessment of the way we view death and its subsequent impact on care for the dying. Importantly, this outcry is not in an isolated field; rather it is fiercely discussed and debated across disciplines. Physicians, nurses, philosophers, bioethicists, scholars, journalists, anthropologists, and the general public alike, have all voiced their concerns about the ways Americans are dying (Warrach 2017; Kaufmann 2005).

One way we can scrutinize this en masse concern is to view it through the lens of culminating dramatic demographic shifts and massive unwise use of resources allocated to end-of-life care (Poo 2015; Gawande 2014). While the United states does not figure in the top thirty of the world’s most aging societies, its older adult population, above 65, is most dynamic, and is projected to increase from 52 million in 2018 to 94 million in 2060 (Population Reference Bureau 2018). To illustrate, an American turns sixty-five every eight seconds, which makes more than ten thousand people every day, almost 4 million per year (Poo 2015: 3). And as projected by the United States Census Bureau, by 2060, older adults will overtake the younger population



under 18 by 94.7 to 79.8 million (2019). An unavoidable challenge that comes with a continuous increase in the aging population is their health care: how we care for them. “For most of them, death comes only after long medical struggle with an ultimately unstoppable condition—advanced cancer, dementia, Parkinson’s disease, progressive organ failure, or just the accumulating debilities of very old age” (Gawande 2014: 156).

According to Gawande, the rising cost of health care, particularly in an aging population’s final year of life, has become the paramount cause of concern of most advanced nations. For instance, in the United States, 5 percent of patients who are in the final year of life consume 25 percent of all Medicare spending; and “most of that money goes for care in their last couple of months that is of little apparent benefit” (2014: 153). Likewise, Ann Neumann argues that the “medicalized death” in contemporary America is much more complicated than we think. For Neumann, the use of “precious medical resources to torture dying patients” should encompass the “physical and emotional expense” besides the financial expense (2016: 50). Others have expressed similar unease, reinforcing the discourse that our ongoing fight against aging and death has to be stopped (Butler 2013, 2019; Warraich 2017).

Having said that, I think it is critical to look at underlying forces that could either make it difficult to solve the existing problem or to exacerbate the situation in end-of-life care. For example, the tendency of physicians to engage in over-treatment of terminal patients and ordering unnecessary testing, as well as the severe lack of preparation on the part of patients for what they want for their final stage serve to amplify the dysfunctional care for dying people (Neumann 2016; Gawande 2014). Social psychologist Sheldon Solomon whose work focuses on studying how we respond to awareness of our death asserts that most of us respond to being reminded of death negatively by being angry and berating others who do not subscribe to our

values and ideas or just feeling bad about ourselves. He attributes such reactions to sheer lack of cultural symbolism and the meaning that comes along with it (Solomon 1991). Solomon and colleagues contend that cultural worldview provides a buffer in dealing with existential anxiety and fear, such as death (1997). Nonetheless, for a hardcore scientist or a typical modern biomedical doctor, cultural symbols and meaning might carry little value, and might, from their perspective, even hinder patients' optimal care.

### **Biopsychosociospiritual Approach to Death and Dying**

In March 2019, I was excited when I received an invitation to share my research at the *Integrative Oncology Symposium* at Emory University. The symposium was well attended with speakers from all major universities and institutions across the United States. However, I felt out of place and a little awkward as one presenter after another spoke about the effect of different therapeutic interventions' effect on cancer cells. None of the presenters said anything about the host of those cancerous cells: a living human being. To be honest, I even developed a bit of disenchantment toward other presenters for their reductionist approach of being so fixated on the cancerous cell; and thought to myself where is the patient, what about the personal agency and the sociocultural component that informs an individual.

As I got ready to walk up to the podium, I wondered if I would make any sense to my fellow presenters. My presentation was focused on the importance of interaction between terminal patients and Tibetan doctors through the lens of ethnographic study examining what do terminal patients aspire to, what do they fear, what makes them feel good; and how do Tibetan doctors and other caregivers address these critical issues while caring for terminal patients. My feelings of discomfort did not help much in connecting with the audience. I felt like I was talking to myself. Nevertheless, to my surprise, two presenters, oncologists, joined me at my table

during the lunch and shared their interest in knowing more about Tibetan medical approach in caring for terminal patients, specifically, as one of them phrased it, “How is it different from what we are doing?”

I do realize that all components—the pathology of illness, the host individual, and the sociocultural forces—are essential in determining the condition of the patient and providing the best care. However, the problem surfaces when any one of these components is prioritized at the expense of others. For instance, I recently was in touch with a patient, a man in his early eighties from the outskirts of Atlanta, who was diagnosed with advanced liver cancer that had metastasized to his lungs and bones. When the patient’s family reached out to me, he was juggling between three oncologists owing to the complexity of his health, but none of them had gone beyond looking at how to contain his cancerous cells that were colonizing his body. Importantly, as Gawande has emphasized all through his book (2014), no one had asked him what was most important to him at the end of his life. He died after almost six months of confusion, pain, and hopelessness, not to mention countless trips to a hospital that was at least an hour commute from his home and, of course, thousands of dollars in expenses.

Katy Butler, in her part memoir, part medical history, and part spiritual guide book, *Knocking on Heaven’s Door* (2013), stresses how much has changed since the Middle Ages with regard to how we view death and care for the dying. Butler writes, “After the mid-1950s, the attitudes of many doctors and patients shifted from faith in God and acceptance of death to faith in medicine and resistance of death. There was always *something*, no matter how ultimately futile, that a doctor or nurses could do. Patients weren’t always grateful” (86, author’s emphasis). In the same vein, referring to Charles Snow’s influential work on the split of Western society into culture of sciences and humanities (1998), David Thomasma and Thomasine Kushner, make

an interesting observation about existing health care. They argue, “Scientific culture and human values culture compete for our loyalties daily, but never more so than when we or someone we care for becomes seriously ill or is dying and needs the assistance of the health care system” (1996: xvi). The persistent divide between biomedicine and sociocultural components of death is proving to be a great disservice to terminally ill patients and their families.

The unavoidable call for rethinking our attitude toward death has led health care professionals and scholars, especially in bioethics, to underscore the importance of marrying biological and sociocultural features of death. Considering death as an “isolated biological event devoid of sociocultural impact has created an unresolvable dilemma in developing a more nuanced definition of death,” asserts Braswell (2014: 24). Likewise, the need for incorporating biological, psychological, social, and spiritual aspects of a dying person has been proposed under the umbrella of the “biopsychosociospiritual” model by bioethicist Jeffery Bishop (2011).

Against the backdrop of a grim perception of end-of-life care—largely due to the secularization of death (Cadge 2013) and divergence between the sciences and humanities as asserted by Snow (1998)—and in an appeal for an alternative paradigm, I propose that the Tibetan Buddhist cultural model could present a new direction in both the conceptualization of death and the care for terminal patients. Insofar as care for the dying in Tibetan Buddhist culture is informed by an inextricable link between Tibetan medicine and the Buddhist psycho-philosophical paradigm where death is conceived as a moment of spiritual practice, the Tibetan Buddhist death model relates to the “biopsychosociospiritual” model (Bishop 2011). Moreover, the Tibetan cultural orchestration of care for the dying build upon a collaboration of Tibetan doctors, monks, and family members presents an interesting case that has not been ethnographically studied before.

The aforementioned interest drove my inquiry and shaped the eighteen months of ethnographic field research and data collection. With a background of more than a decade of experience as a Tibetan medical physician<sup>3</sup> and training as an anthropological researcher, I pursued the central question: What constitutes an ideal death in Tibetan Buddhist culture? This dissertation is my attempt to answer that question.

My approach to conducting this research is grounded upon multifold sources owing to the need to study the relationship between Buddhist texts, conceptual beliefs with regard to death and dying, and complex social reality. This dissertation fills a gap in the literature by providing an additional explanation to the question via a multi-method approach. This work simultaneously builds on and transforms the historical foundations laid by researchers characterizing an ideal death in the fields of religion, sociology, and anthropology (Aronson 1979; Spiro 1970; King 1964). Melford E. Spiro (1970), in his seminal anthropological study of Theravada Buddhism in Burma, underscores the importance of examining the relationship between the beliefs among Buddhist members and the doctrines of Buddhist texts. Such exploration, as emphasized by Spiro, is crucial for this research because, even though the concept of reincarnation is one of the fundamental Buddhist concepts and being reborn as a human is considered an ideal rebirth for engaging in spiritual practice in order to eventually break free from the cycle of birth and death, some of my interlocutors do not subscribe to these ideas surrounding reincarnation. They either were not sure about the concept of reincarnation, or do not necessarily want to be reborn as a human, or see reincarnation as a stepping stone to escape from the cycle of rebirth.

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<sup>3</sup> Tibetan Medicine training is a six-year program. After getting through an entrance exam (similar to MCAT in the US) for the Tibetan Men-Tsee-Khang Tibetan Medical college, students go through six-year of rigorous training focused on memorization of the Root Text (*rGyud bzhi*) and other related text and commentaries on anatomy, physiology, etiology, nosology, pharmacology, diagnostic techniques, treatment, poetry, Buddhist philosophy, etc. Clinical practicum begins in the third year and the sixth year is generally dedicated toward the first phase of internship. Also see Tidwell (2017) for a detailed six-year curricular progression at Men-Tsee-Khang in India and Sorig Loling Medical College in Tibet (546-552).

For instance, a young man with a good education background in Tibetan Buddhism told me it was hard for him to agree with the theory of reincarnation since he cannot see it. Similarly, a middle-aged woman responded to my question of what kind of rebirth she aspires to by saying she would like to be reborn as a bird because she related birds with freedom and spaciousness. In the same vein, on the one hand, many lay Tibetans or novice Buddhist practitioners who believe in reincarnation related their rebirth aspirations to being born again as a Tibetan, being born without health challenges, to be born in a good family, and someone even shared a desire to be reborn in Switzerland. On the other hand, some of the Buddhist practitioners described their rebirth aspirations as an opportunity to be reborn in an environment that is conducive to continue their spiritual practice, and eventually be free from having to undergo rebirth. A freedom from a samsara or a cycle of birth, death and rebirth is referred to as nirvana or enlightenment in Buddhism.

Spiro (1970) made a distinction between these two different aspirations among Buddhist members as *Kammatic* Buddhism where the focus is on a better rebirth (70-71) and *Nibbanic* Buddhism with a focus on being free from the cycle of birth and death, or nirvana (56). In order to gain a more nuanced understanding of the complex interplay between concepts from Buddhist texts and the perspectives of Buddhist actors, Spiro encourages paying attention to both the studies of Buddhist texts (philosophical analysis) and Buddhist actors on the ground in order to achieve a comprehensive anthropological study of Buddhism. He writes:

Indeed, so far as Buddhist scholarship is concerned, one might say that the anthropologist takes off where the textual and historical scholars end, for the anthropologist is not concerned with religious texts per se, but with the interactions between doctrines found in these texts and the conceptions found in the heads of religious devotees, and

consequently, with the relation between these religious conceptions and the general ordering of social and cultural life...Hence the present study [Buddhism and Society], though anthropological in nature, not only does not ignore doctrinal Buddhism, but is especially concerned with the relationship between the beliefs of Buddhist actors and the doctrines of Buddhist text.” (1970: 3-4).

Furthermore, equally important features of this dissertation—such as the synergistic relationship between Tibetan medicine and Buddhism in its care for the dying, the use of death as sociomoral reference among Tibetans, and the ways in which different members of a Tibetan community collaborate in assisting the dying—demands a combination of passive to moderate to active participant-observations and unstructured and semi-structured interviews and surveys. Because of the need to address the aforementioned complexities, this research has to be conducted in a place where Tibetan culture is not only alive, but also has a communal structure that facilitates a collaborative cultural practice between different members of society.

### **THE FIELD SITE: MUNDGOD**

The primary site of this research is the Tibetan refugee settlement in Mundgod in the southern state of Karnataka State in India. Mundgod is located in the north Kanara district of Karnataka State, between two major metropolitan cities: 400 miles south of Mumbai and 240 miles northwest of Bangalore. The closest city from Mundgod is Hubli, which is 30 miles away but takes almost an hour and a half to get there due to narrow roads compounded by high volume traffic. Hubli is the place where most of the Tibetan and Indian locals choose to go in case of a medical emergency. The Tibetan settlement in Mundgod, also known as Doeguling, is one of the largest Tibetan settlements outside Tibet. The settlement is considered a mini-Tibet within India

for being the repository of traditional Tibetan life and culture. This settlement was first set up in 1966 on 4,000 acres of land allocated by the Government of Karnataka for thousands of Tibetan refugees who had escaped to India from Tibet along with the Dalai Lama in 1961. Today, it contains one of the largest concentrations of Tibetan refugees in India, exceeding sixteen-thousand Tibetans (Planning Commission 2009).

The preliminary studies for this dissertation in the summers of 2014 and 2015 indicated the Tibetan settlement in Mundgod is an ideal location for seeking answers to my research questions. I realized that the Mundgod Tibetan settlement was an appropriate setting for the research for two important reasons. First, the settlement mirrors many of the great population centers in Tibetan civilization in pre-1959 Tibet, prior to the communist Chinese government invasion of Tibet which changed the face of Tibetan culture and tradition inside Tibet. The settlement not only is home to the largest concentration of Tibetan refugees in India, it provides an ideal condition to practice and preserve traditional Tibetan culture. This setting also helped me to observe the social structure of the settlement.

Second, besides social structure, the settlement's setting was perfect, for it hosts a unique integration of Tibetan medicine clinics and a Tibetan monastic school system, surrounded by a large lay Tibetan community, which is a societal structure similar to traditional Tibetan society inside Tibet. The settlement comprises ten village camps, including several major monastic communities. There are six Tibetan medical clinics located in and around Mundgod, which are branch clinics of Men-Tsee-Khang (MTK) (Tib. *smān rtsis khang*). These clinics cater to local Tibetan and Indian patients, as well as out-of-state patients.

MTK in Tibetan literally means the House of Medicine and Astrology. MTK was established in Lhasa, Tibet in 1916 by the 13<sup>th</sup> Dalai Lama. When the 14<sup>th</sup> Dalai Lama, along



with thousands of Tibetans fled to India during Communist Chinese invasion of Tibet, MTK was one of the cultural institutions reestablished in India in order to preserve Tibetan culture and tradition. MTK was re-established in Dharamsala, India in 1961 under the guidance of the 14<sup>th</sup> Dalai Lama. Since then, MTK has been the premiere Tibetan Medical Institution outside Tibet. MTK is a charitable medical, research, and educational institute, and currently has 432 regular staff, including 140 doctors and 17 astrologers with 51 branch clinics dispersed all around India.

Likewise, the original Drepung Monastic University was initially established in Tibet in 1416 and was re-established in exile in India in the early 1960s. Drepung, one of my institutional field collaborators along with MTK, became my home during my eighteen-month fieldwork period. Drepung houses over six thousand monks and provides both modern and traditional Buddhist education. It is important to point out that Drepung is affiliated with the Geluk tradition, to which the current Dalai Lama belongs, and it differs from the Tibetan Buddhist tradition from which the teachings and practices related to death and dying I examine in this dissertation originated. For instance, the understanding of body and mind at a coarse and subtle level and the ways in which they change at the time of dying (which I discuss in detail in chapter 2) originate from and are explicated in great detail in the Nyingma tradition. However, I realized during the fieldwork that there was a strong emphasis on *Chos lugs ris med* (pronounced *Chöluk Rimé*) practice at Drepung. *Chos lugs* in Tibetan is understood as tradition, and *Ris* is “one-sided,” “partisan,” or “sectarian,” and *med* is a negation (Ringu Tulku 2006: 1). So, *Ris-med* means not taking sides or non-sectarian. The founders of the *Ris-med* movement, Jamgon Kongtrul (1813-1899) and Jamyang Khentse Wangpo (1820-1892) were trained in the Nyingma and Sakya tradition, respectively. The Dalai Lama who is the head of Geluk tradition, besides being spiritual leader of Tibet, has been hugely influenced by some of the great *Ris-med* teachers

like Khuna Lama Tenzin Gyaltzen, Dilgo Khentse Rinpoche, and the third Dodrupchen, Tenpa Nyima, and publicly encourages Tibetans to embrace *Ris-med* practice (Ringu Tulku 2006).

The existence of Drepung, on the Buddhist institutional side, and MTK clinics, on the Tibetan medical side, at the field site was helpful in studying the interactions, including collaboration, between TBMs and TMDs in dealing with dying persons. Conducting research in this Tibetan settlement specifically and in the exile-community generally allowed me to study the relationship between the dominant cultural religious and medical institutions and its traditional community. At the same time, segments of the community, especially younger members, are increasingly influenced by Western conceptions of practices around death, which sometimes led to conflicts. As Giovanni Bennardo elucidates, “cultural variation within communities is also a result of the nature of cultural models—the core and periphery structure—and how they interact with contexts, i.e., group and/or individual experiences” (2018: 2). The dynamic nature of the Tibetan community provides an opportunity to explore how different community members interact with core cultural models.

However, I think it is worth mentioning here that the geographical location of Mundgod could also be a source of bureaucratic challenge in conducting research. Since I had gained my US citizenship while pursuing my studies in the US, I was now considered a foreigner in India, not an official refugee. I knew that foreigners are required to obtain a “Protective Area Permit” from the India Home Minister Office since the Tibetan settlement in south India is located in an area designated as a Protected Area by the Indian government; and that one needs to acquire a “Residential Permit” for a longer stay. But I did not realize the complexity of all the bureaucratic work related to the foreigner arrival report at the local Foreign Regional Registration Office (FRRO) until I got to the field. The local FRRO office is situated in a bustling town called

Karwar, a little more than a four-hour drive from Mundgod toward the west coast of India. The area is hot and humid most of the year. It took at least two trips of each time waiting an entire day at the FRRO office in order to obtain the documentation. Procuring the document also involved knowing the intricate ways of submitting application forms with required supporting documents to the officer concerned and nimbly paying “under the table money” (which was considered necessary, and not a bribe) in a room filled with other staff; and then, sticking around the hallway for hours where the officer could see you and not forget that you have submitted your file along with the customary money provisions. The Residential Permit document has to be renewed every six months, so I made five exhausting trips to Karwar during my fieldwork. My local host, Drepung and the United States-India Educational Foundation (USIEF), the partner of my funding body, the US Fulbright Educational Foundation in India, did their best in providing supporting letters but one could not avoid the usual ordeal that has become a part of normal bureaucratic working affairs in recent years.



Figure 1: a) The field location in Karnataka state in southern India; b) Men-Tsee-Khang Tibetan doctors and staff in front of one of the MTK Clinics in Mundgod; c) Drepung Loseling Campus.

## **METHODS**

### **Modes of Inquiry**

Participant observation has become a staple mode of inquiry for anthropologists, but different forms of this method have been recognized in the field of anthropology. For instance, anthropologist James Spradley (1980), outlines five types of participant observation: non-participatory, passive, moderate, active, and complete. As the names specify, these different categories range from sole observer to active and complete immersion in the environment and distinctive behaviors of informants in order to understand those behaviors in their suitable cultural context. Participating in what one is observing has become a custom among anthropologists ever since Bronislaw Malinowski encouraged ethnographers “to put aside camera, notebook and pencil, and join in himself in what is going on” (2002/1922: 16). However, one must bear in mind that while leaning more toward simply observing or keeping a healthy distance from study participants could create a detachment between researcher and researched, it also presents a more objective lens. On the other hand, active and becoming “native” could lend closer connection and in-depth understanding of a study population but it could potentially reduce the level of objectivity (Spradley 1980). It is therefore important to decide upon which category to employ based on their utility as Ron Barrett (2008) aptly rationalized in his ethnographic work of Aghor Medicine in Northern India by asserting that it depends on “the degree to which they [different methods] help or hinder in the achievement of certain research objectives” (13).

Likewise, Bisan Salhi (2018) adopted directed observation in her study of destitute individuals in a hospital space in the Emergency Department in Atlanta in order to focus solely on the “processes of patient triage, where they adhered to medical and organizational criteria,

and where they were based in moral criteria and interpersonal negotiation” (41). In contrast, Tawni Tidwell (2017) completely immersed herself in her ethnographic study of the role of embodied knowledge in traditional Tibetan medical diagnosis. Tidwell engaged in complete participation by going through the five-year rigorous training of Tibetan medicine in India and Tibet so that she could not only live and be one of her study population, but also to experience herself how embodied knowledge is processed and is perceptually applied in making a diagnosis.

As not only a native anthropologist, but also a Tibetan doctor, my research required active participation, and a specific form of increased engagement with my study population in order to gain a better understanding of their behavior in this cultural context. As in the well-known maxim among anthropologists attributed to Margaret Mead, “What people say, what people do, and what they say they do are entirely different things” (Ewing et al. 2011), I had to assess the relationship between my informants’ conception of death, what they say they do in caring for the dying, and what happens when someone dies or cares for the dying (in the form of patients as well as loved ones). I had to see how two of my main collaborators—Tibetan doctors and Tibetan monks—collaborate with family members in assisting a dying person. I had to assume that these collaborators think differently and act differently about their own mortality and care for others’ dying. And as I stated before, I had to be part of the community to get a nuanced understanding of the social relationships between my collaborators, as well as within these collaborators.

In order to gain an in-depth understanding of the social relationships between my collaborators and how they care for the dying, I accompanied Tibetan doctors and monks whenever they made a home visit. I invited Tibetan doctors or monks to be present in situations where I was at the dying person’s home. These interactions, though my primary means of

collecting ethnographic data, presented certain challenges (which I discuss further later in this chapter). One of the main challenges was related to my position as a trained Tibetan physician. I made at least two to three home visits in a week once I reached out to Tibetan village camps and started seeing patients at Drepung Loseling clinic. During most of the home visits, family members of terminal patients expected me to participate in almost everything from checking patients, and giving dietary or medical advice, to making treatment decisions and performing death rituals based on astrological charts. I constantly had to be mindful to check myself in drawing a boundary between being a Tibetan doctor and a researcher. This intent of self-checking was to minimize bias as well as to make sure I do not give preference to data collection over patients' wellbeing. In doing so, I constantly switched between participating in caring for terminal patients and observing. In a way, this strategy resembles other ethnographers in similar situations where participation and observation happened tandemly. For example, Barrett's (2008) position of researching leprosy patients juxtaposed with his nurse background and having to care for them; Alter's (1992) study of Indian wrestler health care after years of being a wrestler himself; or Wade's (1984) strategy of role-switching between a school administrator and an ethnographer in her study of African-American student experiences.

This research is also part autoethnography because of my decade of experience as a Tibetan physician which led me to reflect upon things I was observing, and in some cases, providing care to patients. Although I sought to limit myself to being a bridge between my collaborators, there were times when I was the only Tibetan physician by the side of a dying person, and I had to play the role of Tibetan doctor. Since the autoethnography leads the subjectivity of the researcher to recognize its important role in the specific empirical research

(Tidwell 2017), I convert these experiences into a form of autoethnography to shed light on information which are sometimes difficult to obtain.<sup>4</sup>

This work also employs cultural models (Bennardo 2018; Shore 1996) in reference to Tibetan Buddhist core cultural (theoretical) perspectives about death and dying, as well as variations among community members that are nested within broader Tibetan culture. The underlying goal of cultural models theory in bridging a gap between cognitive psychology and anthropology presents an effective tool in studying Tibetan notions of death and dying which are underpinned by the intersection of biology, culture, and mind. Importantly, the cultural models emphasis on making a distinction between instituted models and mental constructs models aligns well with a Tibetan community where its members were constantly engaged in a dialectical relationship between their subjective beliefs and experiences and core Buddhist concepts. Shore's recognition that "Culture on the ground and culture in the mind must be carefully distinguished before they can be usefully related" helps to look at the differences as well as correlations between collective culture and individual behavior (1996: 45-46). In other words, cultural models render an additional layer to examine correlations between what my informants say they do and what they really do.

Likewise, cultural models help to theorize and locate cultural practice such as Tibetan Buddhist culture where mind/consciousness is the primary mode to learn, preserve, practice, and transfer cultural knowledge. And the fact that mentally constructed knowledge is mostly conceived and applied without individuals' awareness, cultural models lend an efficient tactic to elicit this tacit knowledge. Further, cultural models shed light on how we can view different components of cultural knowledge and practices that provide both foundational structure and

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<sup>4</sup> Bisan Salhi (2018) shared similar experience in her ethnographic study of destitute patients in the Emergency Department at Grady Memorial Hospital in Atlanta.

flexibility in everyday life (Shore, Spring 2014).<sup>5</sup> For instance, I observed during my fieldwork that engaging in *thugs dam* or dying with joy was viewed as an ideal death and was aspired for, however, individuals with different levels of Buddhist insights and practices have their own idiosyncratic way of dying (which I elucidate in chapter 5). In that light, I use cultural models to articulate the cultural mechanism of how Tibetan Buddhist phenomenon of *thugs dam* provides a foundation for the specific community members to deal with death and dying in their own personalized manners.

### **Context**

Being a native researcher comes with myriad benefits in terms of being able to have proximity to the people and culture one is investigating through common language, social norms, and importantly, a certain level of trust. However, the same traits could also put a researcher in a precarious situation. In a post-colonial nation like India (and a culture where I am from), locals tend to grant more prestige to Western researchers than to natives. I realized during my fieldwork that, compared to Western researchers, natives either have a higher “burden of proof” to verify their academic credentials or they are simply not respected on par with Westerners.<sup>6</sup> I distinctly remember when I had to give additional explanations to my local Tibetan community members to prove that I am doing a similar kind of (ethnographic) research as two other second-year American graduate students who were planning to conduct in India. Having said that, I must mention that once local Tibetan community members understood my academic work and identical positioning, they became much more supportive and some even showed a vicarious

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<sup>5</sup> During a seminar class on Culture and Mind with Professor Bradd Shore at Emory University, he emphasized that cultural models present a lens to view culture from two spectrums – one end where it provides stability, on the other end, there is a freedom and space to play with a culture. He would also refer to this mechanism as a ‘dual-culture.’

<sup>6</sup> Anthropologist Ron Barrett shared his experience of being treated with a special social position – the “mere status of being a Westerner” distinguished him during his ethnographic work in the north Indian city of Banaras (2008: 16).



sense of joy, achievement and camaraderie in what I was trying to accomplish. In the midst of navigating such a scenario, my additional identity as a trained Tibetan doctor helped a great deal in earning local Tibetan community members' cooperation and trust. Nevertheless, I stayed away from introducing myself as a Tibetan doctor during my fieldwork until I felt the need and had to use that identity explicitly.

Because I was engaging my own society where Tibetan doctors hold a significant social status and expectation, I had many challenges and trade-offs. I initially tried to be a researcher without telling people in the settlement that I was a trained Tibetan physician. I used the strategy of presenting myself as a researcher to those who did not already know of my other identity solely because of challenges I anticipated. As I discussed above, some informants might have expected me to help them make important medical decisions for their family members, which in itself could open the door for bias in favor of my own perspective that they would avoid rushing their dying family members to hospitals and endeavor to help them die well at home. Similarly, some informants might not feel comfortable talking freely with me during an interview if they knew my medical credentials. For instance, during my preliminary research, some of my interviewees instinctively presumed that I knew enough or that I knew more than they did about a subject. Quite often, they were not open with their answers, possibly because of their deference toward me as a Tibetan physician. It was also one of the reasons that I changed my interview tactic from semi-structured to unstructured to elicit a more descriptive and conversational response from my informants.

Nevertheless, my strategy of being a strict researcher was challenged when I experienced a severe lack of terminal patients to observe. I even experienced an ethical dilemma after a certain point of time. There were occasions where I could have assisted patients or family

members without compromising the integrity of my research. Moreover, relying solely on some of my local contacts to inform me of terminal patients and waiting for days created a sense of moral predicament for me. I remember checking my cell phone every time I woke up in the morning or just waiting around in the morning hoping I would get a call informing me of someone seriously ill or dying. Even though I would justify to myself that the purpose and motivation behind the research was to help and improve care for terminal patients, I realized that anticipating someone is dying was not helping much to make sense of the intention and broader benefit of the research. Besides, it also started to bother me that I only had two terminal patient cases by the end of my third month in the field.

After spending considerable amount of time re-strategizing my approach and discussing with my research committee back at Emory University, I decided to wear two hats: that of a Tibetan physician and that of a researcher. I applied my new strategy by reaching out to some key community members. In early November 2016, along with a local Tibetan friend, I went to each village camp to meet with the camp leader to introduce myself. The plan was for my friend to introduce me to the camp leaders by addressing me as a Tibetan doctor and to inform them of my research and request of notification regarding anyone with terminal illness. I also reached out to Western medically trained doctors and nurses at the local Tibetan hospitals (not MTK clinics) and discussed my research with them. Simultaneously, I started volunteering at the local “Tibetan Settlement Old and Infirm People’s Home” where they host elderly Tibetans, as well as people for whom death was impending due to an illness or old age and who do not have regular caretakers in their home. These interactions, despite certain ethical challenges I discussed earlier, proved fruitful in opening the door to observe and participate in caring for dying people.

Another decision I made around the same time in the field that helped in the recruitment of participants was volunteering as a Tibetan doctor at the clinic of Drepung Loseling<sup>7</sup> Monastery. Drepung Loseling Hospital, which has clinics for both Tibetan medicine and Western biomedicine, were looking for a Tibetan doctor around that time and one of their staff approached me to sit in the clinic. Hence, I found myself being ascribed multiple identities halfway through my fieldwork: a researcher, a Tibetan doctor, a science teacher, and for some monks, an office secretary who could help with their office administration work. All these different roles I played shaped the ways I enrolled my informants and collected my ethnographic data.

### **Study Participants Recruitment**

Since “human relationship lies at the heart of the ethnographic method,” my effort in expanding my relationship in the community by donning multiple hats played an important role in expanding access to my study participants (Barrett 2008: 13). The initial recruitment of Tibetan physicians and monks in the research was based on my association with MTK as an alumnus as well as former staff and my previous contacts from preliminary research at Drepung Monastery in Mundgod. Although I was familiar with most of the MTK doctors and administration staff, I was careful in presenting my research in order to gain their support and have them as field collaborators. In the last two decades, MTK, especially the administration, has become somewhat disenchanted with external researchers; and their indifference toward researchers has been (informally) attributed to instances where Tibetan medicine was portrayed negatively; Tibetan medicine pharmacological formulas used inappropriately, or MTK not getting the credit it felt it deserved.

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<sup>7</sup> Drepung Loseling is one of the two main colleges (other is Drepung Gomang) at Drepung Monastic University.

Although MTK was a little apprehensive in the beginning of my research, the administration showed their support by becoming one of my main institutional field collaborators. On my request, MTK sent out a circular to all their branch clinics in south India to provide cooperation during my fieldwork. For my interviews, I reached out to MTK's doctors based in Dharamsala, the headquarters of MTK, in addition to Tibetan doctors in southern India. Nevertheless, it was only in south India where I accompanied and observed Tibetan doctors caring for terminal patients.

My other collaborator, Drepung Monastic University is much larger, both in terms of its community members and space. With over six-thousand monks, Drepung is spread across forty acres of land in the heart of the local Tibetan settlement. Even though my association with Drepung started when I went there in 2008 to conduct a scientific study on Lobsang Nyima Rinpoche who was in the state of *thugs dam* meditation, it was only in 2014 when I had a chance to forge a much closer and sustainable relationship with the monastic community. In the summer of 2014, I had a chance to volunteer as one of the teaching assistants (TA) for the neuroscience class taught at Drepung with the Emory-Tibet Science Initiative (ETSI) Program. ETSI conducts an intensive summer science training for monks and nuns covering philosophy, physics, biology, and neuroscience. Dr. Carol Worthman, a faculty in the Department of Anthropology at Emory University, who was leading the neuroscience team for the ETSI summer program, suggested I volunteer as a TA when she learned I was planning on conducting my preliminary fieldwork in Mundgod. The TA opportunity was instrumental in shaping my relationship with the monastic community and settlement members as well.

My work with ETSI not only helped in creating a network among the monks, it made me part of the monastic community. Later that summer in 2014, I got introduced to my Buddhist

philosophy teacher, Gen<sup>8</sup> Phuntsok Dhondup, who ended up becoming my field supervisor for my fieldwork. I spent two months with him, studying basic Buddhist texts on epistemology and ontology in the morning; and on numerous evenings, I hung around his place to discuss Buddhism in general or talk about his life in Tibet. Gen Phuntsok was one of the many senior teachers at Drepung who saw guiding my project as his responsibility and would constantly encourage me. On many occasions, he would take me around the monastery to introduce me to his colleagues and other teachers and ask them to assist my research.

I continued my association with ETSI and accepted Drepung Loseling Science Center's offer to be one of their volunteer teachers during my fieldwork. All through my fieldwork, except for the last three months, I taught neuroscience to monks three days a week. There were 70-100 students in each class and these students were monks in their mid- to advanced-level of monastic education. This regular interaction with monks provided a great avenue to discuss their views on the brain and consciousness, as well as what they think happens to them at the time of death.

In addition, as I stated earlier, I worked with Drepung Loseling medical administration as a volunteer in their Tibetan medicine clinic. The clinic is primarily aimed at providing free-treatment for the monastic community, but it also provides health care services to the local Tibetan and Indian population at minimal charge. I sat in the clinic every Wednesday and Thursday, which provided a dual-opportunity for me to serve my host community and to reach out to any terminal patient I could observe for my research. The hospital arranged for me to give a health talk on a regular basis in the monastic and lay community, which connected me to most

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<sup>8</sup> Gen (*rgan*) in Tibetan literally means "adult" or "elder," but it forms the word "teacher" (*dge rgan*) when it is combined with another syllable *dge*, meaning "merit" or "virtue"— thus, teacher is literally "virtuous elder." The term 'gen' (the second syllable of teacher) is commonly used in single syllabic form to refer to a teacher as well as among peers in the monastic community. Here, I used the term 'Gen' to refer to senior teachers.

of the informants and families I observed caring for dying loved ones. However, the downside of my increased connection was lack of time. I found myself constantly juggling the multiple roles of researcher, Tibetan doctor, science teacher, and office secretary. People would show up at my door at odd hours with problems ranging from a common cold, to minor accidents to chronic health issues. There were times when I had to leave my place early in the morning in order to avoid people so that I could work on my field notes. Nevertheless, if it were not for these interactions, I could not have conducted my ethnographic study with such a rich cross-section of participants and close observational experiences. By the end of my fieldwork, I interviewed 105 individuals (28 TMDs, 39 TBMs, and 38 family members) and observed 22 dying persons, out of which five stayed in *thugs dam*.

### **Procedure**

Given a close association between caregivers' conception of death and how they care for the dying (Warraich 2017; Swanson & Cooper 2005), it was crucial for my research to examine the attitudes of my collaborators'—Tibetan Doctors, Tibetan Monks, and Family Members—toward death as well as to observe them in action.<sup>9</sup> The collaborators' actions encompass the ways they care for dying people and cooperate with other caregivers to facilitate a condition for the dying to die well. With that understanding, I employed two main research strategies in order to tackle the complexity of how these actors collaborate in assisting a dying person despite possible differences. First, I relied upon an unstructured and semi-structured interview of my collaborators over the course of the initial six months of my fieldwork. Second, I relied upon a combination of passive and active participant-observation to gather more nuanced information

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<sup>9</sup> In Glaser and Strauss' (1965) seminal study on how Americans are dying in the hospital and the interactions = between hospital staff and patients, they asserted their focus drew from the “context of action rather than merely on ‘attitudes toward death’” (viii).

related to the ways collaborators care for a dying person, as well as any potential conflict that could arise between the collaborators while they were caring for the dying, and how they negotiate such scenarios. My role as both passive-observer and caregiver member as a Tibetan physician helped me glean data which might have been difficult to collect through passive-participation or interviewing. Moreover, during the last three months of my fieldwork and the following summer in 2018, I conducted surveys comprised of a Likert Scale to see how much someone agrees or disagrees with a specific statement, as well as other close-ended questions to validate key themes and beliefs among my interlocutors.

### **Studying Tibetan Doctors and Tibetan Monks**

I began my fieldwork with semi-structured interviewing and observation with Tibetan doctors and Tibetan monks. Other than gleaning information about their conceptions of death and dying and how they attend to dying people, this research required examination of variations among my collaborators and how they communicate with each other in the midst of potential conflict. Although the practice of Tibetan medicine and Buddhism is not mutually exclusive, I noticed some key differences in the ways they view death and care for the dying. For example, most of the Tibetan doctors I interviewed related to death as part and parcel of life and something that aids in living a better life, however, monks would share a more nuanced stance in terms of interpreting the relationship between life and death as well as its spiritual utility when a person is going through the dying process. Likewise, in caring for the dying, while both Tibetan doctors and monks focused on protecting a dying person's consciousness, they differed in terms of their application. I observed that Tibetan doctors' role was more explicit in making sure a dying person's state of mind was stable, monks' role became forefront in assisting a dying person's consciousness to make a swift transition to the next life.

Interviews were conducted in two phases: initial and follow-up. Out of 105 people that I interviewed, I managed to do a follow-up interview with 73 of them. The latter group of 73 people comprised mainly of family members, Tibetan doctors, and monks with whom I participated or observed dying people. The initial interviews were comprised of open-ended questions, employed before the participant-observations, and aimed to gather subjective experiences of Tibetan doctors and monks related to their understanding of death and dying, the process of dying, their respective practices, and their role in caring for dying persons. Interviews were intended to generate richly detailed transcripts for later analysis. For example, doctors and monks were prompted to narrate stories related to their experiences of attending to terminally ill or dying persons in order to elicit rich detail. Some examples of open-ended questions are: Could you tell me how you conceive of death? Could you share any of your experience of caring for a dying person? What does death mean to you? The follow-up interviews were comprised of survey questionnaire with a Likert scale and close-ended questions, employed after the observation and participant-observation. The close-ended questions were directed toward individuals' belief in reincarnation, fear of death, importance of caring for the dying, and so forth. The follow-up interviews were intended to glean any additional information as well as to further inquire about certain activities performed during the observation. By using both open-ended and close-ended questions in interviews, this study generates qualitative as well as quantitative data.

As I discussed earlier, I made it a point to accompany Tibetan doctors and monks whenever they made a home-visit to attend to a dying person. Given that this research required a combination of passive and active participant-observation, I spent a great deal of time juggling between simply "hanging around" and observing, or fully participating in caring for terminal



patients. Most of the time, I decided between the two approaches based on the need of the participants. Through the course of my fieldwork, as I started to know more people, I found myself by a dying person's bedside before Tibetan doctors or monks arrived. So, on several occasions, I had to reach out to doctors and monks to see patients. I also noticed that it was mostly Tibetan doctors who were invited to attend dying persons before monks. Monks were invited when death was imminent, or if patients have specifically asked for them. It was especially interesting when Tibetan doctors attend to a dying person who happened to be a monk. In such situations, I observed a genuine sense of honesty between a dying person (monk) and a Tibetan doctor. The patient simply wanted to know how close they are to death, and once the message of imminent death was established, it was a collaborative work between them to attend to or safeguard the consciousness.

### **Studying Family Members**

Inclusion of family members of dying people was critical for this dissertation for two important reasons. First, all the patients I intended to study were either in an advanced stage of terminal illnesses with impending death or were dying due to old age and therefore had little to no cognitive ability to make any treatment decisions for themselves. Hence, the role of family members was critical both in making treatment decisions as well as facilitating appropriate conditions for dying people to die well. Desjarlais (2016) and Gawande (2014) explain how family members in both Tibetan and Western culture play important role in helping terminal patients prepare for death as well as during the process of dying.

Second, there is a paucity of research focused on the role of family members as one of the collaborators in caring for dying people. Most of the studies on end-of-life care focus on the interactions between medical staff and patients (Kaufmann 2005; Glaser & Strauss 1965), or in

other cases, terminal patients themselves (Kubler-Ross 1969), but not dynamics with family members. I noticed during my fieldwork that family members play a key role not only in caring for dying patients and making important health decisions, but they also play a central role in negotiating with the doctors and monks regarding when and how to initiate rituals. These rituals are meant to assist the dying to be calm and at peace before death, as well as for the deceased consciousness to transit to the next life smoothly. Spending time and talking to family members helped me to understand how they are informed by common Tibetan Buddhist cultural models of caring for dying people despite a lack of in-depth understanding of Tibetan medicine or Buddhist psychology and philosophy.

I conducted both initial and follow-up interviews for family members post-observation during follow-up interviews (during phase 2) in order to avoid any ethical issues. I did so because asking family members about their conceptions of death and dying while engaged in attending to their dying loved ones could likely prove an unnecessary stressor for them. Despite challenges and trade-offs, I ended up developing close relationships with many families who had one of their family members diagnosed with terminal illness. Some of the terminal patients would live beyond their stipulated survival time, so I ended up being the go-to person for their families – both in terms of coordinating with doctors (Tibetan medicine doctors as well as Western biomedicine doctors) and monks and providing medical care when the situation demanded. During active participant-observation, I took part in certain death rituals when family members had difficulties in comprehending a Tibetan text or when they expressed uncertainty. One of the things that proved significant in studying family members along with Tibetan doctors and monks was that it gave me an opportunity to observe the importance of a cultural framework that spoke to all the caregivers irrespective of their professional or educational background. Such

a cultural framework offers a common ground where family members initiate their role in their collaboration with Tibetan doctors and monks.

### **Anonymity and Data Protection**

To safeguard the confidentiality of all study participants, all research for this project was conducted in accordance with Emory University's Institutional Review Board. Hand written field notes were kept in a locked cabinet at all times. All interview (audio and written) and participant observation data was entered electronically to ensure safe storage. All files are password protected and backed up on a hard-drive to which only the researcher has accessed. All names of informants used in this dissertation are pseudonyms except for those who either gave consents to present their names or who have personally asked the researcher to disclose their names.

## **CHAPTER OVERVIEW**

The first two chapters of this dissertation elucidate the Tibetan Buddhist cultural model that shapes the epistemology of death and dying; and how such an understanding of death informs the sociomoral fabric of society, how individuals live and die, and the ways in which they care for dying people. **Chapter 1** begins by elaborating on the cultural significance of death for Tibetan Buddhists, specifically, the role of death as a moral "heuristic" ground. This cultural conception of death not only shapes the ontology of death and dying, but also informs the relationship Tibetans have with their mortality. I introduce the heart of this chapter with my first encounter with *thugs dam*, Tibetan Buddhist meditation practice achieved in the process of dying (which is post-clinical death in biomedicine). I use *thugs dam* as a medium to show how a nuanced understanding of the process of dying is applied and enacted in the form of *thugs dam* whereby death is employed as a technique for cultivating compassion and generating resilience

in the face of this existential fear. Furthermore, I underscore *thugs dam* as a Tibetan Buddhist cultural phenomenon that underpins the core component of cultural models that deal with death and care of dying people. I propose that *thugs dam*, therefore, not only informs key Buddhist philosophical concepts, but also inspires and motivates cultural practices—including medical practice—focused on leading a meaningful life and ethical care for a dying person.

Building on this context, **chapter 2** presents how our conception of death determines the way we respond to death. I illustrate this relationship by juxtaposing two different traditions—modern biomedicine and Tibetan Buddhist culture—as to how death is defined and situated in their societies. I show that while the conception of death in modern biomedicine has constantly evolved with technological development, economic incentives, and legal pressure, death in Tibetan Buddhist culture is firmly based on the ancient Buddhist notion of death. Besides outlining the historical and theoretical roots in anthropological studies of death and dying in Western culture, I look at the persistent debate about defining death as simply a biological event or a biosocial dynamic. I describe a more holistic approach toward death in Tibetan culture where death is rigorously examined and understood based on its biological, philosophical, psychological, and spiritual components. I suggest the “biopsychosociospiritual” model, proposed by Jeffery Bishop (2011) is appropriate to understanding the complexities of death as analytical subject. I propose that the view of death is an adaptive cultural tool in Tibetan society that draws on how death not only plays a collective socio-moral reference point, but also serves as an aid in individual wellbeing.

**Chapter 3** shows how Tibetan medical practice is an extension of the broader Tibetan Buddhist cultural framework and focuses on two overarching questions of this dissertation: (1) how does end-of-life care in Tibetan medical practice necessitate the integration of medicine and

Buddhist philosophy and psychology; and (2) how does the integration of medicine and religion stimulate a paradigm shift in caring for dying patients and their family members? In response to these questions, I explicate the ways in which key Tibetan Buddhist concepts of reincarnation and compassion are inextricably linked to Tibetan medical practice, particularly in caring for dying people. I describe the intersection of Tibetan medicine and Buddhism by bringing in the respective ontological views of the human body and its relationship to the mind paying close attention to how mind is viewed as critical component both in identifying the root cause of illness and for a dying person to die well. I use the Tibetan Buddhist conceptual framework of the Four Noble Truths to illuminate how this framework underpins the epistemology in Tibetan medicine of health, illness, and suffering. I then incorporate ethnographic data to elucidate how these features lend Tibetan medical doctors a distinctive lens for viewing death and dying and the way they care for dying persons. I demonstrate how the integration of Tibetan medical and Buddhist practice not only provides Tibetan doctors an additional tool to care for the dying, it also influences the way family members make best use of seeking help from both TMDs and TBMs.

**Chapter 4** draws from ethnographic data to demonstrate how Tibetan doctors attend to terminal patients, that is, the Tibetan doctors' philosophy of being open and honest with a dying patient and assisting a patient to keep a stable mind and be prepared to die peacefully. I discuss how Tibetan doctors' mode of end-of-life care practice would be considered an anomaly in biomedicine where a lack of openness is the norm and a philosophy of "prolonging life at any cost" is embraced (Neumann 2016; Gawande 2014). To illustrate clinical nuances of Tibetan doctors' interaction with terminal patients, I present the ways in which Tibetan doctors make diagnoses and prognoses based on pulse reading and urine analysis; and employ a unique Tibetan

medical concept of the “Individual Constitutional Nature” (Tib. *rang bzhin*) in designing personalized care for patients. Furthermore, I reveal how for Tibetan doctors, identification of a dying person’s constitutional nature is crucial in determining how and what kind of assistance a doctor can provide to patients. For instance, a person with a predominant fire or *tripa*<sup>10</sup> nature might become mentally irritable, aggressive, and physiologically prone to inflammation and sharp pain at the time of death. Tibetan doctors assert that having such information helps to prepare them, as well as other caregivers, in facilitating a favorable condition for a dying person to die well.

In **chapter 5**, I examine what happens when a dying person is not familiar enough with the Tibetan Buddhist cultural models of death and dying, and hence might not be confident of dying well. What happens when the concerns about dying well, unlike some Tibetan Buddhist practitioners I discussed in previous chapter, fall primarily on caregivers? In dealing with these questions, I turn to how my research collaborators—Tibetan doctors, Tibetan monks, and family members—collaborate, with special attention to death rituals, in assisting a dying person to die as prescribed in Tibetan Buddhist culture: to die without or with minimal mental stress. Bearing in mind one of my hypotheses that “Tibetan doctors, Tibetan monks, and family members have distinctive ideas about their roles in caring for a dying person; what constitutes an ideal death, and the appropriate roles for the respective other groups in relation to a dying person,” I focus on death rituals to demonstrate a constant negotiation happening among these collaborators in the operationalization of these different cultural models pertaining to death and dying. I claim that death rituals provide these collaborators fertile ground to engage and enact fundamental Tibetan Buddhist cultural models despite contradiction and conflict. Importantly, I suggest that the

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<sup>10</sup> Tripa, based on fire element, is one of the three principal energies in Tibetan medicine, primarily responsible for metabolism and maintaining heat in the body.

Tibetan Buddhist emphasis on protecting a dying person's consciousness renders a sense of a collective goal among all the collaborators to create a synchronized act of caring.

To expound on the practice of death rituals, the chapter probes two interrelated questions: (1) Why are death rituals important in caring for dying people? (2) What role do death rituals play? I respond to these questions by examining death rituals I observed and participated in during my fieldwork. These death rituals were employed during the process of dying as well as after the death of a person. Likewise, I demonstrate the bi-directional relationship of a Tibetan Buddhist cultural worldview and the cultural members. In doing so, I explicate how death rituals carry a dual-purpose of assisting the dying person to die well and to acquire a good rebirth; as well as supporting family members in dealing with the aftermath of their loved ones' death.

Lastly, I discuss how even though Tibetan Buddhist practitioners with more intellectual acquisition and contemplative practices would see their acts as non-ritual compared to lay Tibetans who follow a strict cultural script, but the practitioners' practices are structured around repetition, formality, and strict discipline, which qualifies as ritual. I assert that the monks' practices which are private and less expressive could be viewed as "implicit rituals;" and highly elaborated or collective rituals such as the funeral rites performed in public could be referred to as "explicit rituals" (Shore [in press]: 7). Overall, this chapter describes the mechanics of how Tibetan death rituals not only provide a fecund ground for the collaborators to work together, it collapses the typical hierarchy of "doctors-in-charge of everything" (Gawande 2014; Kaufman 2005) and creates a situation where each collaborators has independent time and space to lead the procedure of assisting a dying person to die in the most appropriate manner.

In **chapter 6**, I address the most sought-after question in the field of end-of-life care: "What is good death?" I critically discuss the quandary surrounding the notion of a good death

by juxtaposing historical and current literature on the problems raised by dichotomizing a good and a bad death without understanding its complexity. Besides investigating the dilemma of the “good and bad death,” I make a case, based on my ethnographic study, as to whether the so-called good death, prescribed exclusively in modern hospice care, is good enough. I present three cases from my fieldwork, which animate the Tibetan Buddhist version of deaths resulting from dying persons’ understanding of death and dying and their state of mind. These ethnographic vignettes stimulate questions concerning a good death by asking: Is a peaceful death a good death? Is a good death a death without pain and anxiety? How does a good death, generated in contemporary society, assist people to die peacefully? Considering these questions, I argue that facilitating an ideal death, in the context of Tibetan Buddhist culture, demands more than providing physically comforting care at the end of life.

Building upon this background, I examine the concept of a “good death” in the context of Tibetan Buddhist culture. While exploring why the concept of a good death has been the subject of contentious debate, the chapter inquires: how do different notions of death and dying in Tibetan medical and Buddhist practice inform the way death and dying are conceived and enacted? This chapter aims to respond to this question via two main approaches using my ethnographic data: (1) articulating interviews of my interlocutors (comprised of Tibetan doctors and monks) to inform the philosophical stance toward death and dying, and (2) presenting cases of dying people to illustrate the process of dying. Further, I show how the quality of death is understood and applied among Tibetans; and what implications it has on the dying person as well as his or her caregivers.



## CHAPTER 1

### DEATH AS A *MORAL-HEURISTIC* GROUND: PARADIGMS OF GENERATING RESILIENCE AND CULTIVATING COMPASSION

*In horror of death, I took to the mountains—  
Again and again I meditated on the uncertainty of the hour of death,  
Capturing the fortress of the deathless unending nature of mind.  
Now all fear of death is over and done.  
- Milarepa<sup>11</sup>*

#### INTRODUCTION

It has been a decade and I still remember it vividly. It was a hot and humid evening on September 24, 2008 in Mundgod Tibetan Settlement, where two of the largest Tibetan Buddhist Monastic Universities—Drepung and Gaden—are located. My colleague and I nervously unpacked all the scientific devices—electroencephalography (EEG), electrocardiogram (ECG), thermal camera, among others—and fiddled with the myriad of electric cords. We were at Drepung Loseling Monastery to implement a scientific study on a senior monk who had been clinically dead for more than a week, yet his body had remained intact because he was in the state of meditation called *thugs dam* (*tukdam*). In other words, the senior monk, Lobsang Nyima Rinpoche,<sup>12</sup> who was the hundredth Gaden *Khri pa*,<sup>13</sup> was engaged in a contemplative technique whereby he maintained complete control over the physiological decay of his body via regulation

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<sup>11</sup> A famous verse by Milarepa, quoted by Patrul Rinpoche in his *Kunzang Lama Syalung*.

<sup>12</sup> Rinpoche in Tibetan literally means “precious one or jewel;” and in the context of Tibetan Buddhism, it is employed to refer to a reincarnate lama or highly respected religious teacher.

Note: All the names for my informants are used by consent unless otherwise specified.

<sup>13</sup> Gaden (also transliterated as Ganden) *Khri pa* is the title of the spiritual leader of the Gelug school of Tibetan Buddhism. Unlike the system of recognizing reincarnations, the Gaden Tripa is an appointed position, based solely on the intellectual and spiritual merit of a practitioner.

of his subtlest consciousness. We were there to investigate what was happening during this process by employing scientific devices.

Tanya Zivkovic (2010), in her ethnographic account of Tibetan Buddhist practice, describes *thugs dam* as a form of Buddhist lamas' way of displaying control over death. She explains *thugs dam* as a state of meditation where lamas are able to "impede physical flaccidity ordinarily preceding rigor mortis, retain a meditative state, suspend the processes of decomposition, maintain warmth in the body, produce a pleasant scent, transmogrify bones into images of Buddhist deities and manifest rainbows" (176).

Lobsang Rinpoche's body had no signs of decomposition, putrefaction, or discoloration, and was warm. Besides being anxious about properly setting up devices since it was our first study participant, I was a little fazed by everything I was witnessing – a week-long dead meditator who looked every bit alive in the midst of rather excited monks completely engrossed in their roles. I could not help myself thinking this is very different from deaths I had observed in the past and wondered: Why would a Buddhist practitioner choose "dying" as a specific time/moment to engage in meditation? How is it different from meditation practiced while alive? What is the purpose of such a contemplative technique? And importantly, what effect does it have on the way such practitioners and other members of society choose to die, and care for others who are dying?

This chapter elucidates the role of and techniques for the cultivation of compassion and resilience as a Tibetan Buddhist response to an existential human fear of death. The chapter explores the cultural significance of death for Tibetan Buddhists and its role as a "moral heuristic ground," to transform orientations to self and other. Tibetan Buddhist monks use death to contemplate two fundamental Buddhist concepts: impermanence (*mi rtag pa*) and the

interdependent nature (*rten 'brel*) of phenomena. While contemplating impermanence provides an alternative perspective about death, contemplating interdependence helps one deconstruct the conceptual-experiential importance of the “self.” This technique, according to the Tibetan monks I interviewed, generates heart power (*snying stobs*), also described as mental strength, offering a spiritual opportunity at the time of dying and a buffer against fears of death. Such acquired attributes that strengthen one’s resilience and generates compassion, in addition to Buddhist ontological knowledge of death and dying, impart potent skills in facilitating the ability to care for a dying person, which I will discuss in chapter 4.

I realized that, given the inextricable link between Tibetan Buddhism with Tibetan medical practice and Tibetans’ way of life in general, *thugs dam* holds an important place in any investigation of death in a Tibetan cultural context. The philosophy and psychology that underpin *thugs dam* inform the core components of cultural models that deal with death and care of dying people among Tibetan populations. *Thugs dam*, therefore, not only animates the Buddhist philosophical concepts, but also inspires and motivates cultural practices—including medical practice—focused on leading a meaningful life and ethical care for a dying person. I propose that the Tibetan Buddhist practice of *thugs dam* symbolizes the way death and dying is assumed to be approached, and thereby, encourages a culturally “appropriate” or an “ideal” death for oneself and others. With this background, I intend to use *thugs dam* practice as a framework that provides a fundamental structure to Tibetan cultural notions and practices of death and dying. From there, I will present variations on this structure that are prevalent among Tibetan monks, Tibetan medical doctors and laypeople regarding their attitudes toward death and dying with nuanced analysis in rest of the chapters.

Interweaving my initial introduction to *thugs dam* in 2008 and 18 months of ethnographic study in 2016 and 2017 among Tibetan refugees in south India in which I encountered several additional cases of *thugs dam*, I explore how the particular cultural significance ascribed to death motivates a unique ontology of death. I outline the basic framework for this ontology in this chapter. I show how such an understanding of death propels an in-depth self-investigation of death and the process of dying that implicates transformations in body, mind, and consciousness. This chapter sets the stage of the subsequent chapters by examining how such an epistemology of death is applied in one's own process of dying, as well as in caring for others in their process of dying. Lastly, I propose that such practices not only suggest a novel mode of viewing death but contribute to the debate about the notion of an ideal death, and therefore, provide a transformative paradigm in caring for individuals at the end of life.

### **FIRST ENCOUNTER WITH *THUGS DAM***

Two days before we were sitting by the side of Lobsang Rinpoche, who was in *thugs dam*, I was preparing for a health outreach trip to Kathmandu, Nepal. It was a bright fall morning after the last stretch of Dharamsala's notorious monsoon when I got a phone call from the director of Men-Tsee-Khang, the Tibetan Medical and Astrological Institute headquartered in north India, relaying information from the Dalai Lama's office. The director told me I need to urgently go to Drepung Monastic University in south India to attend to a senior monk who had died a week prior, and who was in the state of *thugs dam*. Drepung Monastery, one of the three largest Tibetan Buddhist academic monasteries reestablished in India, is in Mundgod, 1,450 miles from Dharamsala, in Karnataka State of south India.

A year earlier, our research team had been trained in data collection and the handling of relevant machines, such as electroencephalography (EEG) for recording electrical activity of the brain, electrocardiogram (ECG) to read the electrical activity of the heart, and thermal camera to record body temperature, for the study but we had not had any opportunity to assess an actual subject until then. We were excited to get our first potential study participant. I had sparse knowledge about *thugs dam* and its practice at that time, and I was a little skeptical as well. However, I was curious to learn more about *thugs dam*. After canceling my trip to Kathmandu and frantically working with a local travel agency to book a flight that morning, I, along with a colleague who was trained in Western medicine, flew down to Mundgod. We landed at the small airport in Hubli and saw an elderly Tibetan man waving at us right by the exit gate. Without saying anything, he smiled, grabbed our over-sized baggage trolley and said, “Everyone is waiting for you two.”

Drepung Monastery is an hour and a half drive from Hubli airport. We could hear prayers and see monks sitting in a group inside the compound as we drove toward the gate of a small two-story house where Lobsang Rinpoche’s meditative (dead) body was kept. A group of monks were reciting prayers while some were busy cleaning butter lamps and preparing food in a make-shift kitchen for the monks who were there to recite prayers. We were greeted enthusiastically by Choesang and Loden, the main attendants of Lobsang Rinpoche.

Given that it was our first study participant, and that he had been declared clinically dead at the hospital, I was not sure how it would go. The attendants told us it had been nine days since their teacher entered *thugs dam*. They quickly ushered me and my colleague into a small room on the second floor of the house. An older monk was already in the room, who Loden introduced to us as Jampa Rinpoche. Jampa Rinpoche, probably in his late 60s, had a relaxed, calm attitude

as he welcomed us and instantly made us feel comfortable. Jampa Rinpoche was well respected at the monastery, and especially revered for his vast experience in supervising someone in *thugs dam* meditation. He had been observing Lobsang Rinpoche since he entered *thugs dam*.

The small room was sparsely furnished with just a bed by the window overlooking the backyard on which Lobsang Rinpoche was lying. There was an altar with the Dalai Lama's portrait and a couple of blockprint Buddhist texts wrapped neatly in a yellow cloth. Lobsang Rinpoche's body was covered with a yellow-colored cloth. It was hot inside the room even though a ceiling fan was on. While I surveyed the room to find an appropriate spot to set up our devices, I looked at Lobsang Rinpoche's face and was riveted by what I saw: he looked like he was just sleeping. As we uncovered his body, I observed that there were no signs of decomposition nor any foul odor despite his having been declared dead more than a week earlier.

As we were getting ready Choesang whispered to us that it would be more appropriate if we could set up our investigative devices, including the electrodes that would be plastered to his head and chest and a thermal camera that detects core body temperature, in the evening after the group prayer session because some of the senior monks who had been Lobsang Rinpoche's students were feeling uncomfortable. We readily agreed with his suggestion as it is usually almost impossible to get access to a monk in such a meditative condition. Also, if it were not for the Dalai Lama's keen interest in scientifically studying *thugs dam* in order to make its benefit understood by a wider population, it would have been extremely difficult to convince monks to let us study someone engaged in *thugs dam* practice.

### **Supranormal Experiences**

For the next fourteen days, my colleague and I had the privilege of being around Lobsang Rinpoche's body to collect data – hooking him up to electrodes for EEG and ECG and setting up

a thermal camera to measure the core body temperature every evening and taking them off early in the morning. During this whole process of observing and collecting data, I witnessed a few things which I would have never believed prior to the experience. When I surveyed the room earlier while setting up our machines, I noticed a small jar half-filled with water and a twig with a few leaves placed in it on a small stool next to the altar.

The plant looked like a small twig plucked from one of the mango trees all over the backyard of the house. I saw that one of the monks would get a fresh plant every morning or every other day. Then one morning a monk who came to change the plant sat there rather amused and kept on looking closely at the plant. I noticed him but did not ask anything until the monk looked at me and my colleague and told us there was no way the twig can be growing in the jar. He pointed at leaves growing out of the twig and excitedly blurted, “Look at these leaves!” as if there were all precious gems hanging from the twig. From that morning, the small twig in the jar kept growing and the monk responsible for changing the plant would come, look at the twig, and leave it as it was. The attendants and other monks related the unusual growth of the plant to the power of Lobsang Rinpoche’s meditation, and could not stop talking about the marvel of the meditative power.

A couple of days later, my colleague and I were embarking on our daily routine heading over to Lobsang Rinpoche’s house from our guest house to detach the research devices. It was around 6:30 am and some of the younger monks were already in the kitchen preparing breakfast. As I opened the door to the Rinpoche’s room, I smelled a fragrance which I had never detected earlier. I knew it was not only me, since my colleague and I looked at each other validating one another’s experience without saying anything. It smelled like an amalgam of flowers, and the fragrance became more and more pronounced with each passing day. We would smell the

fragrance every morning when we entered the room to remove all the devices; and the scent would gradually fade away through the course of a day. I initially thought one of the attendants might have sprayed some kind of room freshener, but this was not the case. It was quite clear that the fragrance was oozing out of Lobsang Rinpoche's body. Jampa Rinpoche later told us that such a fragrance is called *tshul khrims kyi dri*, meaning a "fragrance of pure morality or an ethical discipline."

Presentation of such a fragrance during *thugs dam*, I was told, is associated with a practitioner's dedication toward his or her commitment to tantric practice as well as commitment to one's students. However, it is not customary that such a sign would be present by every practitioner in *thugs dam*. I also realized that, during the course of my fieldwork, practitioners who entered the state of *thugs dam* did not produce a fragrance even though their bodies did not present any foul smell either.

Another incident that astonished me were pearl-like objects that naturally started to appear on Lobsang Rinpoche's body. One morning as we were getting ready to unhook all the devices, Jampa Rinpoche said, "We need to be careful today as it looks like we have *ringsel* on Lobsang Rinpoche's body." Jampa Rinpoche and Choesang carefully scanned the cloth placed on Rinpoche's body, using a particular spoon made of silver to collect the pearl-like objects and put them in a container. *Ringsel* are also known as sacred relics and are seen to reify a practitioner's spiritual realization. Hence, the practitioners who are able to produce sacred relics after death are understood to have attained spiritual mastery that occurred at the time of death. The *ringsel* are perceived as one way in which Buddhist practitioners transmogrify their connection with their students into material form (see Zivkovic, 2014).





Figure 2: Jampa Rinpoche and Choesang collecting *ringsel* from Lobsang Rinpoche’s body

### **Interaction with biomedical doctors**

Local residents as well as media flocked to the monastery, and within no time, the news of a “miraculous monk in meditation” spread out. Lobsang Rinpoche’s feat of continued meditation even after his (clinical) death had reinforced his colleagues’ and students’ faith in his spiritual insight. It had amazed local communities—both Tibetan and Indian—to witness something that they have only heard about from spiritual teachers or read in ancient texts. Likewise, the news baffled local doctors and scientists. In the following days, delegates from hospitals and scientific organizations came to see the Lobsang Rinpoche’s dead yet “meditative” body.

On the fourteenth day of Lobsang Rinpoche’s *thugs dam*, a team of doctors from KLES Prabhakar Core Hospital came to the monastery to see Rinpoche’s body. KLES is one of the largest hospitals in north Karnataka state and is approximately 90 miles from Mundgod. The team was led by a doctor who attended to Lobsang Rinpoche at the time of his death and apparently signed his death certificate. The doctor told us that they had been curious when they

read about the meditative state of Lobsang Rinpoche in the local newspaper and wanted to see it for themselves. I escorted them into the room where Lobsang Rinpoche was lying, and as the doctor got near the bed, he stood there staring for few minutes, and then got all teared up. Once outside, the doctor said it was hard for him to believe what he saw: “The person who died in front of me two weeks ago looks every bit alive and has no signs of decomposition. This is unbelievable.” Moreover, the doctor said he was overwhelmed by emotion because he had heard of such spiritual practice but seeing it in person was something he had never imagined.

As we were talking, I realized I had a similar feeling – a deep sense of respect for Lobsang Rinpoche and curiosity about a cultural phenomenon that seemed supranormal. Hence, in the midst of everyone experiencing a collective state of reverence and amazement at the meditator’s feat, it made me wonder what the meditator—Lobsang Rinpoche, in this case—must be experiencing while in *thugs dam*. Why would he choose to dedicate his life to prepare for a particular moment at the time of dying to engage in a complex contemplative technique of this nature? What is the purpose of staying in *thugs dam*? And how is one able to stay in *thugs dam*?



Figure 3: Lobsang Rinpoche in his thirteenth day of *thugs dam* after clinical death

### ***Thugs Dam: Nexus of Supreme Technique and Sublime Knowledge***

I thought that the best way to respond to my curiosity would be to talk to monks at the monastery, who, besides possessing a certain level of academic authority, are adept practitioners. So, my colleague and I contacted Loden and Choesang, and they helped arrange a meeting with Geshe<sup>14</sup> Namgyal Wangchen. Geshe Wangchen was popular among the monastic community owing to his intellectual credentials as well as being an extremely open and kind teacher. He had spent a decade in London as a teacher and thus was fluent in English. Though excited, I was a little intimidated when we went to see him.

Geshe Wangchen greeted us with a warm smile, and said, “They told me you two are trained in both the Western and Tibetan medical systems, so this is great because I am taking both Tibetan and Western medicine.” Emphasizing the benefit of integrating Western and Tibetan medicine, he burst into a mild laughter and said he also has questions for us related to his health and modern science. Geshe Wangchen has been diabetic for many years and was recently diagnosed with hypertension. We discussed the management of diabetes from both a Tibetan medical and Western medical perspective through diet, behavior, and medication. He also seemed very interested in the intersection of Buddhism and science, and he talked about a book he was working on focused on the philosophy and psychology of Buddhism and modern science.

As we started to talk about the scientific study of *thugs dam*, Geshe Wangchen said, “I know Lobsang Rinpoche well and have worked closely with him. He was a wonderful scholar and an adept practitioner.” With a little hesitation, I asked him the purpose of *thugs dam* for a practitioner like Lobsang Rinpoche, who was highly respected and had little to prove in terms of

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<sup>14</sup> Geshe (Tib. *dge bshes*) or Geshema is a Tibetan Buddhist academic degree for monks and nuns. Geshe Lharam, which is a highest degree in Geluk tradition, is considered equivalent to a PhD degree in the Western educational system.

his spiritual practice. I realized later as I spent more time in the field, though, that *thugs dam* has nothing to do with ‘proving’ anything. It was good to know because I remember wondering if students and other followers’ expectation that their teachers should stay in *thugs dam* would put pressure on practitioners.

Zivkovic’s (2010) important work on spiritual biographies of Buddhist practitioners showed the significance of having control over body, mind and consciousness at the time of death. She noted that understanding death and controlling the process of dying hold the key to assessing the spiritual achievement of Buddhist lamas as illustrated through one of her interlocutor’s remark: “It is after death that we can truly know a lama and their ability” (175).

Geshe Wangchen, however, was clear that *thugs dam* should never be employed as a measure of a practitioner’s spiritual achievement. He also wanted us to know that not everyone whose body does not decompose right away is in the state of *thugs dam*. He noted,

*Thugs dam* is a powerful contemplative technique but it is also important to differentiate *thugs dam* propelled by strong emotions from one that is spiritually motivated based on years of study and practice. *Thugs dam* motivated by strong anger or an attachment generally lasts two to three days whereas the one facilitated by spiritual tantric endeavor could continue for weeks or months. Anyone might stay in a *thugs dam*-like state, however, there is a difference between a person dying with lots of attachment or anger and a practitioner who dies confidently with complete clarity about the process of dying and how to use a dying stage to coincide with the subtlest states of mind.<sup>15</sup>

Geshe Wangchen’s emphasis on differentiating *thugs dam* from a *thugs dam*-like state or pseudo-*thugs dam* was crucially informative because I would later come across several occasions

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<sup>15</sup> All conversations occurred in Tibetan and are translated by the author unless otherwise noted.

during my fieldwork where the line between someone being in *thugs dam* and not was blurry, and in some cases, complicated by various related factors. There was a case where a deceased senior monk's body was showing all the signs of decomposition, but his students were adamant about his continued meditation. At this time, Geshe Wangchen's assertion about the length of *thugs dam* was helpful for me as well as others at the monastery when I explained it to them both an adept practitioner's perspective like that of Geshe Wangchen and the bio-medical interpretation of post-death physiological changes.

However, my insatiable curiosity about how one can stay in *thugs dam* led me to meet with a well-known senior teacher, Geshe Lobsang Dukdha, during my fieldwork in the spring of 2017. Geshe Dukdha is one of the senior teachers at the Gyudmey Tantric School in a small Tibetan refugee settlement in Hunsur. Hunsur is located south of Mundgod, 260 miles from my base in the field.

Geshe Dukdha was in his early 50s. He is unusually tall for Tibetans and had a serious look that could be intimidating for people who do not know him well. I remember meeting him briefly during my pre-dissertation research in 2014. At that time, he was supportive of my research, encouraging me by saying that my work would not only help further academic understandings, but also provide personal (spiritual) growth via a deeper understanding of life and death. I was delighted to see him again given this earlier encounter. I had prepared a set of questions for him but started by asking how one stays in *thugs dam* and the reason it is important for practitioners who choose to stay in *thugs dam*. Geshe Dukdha posited three ways in which one can stay in *thugs dam*: 1) based on one's life-long practice; 2) based on an initiation received from high lamas and being profoundly committed to the vows taken during those teachings; and

3) through a deep sense of reverence and faith toward one's spiritual teacher (for example, the Dalai Lama) at the moment of death.

“*Thugs dam* is really about gradually suspending one's sensory consciousness and then, being focused, contemplating at the subtle, and very subtle levels of consciousness,” Geshe Dukdha said. “It is similar to falling asleep when slowly one's sensory faculties fade away and after a while, what one has is just subtle consciousness.” “Likewise,” he continued, “When one engages in meditation to slow down gross consciousness, the primary approach is to simulate a sleep-like state, or if possible, stages of dying, and get to the subtlest form of consciousness to examine oneself and one's relationship to others by contemplating on *stong nyid*, pronounced *tong nyi* (Emptiness).”

*Thugs dam*, therefore, becomes an extremely important time and space to investigate ultimate truth in a most effective manner. It is a meditative technique that helps a practitioner to contemplate and become familiarized to the ultimate truth, *stong nyid*. One engages in *thugs dam* at the stage of ‘*chi ba'i 'od gsal*, pronounced *cheway woesel* (Clear Light State) at the subtlest level of consciousness during the process of dying. At the clear light state, one's level of mental faculty is hyper amplified; and attention, completely undivided.

### **Consciousness (Tib. *rnam par shes pa*): Clear and Knowing**

Unlike in modern science where consciousness is understood through the anatomical and functional underpinnings of neural pathways (Laureys et al. 2015). Consciousness, according to Tibetan Buddhism, is conceived as something which is “merely clear” and “merely knowing” (Phende 2014: 44). In his book, *Reducing Suffering through the Study and Practice of Buddhist Psychology*, Ngawang Phende, asserts that “The words “clear” and “luminous” mean that it is

not a physical entity, not a material substance which possesses form...so that entity which is merely clear and merely knowing is what we call consciousness. The word merely here means it is just like that, and nothing else” (2014: 44). In other words, in Tibetan Buddhist philosophy, consciousness in its natural state is defined as luminous and knowing. Luminous means the ability of consciousness to reveal and disclose; and knowing relates to the ability of consciousness to perceive and apprehend what appears (Thompson 2015).

I noticed that my interlocutors would use multiple words to refer to consciousness. For instance, words like *sems* (mind), *yid* (awareness), and *rnam par shes pa* (consciousness) are often used interchangeably with similar meaning. As Phende explains in his book, I realized that these terms are mutually inclusive in regular conversation but could have different technical meanings at deeper level (2014: 46-47). Phende writes:

If we do not look at the official scriptural definitions of each of these words and explain the words directly instead, the first one, *sems* (mind) is explained as being the ground upon which habitual tendencies or karmic imprints are accumulated and stored. The second word, *yid* (awareness) is explained as being the aspect of mind which knows or holds an object. And lastly, *rnam par shes pa* (consciousness) is that which knows individual objects in a distinct way. It is in this context that we speak about the six sense consciousness—the eye sense consciousness, ear sense consciousness, nose sense consciousness, nose sense consciousness, and mental sense consciousness. (ibid 47).

### *Gross and Subtle Consciousness*

The interesting aspect of the understanding of consciousness in Tibetan Buddhism is the classification of consciousness into gross and subtle consciousness. Most common way of categorizing these two different levels, as per my interlocutors, is to view consciousness at

surface (sensory) level and at deeper or heightened level that is not directly associated with sensory organs. Phende argues that on one level, “the physical, atomically composed world is able to affect the gross level of the mind in various ways. However, this is not the case when it comes to the subtlest levels of mind. No matter what we do on a physical level, these subtle minds cannot be influenced in any way, because they do not rely upon the gross external body” (2014: 49).

Most of the practitioners I interviewed told me that this is the reason a practitioner would find it hard to meditate at the subtlest level of consciousness in order to avoid any form of distraction that sensory faculties could cause. Likewise, practitioners who would simulate dying process or meditate at the time of death tend to use the subtlest consciousness.

The technique of meditating at the subtlest level of consciousness requires years of dedicated study and self-investigative modes of practice. Thus, it is regarded as a supreme method among all techniques by Tibetan Buddhist practitioners. This is so because when the sensory organs associated with brain cease to function—either while simulating a dying process or at the time of actually dying—the subtlest mind is free from any distraction that is usually caused by a sensory reaction to stimuli. This is particularly true at the stage of dying called the Clear Light State when the subtlest level of consciousness is so clear and sharp that it can realize the nature of whatever it engages.

Tibetan Buddhist practitioners assert that employing meditative techniques to contemplate *tong nyi* at this specific time of the dying process can produce supreme insight. Geshe Samten Gyatso, one of the senior practitioners at Gomang Monastic School, affirmed the importance of studying the eight stages of dying. “The knowledge about the stages of dying,” Geshe Gyatso said, “is imperative for anyone, whether they are Buddhist practitioners,



healthcare personnel, or lay people.” The eight stages of dying go from a coarse or gross physical and mental state, to the subtle and then to the very subtle. Below I have provided a summary of his description.

### **EIGHT STAGES OF DYING**

Tibetans who have studied and are familiar with the process of dying employ this understanding at the time of their own death, as well as while caring for dying people to help prepare them for impending death. As the body disintegrates, stages of dying are marked by external physiological changes, weakening of sensory faculties, and internal experiences.

In the Tibetan text, the *first stage* is manifested as the earth element, one of the five sources<sup>16</sup> of human body, slowly diminishes. This leads to the external signs of the body becoming thin yet heavy, the loosening of joints, the loss of eyesight, and difficulty in opening or closing the eyes. The internal experience is that of sinking into the earth and seeing a mirage. In the *second stage*, as the water element diminishes, the external signs includes losing control of bodily fluids; saliva, sweat, and urine dries up extensively; and the auditory faculty becomes weak. Internally, the dying person would perceive the appearance of smoke everywhere. In the *third stage*, as the fire element diminishes, the warmth of body fades away; nothing could be digested; memory will decline, and the person would lose sense of sense of smell. The dying person would experience seeing fireflies in the sky. In the *fourth stage*, as the air element diminishes, the external signs includes difficulty in breathing, hallucination, losing one’s senses of touch and taste, experiencing one’s tongue becoming thick and short, and gradually experiencing the cessation of breath. The person would experience perceiving the appearance of

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<sup>16</sup> Five sources or *byung ba lnga*, pronounced *Joong wa nga* (also translated as 5 elements), is one of the fundamental theories, related to the formation of physical body in Tibetan medical science and Tibetan Buddhist Tantric practice. The five sources are: earth, water, fire, air, and space.

a spluttering butter lamp. At this stage, the dying person is clinically dead, and the gross consciousness dissolves, making the subtle consciousness more prominent.

In the *fifth stage*, the white-path (*snang wa kar lam pa*) appears where the crown point at the middle of the crown of the head connected to the central channel of the body loosens and the white drop or essence (sperm) of the father descends towards the heart. This leads to the experience of the proceeding along a white path like the clear autumn sky permeated by moonlight. In the *sixth stage*, the red-path (*mched pa dmar lam pa*) appears, where the navel point related to the sexual organ loosens and the red drop or essence (ovum) from the mother ascends toward the heart. This leads to the experience of perceiving an autumn sky pervaded by the sunset. The *seventh stage* is known as the Mind of Near Attainment (*Nyer thob nag lam pa*), where the white and red drops unite at the heart and cause the dying person to experience vivid blackness. Finally, the *eighth stage* is known as the Mind of Clear Light (*'chi ba 'od sel*), where the merged white and red essence dissolves into an indestructible drop at the heart and the subtle *rlung*<sup>17</sup> energy dissolves into the subtlest mind. At this stage, the mind is clear, and receptive to the highest level of mental function (*rGya mtsho* 2004: 81-82).

A pertinent question that might be asked is, do all dying people go through the aforementioned stages, or is it only a Buddhist practitioner? Geshe Gyatso gave me an affirming smile when I asked this to him. “I am glad you asked this,” he said. “This is important to know because being calm, mindful, and attentive to what is happening while dying is crucial for a dying person. It is crucial because although everyone goes through these dying stages, only those dying with a calm mind are able to be aware of these subtle stages, particularly, the very subtle

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<sup>17</sup> *rlung*, pronounced *Loong*, is one of the three principle energies in the Tibetan Medical system, responsible for every moment in the body, akin to nervous system in the Western biomedicine. Since *loong* is understood as having a bi-directional relationship with mind, it is explained in length in Tibetan Buddhist Tantric practice.

stage—the clear light state—when a person can employ that opportunity to meditate.” I observed regularly during my fieldwork that people dying calmly were less anxious generally and more positive as things unfolded in the last phases of their life.<sup>18</sup>

### **Investigating the Ultimate Truth**

During the course of my fieldwork, one theme that arose frequently during my interviews and interactions with senior Buddhist teachers and monks at monasteries was the importance of being in touch with the true nature of “reality.” I was not fully aware of the context in which my interlocutors understood reality in the beginning but as I spent more time with the monks, particularly with my field supervisor, Geshe Phuntsok Dhondup, I realized that (their) “reality” referred to the ultimate truth. They would contend that the ultimate truth is different from the reality we usually refer to, which in Buddhist philosophy, is interpreted as conventional truth.

The two truths—conventional truth (Tib. *kun rdzub bden pa*) and ultimate truth (Tib. *don dam bden pa*)—is one of the main epistemological doctrines in Buddhist philosophy that underpins the socio-moral fabric of a community. For instance, the reality that the source of happiness depends upon external factors, or the reality of an intrinsic self is perceived as reality that is not fully examined (also see Tsondu and Dodson-Lavelle, 2009; Ozawa-de Silva 2006). The intriguing aspect of viewing reality based on two truths is that no reality is more or less real, but it is more a matter of gaining an agency to analyze and infer the mechanism and outcome of an individual’s behavior and make informed life choices. I remember one of my first interviews during my fieldwork, Geshe Dhondup started by saying, “All the problems we are facing are due to our actions that are not aligned with reality.” He further added that the reality that is intellectually investigated and understood has a profound positive impact on one’s well-being.

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<sup>18</sup> Robert Desjarlais related similar understanding of the importance of a state of mind at the time of death in his interaction with Yolmo Buddhist community (2016)

All the sufferings in our life can be traced to our failure to differentiate between conventional reality and ultimate reality. Conventional reality is based strongly on our daily life, triggered by sensory emotions, such as seeing something beautiful, listening to nice music, or being physically attracted to someone; and these phenomena might be conceived as a source of happiness but could lead to suffering. Conversely, being able to control these emotions by examining and understanding both the immediate and long-term outcome of our behaviors; and being happy without relying on external conditions. Geshe Dhondup had a distinct way of conveying complex Buddhist concepts as easily relatable and motivating. He had a humble, warm smile when he talked, and his facial expression carried an unequivocal sense of genuine care and concern. I realized over the course of time that I was not the only person who felt his positive ambience. I first met Geshe Dhondup in the summer of 2014 when I was scouting out field sites as well as a Buddhist teacher. Given the intersection of Tibetan medicine and Buddhism I wanted to investigate in my doctoral research, I wanted to learn more about Buddhist philosophy and psychology in the process of conducting the research. Loden, one of the attendants of Lobsang Rinpoche, came to my rescue by arranging a meeting with Geshe Dhondup.



Figure 4: The author with his field supervisor, Geshe Phuntsok Dhondup

During our first meeting, I explained to him about my intended research on death and dying from the Tibetan Buddhist and medicine perspectives. He said, “This is good but before you study much of death and the process of dying in Tibetan Buddhism, you should have some understanding of *blo rig (lorig)*.”

*Blo rig* or “cognition and knowledge” is one of the foundational prerequisite subjects at the monastic college. *Blo rig* deals with the study of how knowledge is gained through cognition. For two and half months, I met with Geshe Dhondup, five days a week for two hours, to study *blo rig* and the Tibetan Buddhist interpretation of death and dying. Geshe Dhondup became more than my teacher, he took me under his wing. Beyond taking out time for a private class daily despite his hectic schedule, he took it upon himself to take me around the monastery and introduce me to other teachers to develop a network for my future research.

During his teaching, Geshe Dhondup accentuated the way Buddhist practitioners would use their amplified consciousness to gain deeper knowledge about their minds, and importantly, the way adept practitioners would employ their focused-mind to meditate on *stong nyid* (pronounced *tong nyi*). “Contemplating *tong nyi* and being able to comprehend the operation of *tong nyi*,” he says, “is the essence of knowledge.” And as usual, with a child-like smile, he further highlighted the importance of *tong nyi* by saying, “Just like you have *rinchen rilbu*<sup>19</sup> (precious pills) in Tibetan medical practice that are considered more efficacious than other pills in treating illness, the knowledge and insights one gains from contemplating *tong nyi* is like the king of medicine for curing our mental suffering.” When I asked him about the relationship

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<sup>19</sup> *Rinchen rilbu*, based on multiple herbs, precious gems and metals, is considered the most potent class of Tibetan medical formulations, and is used for treating various ailments. It is also prescribed as a prophylactic and rejuvenating medicine (see Czaja 2015 for detailed description).

between gaining deeper insight into *tong nyi* and one's preparation for death, Geshe Dhondup said:

*Tong nyi* is one of the key concepts of Buddhist philosophy. Although *tong nyi* is explained at different levels, it essentially asserts that there is no independent or intrinsic self. Everything is dependent upon multiple factors. For instance, if it is not for the love, care, nurturing and support of our parents and everyone in our life, we would not have survived. This is the reality we all need to be in touch with. Likewise, death is another reality of our life. One of the reasons we are so scared and anxious about death is that we are not able to accept the reality that we all will die and that it could happen at any moment of our life.

### ***stong nyid (tong nyi) and Wellbeing***

Both the Tibetan Buddhist practitioners as well as laypeople subscribed strongly to the idea that contemplating *stong nyid* is an important component to facilitating being a better and happier person. There was also a strong consensus that the practice of *thugs dam* is particularly effective for investigating *tong nyi*. In my survey study, 82 percent of monks and 74 percent of laypeople associated *thugs dam* with contemplating *tong nyi*. Similarly, there was also a strong emphasis among most of my interlocutors on getting intimate with *tong nyi* through examining the interdependent nature (*rten 'brel*) of phenomena. This is the key tool in cultivating compassion and generating resilience in the face of suffering, and existential fears, such as death. However, it is important to point out that generating resilience does not mean these practitioners are not intimidated by the inevitable and uncertain nature of death (see Goss and Klass 1997; Thurman 1994, for similar argument).

In a recent study looking at the relationship between attitudes toward death and the self among Hindus, Westerners, and Buddhist populations, Shaun Nichols and colleagues (2018) reported that, contrary to their hypothesis, Tibetan Buddhist monks actually fear death. Likewise, they stated that Tibetan monastics were also less generous compared to any other group about the possibility of giving up a slightly longer life in order to prolong the life of another. These are interesting observations in examining the degree of correlation between theory and praxis, but I feel the study lacks the nuanced understanding of the dynamic relationship that these cultural models share with the members of the community.

My interviews and field observations demonstrate that the effectiveness of cultural models hinges on the dynamic intersubjective relation they share with the community group, as well as within community members, rather than models acting as an “externally imposed...undynamic” objective cultural remedy (Ortner 1978: 1; also see Shore 1996 for constant interaction between collective and idiosyncratic cultural models). For instance, most of my informants would say that the very seed of being motivated stems from the fact that they are constantly reminded of the suffering and impermanent nature of their life (see Desjarlais 2003, 2016). This culturally-specific view is informed by the fundamental doctrine of a Buddhist worldview – the first of the four noble truths (see Dalai Lama 1997). Furthermore, in the survey, 91 percent of the monks said they feared death, and over 82 percent said there is not much to do for others at the time of death.

“It is the law of karma – everyone’s lifespan and the way a person dies are shaped by their deeds,” said a senior monk who came to visit an ailing monk at the monastery hospital I volunteered during my fieldwork. There is a clear indication that in Tibetan Buddhist culture,

where there is constant examining and reexamining of every phenomenon, everything is a work-in-progress until it happens.

In that respect, an endeavor to study, prepare, and overcome a fear of death is a part of tacit knowledge that precipitates when a challenging event arises, such as a death. There certainly seems to be no silver-bullet remedy that takes care of suffering. I had countless meals and hours of sitting with my field supervisor, Geshe Dhondup, and one thing he always emphasized when our conversation neared the end was: “One needs to work toward finding a profound realization that the most reliable way to be happy is by cultivating genuine compassion for others, even when one is in a difficult situation. That can also help one to be [mentally] strong in the midst of adversities.”

### **Cultivation of Compassion and Resilience**

It was captivating to hear everything these learned teachers were telling me and to witness an adept practitioner like Lobsang Rinpoche in the state of meditation that transcended my limited understanding of Tibetan Buddhist practice. One thing was clear – these practitioners seemed to use the most vulnerable moment of their life, death, to engage in spiritual practice that helps to uncover some of the most mysterious features of human life. Death, which apparently carries a maximum degree of uncertainty and suffering and is viewed generally as an existential fear seemed to have an entirely different meaning for the Tibetan Buddhist practitioners I interviewed. I witnessed my father’s death who died a year before I observed Lobsang Rinpoche in *thugs dam*. My father’s death was not a heartwarming experience, nor inspiring. He seemed to be emotionally unprepared, disoriented, and struggled to let himself go peacefully.

However, death, for these practitioners, is not only a moment of potent spiritual opportunity, but a part of life that is awaited with enthusiasm and joy. One could say death is



tamed in this cultural practice. But I would argue that it is more than “tamed” if we understand it from what Phillipe Aries (1974) wrote in his seminal work on attitudes toward death in medieval Christian traditions. Aries refers to a tamed death as being aware of death and accepting it, but Tibetan monks on the other hand, appeared to “tame” death by studying the very anatomy and physiology of death and the process of dying. These adept Buddhist practitioners seemed to use the dying process as a vantage point to contemplate *tong nyi* in order to cultivate deep-rooted compassion.

Jampa Rinpoche, who was monitoring Lobsang Rinpoche’s *thugs dam*, elucidated the importance of having a nuanced understanding of the dissolution of body—physical as well as mental—at death from the grossest to the subtlest level. “Such knowledge,” he said, “is employed in heightening mental clarity as Buddhist practitioners contemplatively analyze the ultimate reality.”

Geshe Wangchen, talking about the practice of *thugs dam*, emphasized the significance of ethically informed motivation – a motivation that is generated through deep investigation of the nature of the self. He said that along with comprehensive study and understanding of the human body and its relationship to mind, a practitioner develops unshakable motivation and a deep sense of purpose. He said,

In addition to the rigorous study of the nature of mind and body and their interplay, and the integration and disintegration of body, if one has clear motivation and purpose, one can simulate a dying process while alive; and if needed, can stay in *thugs dam* at the time of dying.

It is quite understandable that any individual who aspires to be happy and avoid suffering might accept a bargain of being less egotistical and try to help others more; but using death as a point

of reference in that pursuit might sound confusing, and even counterintuitive. Likewise, meditating on emptiness (*tong nyi*) could draw a distance or lack of relationship between the goal of being compassionate and the technique of contemplating emptiness. I struggled to make sense of that when I sat with numerous senior teachers at the monastery in the beginning. Almost all of them told me that the essence of Buddhist practice (including staying in *thugs dam*) is to meditate on emptiness. They said dedicated hard work can lead to sustainable happiness and heart power (courage), *snying stops*. The concept of this “heart power” is fascinating considering its relationship to the quality of death. Interestingly, the relationship between heart and courage is reflected in the etymology of the word “courage” itself: the word “courage” comes from the word “cour” which means heart (Brown 2012).

## **NOTHING IS PERMANENTLY ATTACHED**

In December 2016, while I was in the field, the Emory-Tibet Partnership between Emory University and Drepung Loseling Monastery organized a conference focused on bridging “Tibetan Buddhism and Modern Science.” Geshe Ngawang Phende who is from Drepung Loseling Monastery, and also a resident Buddhist teacher at the Atlanta Loseling Center, had come to participate. We had a lively discussion during one of his teachings at the Loseling Atlanta Center, and I did not want to miss the opportunity to interview him. I started by asking my key question: “Why is contemplating death important for Tibetan Buddhist practitioners?” Geshe Phende looked straight at me, half-smiling and said, “I almost died a few years ago and went through major treatment. It was quite scary, I tried my best, but it was hard. That much I can say, and he laughed looking at me and his student who was in the room.” He readjusted his folded cross-legged position, which is often a monks’ preferred sitting position, and got serious:

Death, and the need of befriending death is important for various reasons, and one way to look at that is: in Buddhism, one of the most important components is the training of our mind. We say that our consciousness is governed by three primary afflictive emotions—attachment, anger, and delusion—due to our ignorant belief about an intrinsic self. These emotions, if not controlled, can cause lots of suffering. Emotions like anger and delusion are easy to recognize and hence check on them or at least know it is not good when they arise. However, this attachment can be very deceiving – we get attached to so many things, such as nice clothes, gadgets like a new iPhone, car, romantic partner, etcetera. And we think they are the source of happiness, but quickly or slowly, we realize those are actually the cause of suffering. That is thinking about death, and knowing that everything is impermanent, that nothing lasts, is a helpful antidote. It also helps to have a different perspective about our endless desires and being attached to those desires.

To complement what Geshe Phende said about the importance of thinking about death, I had a wonderful opportunity to interview the Dalai Lama.<sup>20</sup> It was during a private audience I had in leading a summer program for University of Minnesota students. I asked the Dalai Lama the same question that I had asked Geshe Phende. He responded initially in English but switched to Tibetan as he elaborated on relationship between death and meditation practice.

So, you mean meditating on impermanence? Well, reminding oneself of impermanence, including death, does not mean it is important to [just] think about death. On the other hand, our thinking that I would live a hundred years or forever, and then, develop certain sort of attraction in this life towards money, fame, material things by exploiting others, is not good, and could lead to many negative things. In order to avoid such deleterious

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<sup>20</sup> Dalai Lama. 05/20/2018, Dharamsala. Personal Interview at His residence.

things to happen, it is important to use death to be cognizant of the limitation of our life.

Therefore, thinking about death or our mortality has to be understood in the context of monitoring our never-ending greed and desire.

While in the field, everything I was observing was intellectually stimulating and emotionally exhilarating for me. It might not be perceived that way by others because I am a native Tibetan researcher and was born and raised in a Tibetan community in India. As I pointed out earlier, if it were not for a strong push by someone like the Dalai Lama to scientifically study meditation surrounding death, I wonder if there would be a growing number of researchers and academicians interested in studying death and dying in Tibetan Buddhist culture.

During my fieldwork, I stayed in a tiny little room on the top floor of a building, which was built as an Old Age Home for monastics. I would go and see one of the old monks who lives there because he could not come to the clinic due to significant sciatica pain. During one of our sittings, we discussed my research about death and dying. After stressing the importance of the work, he said it is important to differentiate death and dying (*shi wa* and *chi wa*) because each of them play different role for practitioners. He said,

By understanding and familiarizing death and dying at a nuanced level, Buddhist practitioners use death to find a deeper meaning of life by thinking about impermanence; and the dying process is a vantage point to cultivate compassion and generate resilience.

### **Conclusion of Lobsang Rinpoche's *thugs dam***

It was the seventeenth day since Lobsang Rinpoche had entered *thugs dam* when, one evening as we were just getting done setting up our devices and attaching electrodes to Lobsang Rinpoche's head and chest, Jampa Rinpoche summoned us. He said he had dreamt certain signs, which might indicate the conclusion of *thugs dam*. He wanted us to be prepared in case Lobsang

Rinpoche would conclude his *thugs dam*. Jampa Rinpoche expounded upon the signs associated with the conclusion of *thugs dam* upon us asking.

Usually, the meditator will let go of control over the subtle *loong* and the consciousness.

When that happens, we start seeing physiological changes, such as discoloration, putrefaction, loss of body heat, etcetera. I dreamt Rinpoche's body had some smell and changes happening in his body. Also, when *thugs dam* is about to be concluded, the weather gets cooler, clouds start forming, and a rainbow can appear.

Jampa Rinpoche was right. The next day, we had unusual weather. It got unbearably hot in the morning, followed by a strong wind, churned up red dry dust in the air, and a heavy downpour for almost an hour. By noon, the rain had stopped, the temperature cooled, and we had a clear sky where a rainbow appeared. Loden, one of the main attendants of Lobsang Rinpoche, came to us, and with seemingly mixed feelings, he told us, "It seems like [Lobsang] Rinpoche has released his subtle consciousness," meaning, Rinpoche has concluded his *thugs dam*.

Loden mentioned there was a little discharge of semi-red fluid from Rinpoche's nostril. It is generally observed that a light-red fluid and a light-white fluid will be released from the nostrils and genitals, respectively, when a practitioner releases their subtlest consciousness at the conclusion of *thugs dam*. By the time we went to the room, Rinpoche's body had started to change, already showing signs of decomposition. It was quite astonishing to see how fast Rinpoche's body started to change as he concluded his meditation. The radiance on his face was quickly vanishing, his skin color changed, especially under the chin, behind the ears, under the arms, and some parts of legs; and fluid started to retain in his back and legs.

Everyone was preparing for the cremation but all of a sudden, everything changed. Loden and Choesang were running around arranging a new casket made especially of oak. By late

afternoon, Lobsang Rinpoche's body has been washed, ceremonies performed, and a truck filled with raw sea-salt showed up by the gate of Rinpoche's house. As I was wondering what was going on, Loden came over and told me that the Dalai Lama has specifically directed them to mummify Lobsang Rinpoche's body. I was told that mummification of a body is usually done for selected practitioners to continue their connection with their students as well as to inspire them to be committed to their practices (see Zivkovic 2014).

When my colleague and I left Drepung Loseling, the monks were in the process of mummifying Lobsang Rinpoche's body employing the traditional method of using sea salt. Along with Rinpoche's body, the attendants filled the casket with sea salt, changing the salt every three to four days to a week. It was an extraordinary experience for me to see someone in *thugs dam* so closely and then to be part of the whole milieu that was generated during and after *thugs dam*. This cultural phenomenon raises an interesting question about if someone in *thugs dam* is dead or dying. For instance, Lobsang Rinpoche was declared dead at the hospital based on the cessation of his brain and cardiopulmonary functions. However, for Rinpoche's followers and others around him, he was in the process of dying, for his (subtle) consciousness has not left his body yet. Such practice challenges the modern biomedicine's determination of death, which strictly relies on biological markers that can be observed and measured.

I distinctly remember going back to Dharamsala with a conviction that I wanted to know more about *thugs dam*, a cultural phenomenon that uses death as a vantage point in one's self-investigation of self and its relationship to others. I was particularly intrigued by the unique cultural phenomenon where death is not only viewed as a heuristic ground in investigating and shaping the socio-moral fabric of life, but also in cultivating profound compassion and resilience in the face of an existential fear of death. It made me question the very purpose of death.

## WHAT IS DEATH?

Both my early encounter of the monk in *thugs dam* and ethnographic fieldwork of studying how Tibetans care for dying people present dilemmas that not only challenge the way death is conceived, but also the role death plays in shaping and reinforcing cultural values and beliefs. The question of “what is death” or “what is the purpose of death” is inevitable considering the way death and dying are understood and applied in everyday life as well as spiritual practice among Tibetans. I have the follow-up question referring to the “purpose” of death because interestingly, many of my interlocutors, while explaining what death is, also talked about the “utility” of death for spiritual practice.

Likewise, When I asked my interlocutors, “How do you conceive death?”, they would respond with some variations based on their education background or age, but one overarching response was, “Death is a part of life. Whoever is born has to die.” Some of them would elaborate further about distinction between life and death by saying, “Death is a moment when consciousness leaves the body.” My field supervisor, Geshe Dhondup summed up the cultural significance of death by relating death to a constant reminder of the reality that we should always be in sync with.

The reality of death is important for us to remind ourselves not only of the constant changes occurring in our body and outside in the environment, but also to tame our insatiable desire and attachment. Similarly, for advanced practitioners, stages of dying are crucial moments for further advancement of their spiritual practice. In that sense, death and dying holds an important place in worldly life as well as spiritual practice.

## CONCLUSION

The treatment of death and dying reflects fundamental components of a cultural practice and its impact on the way people view death and care for dying people. Tibetan Buddhist culture has a specific way of dealing with death, but its uniqueness is the epistemological “status” of the death. Death and dying are feared, but not because they are unknown, or I death ruptures life, but because they are intimately understood, are a source of flourishing, and if used well, enlightenment. I have observed that practitioners—both monastics and laypeople—employ death to extrapolate an alternative meaning in combating limitless desire and attachment fueled by an ignorant mind. Likewise, dying is used in generating an altered consciousness that presents a hyper-receptive agency in investigating, realizing, and embodying emptiness; cultivating profound compassion; and creating a resilience. Such mental engagement at the subtlest level with a clear motivation and purpose, I argue, amounts to a mechanism to alchemize the existential fear and suffering of death to existential clarity and joy.

The current practice of end-of-life care in the U.S., comprising hospice as well as palliative care, is strongly focused on minimizing physical pain and discomfort (Rubio 2016; Neumann 2016; Bishop 2011; Gawande 2014). The support for a dying person’s state of mind that exists in some of the facilities is more informed by functions of brain. The transformative paradigm of assigning mind as a key subject of caring could complement the care for a population whose only media of connecting with themselves and others are their minds.

Furthermore, considering the intimate relationship between the conception of death and the care of dying people is critical to frame a more inclusive understanding of death. I refer to a more inclusive approach here as looking at diverse markers—mainly biological and cultural—that underpin the characterization of death. Of course, the mode of determining death could vary across societies as well as situations, but I would argue that the intention and its underlying



motivation should be driven solely by the interest of the dying person. To fulfill such a project, it is essential not only to engage in cross-cultural analysis of death and dying, but also to embrace both the biological and cultural components that inform the determination of death (see Braswell 2014; Bishop 2011). The next chapter will examine the understanding of death and dying across cultures, specifically, looking at the biocultural components and its implication on the care for dying people.

## CHAPTER 2

### RE-EXAMINING DEATH: DOOR TO RESILIENCE AND WELLBEING

*No longer defended by the ego, the gate between self and other—Huxley’s reducing valve—is thrown wide open. And what comes through that opening for many people, in a great flood, is love.*

- Michael Pollan, *How to Change your Mind*, 2018: 353.

#### INTRODUCTION

The recent studies in the field of psychotherapy, specifically in the care for terminal patients, speak to the rather counterintuitive Tibetan Buddhist notions of death as a source of investigating self, forming positive behaviors, as well as a means to generating resilience and compassion. Michael Pollan’s recently well-received book, *“How to Change Your Mind: What a New Science of Psychedelics Teaches Us about Consciousness, Dying, Addiction, Depression, and Transcendence”* (2018) also testifies to this. Having earned a reputation for exploring the complex interplay of nature and culture, Pollan explored the relationship between hallucinogenic plants (psilocybin) and the Western cultural fear of death. Pollan narrated some impressive results of clinical trials at NYU and Johns Hopkins School of Medicine where researchers administered psilocybin to cancer patients in an effort to relieve their anxiety and existential distress.

Pollan further explains that according to the researchers he interviewed, patients reported transcendental feelings of profound love, calmness, and a loss of fear of death after a session of psilocybin. Likewise, patients experienced a dissolution of *self* along with a sense of connectedness to others. This was validated via fMRI which showed that the activity in the part of the brain called the “default-mode network” that relates to the construction of an

“autobiographical self or ego” was noticeably reduced (2018: 351-52). A double-blind clinical study shows that an administration of a single dose of psilocybin produced substantial and sustainable decreases in depressed mood and death anxiety in patients with life-threatening cancer (Griffiths et al. 2016).

These reports were reminiscent of what I had repeatedly heard from my interlocutors during my doctoral fieldwork in Tibetan communities in south India. For Tibetans, death is more than an event or an end-point.<sup>21</sup> Death, according to Tibetan Buddhist monastics I interviewed in Mundgod, is rather viewed as a phenomenon that informs key Buddhist concepts, as well as being a biological process that could be employed to engage in potent meditative practice aimed at achieving a state of *selflessness* and profound love for others. As one of my monk informants, who was caring for a senior monk with terminal illness explained: “Such a state of mind helps to generate resilience toward pain and suffering”.

Geshe Samten, one of the monks with whom I spent a considerable amount of time in the field, said, “Thinking about death helps me to internalize the concept of impermanence.” Geshe Samten would go on to describe how the transience of our existence that frames the reality of death for all of us, motivates an understanding of the impermanence of all things in life. Thus, this view of death is central to Buddhist concepts of the impermanence of all conditioned phenomena. Likewise, an elderly lay Tibetan acknowledged that being aware of death motivates him to reduce greed and attachment. Furthermore, akin to what psilocybin clinical trials have demonstrated, some Tibetans, particularly Buddhist practitioners, relate a sense of joy, fulfillment, and love at the moment of impending death, as well as during post-clinical death meditation, where they are in the state of pure luminous mind. Tibetan Buddhist practitioners

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<sup>21</sup> Margaret Lock makes a similar case in her cross-cultural analysis of death (see, for instance, Lock 2002)

refer to this post-death meditation as *thugs dam* (pronounced *tukdam*), which I elaborate on further in previous chapter. These myriad ways in which Tibetans conceive of death and apply it in their life provide a fertile ground in which to examine the relationship between the conception of death and the manner in which a person dies, as well as how best to care for a dying person.

In this chapter, I attempt to explore how the manner in which we conceive of death and the ways in which we respond to death determine the way we live and die. Can a primal account of death contribute to the development of adaptive social traits that could lead to sustainable happiness and human flourishing? Employing an anthropological lens, I address the initial inquiry of “what is death?” by looking at the historical and theoretical exploration of death and compare the modern (medicalized) death to the Tibetan Buddhist notion of death. I explore the concept of “biopsychosociospiritual” death to gain a holistic understanding of human mortality. This analysis, based on my 18-month ethnographic study and existing literature, explores the conception of death using biological and cultural lenses. It explores how the practice of “medicalized death” has shaped the understanding of contemporary death and the ways in which we are dying.

Moreover, I present conceptions of death in Tibetan Buddhist culture, paying particular attention as to how death is employed as an adaptive cultural tool in pursuance of positive behavioral changes and happiness at both the individual and societal levels. In doing so, I present both the theoretical conception of death and dying as well as its role in animating Buddhist cultural values and beliefs. Importantly, I present a general landscape of Tibetan Buddhist cultural models that facilitates multiple ways of dying that is specifically depended on an individual’s familiarity with death and dying and his or her own level of spiritual practice.

Finally, I hope the aforementioned discussion will shed some light on an underlying question of this dissertation: What does death mean for someone who believes in reincarnation?

### **WHAT IS DEATH? NEW ANSWERS TO AN OLD QUESTION**

*Clearly, death is not a self-evident phenomenon. The margins between life and death are socially and culturally constructed, mobile, multiple, and open to dispute and reformulation.*

- Margaret Lock, 2002:11.

Pema had been unconscious for six days when I went to see her, accompanied by her uncle, in the Intensive Care Unit (ICU). She was lying motionless, hooked up to multiple tubes, breathing via tracheostomy, a medical procedure where an opening is made in the throat to insert a tube into the windpipe in order to deliver air directly to the lungs. A nurse, who was observing an electrocardiogram (ECG) and other vital signs displayed on the nearby monitor, smiled at us. She scribbled something on the patient record board tied to the foot of the bed and left the station without saying anything. Pema's parents were standing by each side of the bed as if waiting for their daughter to respond and start talking to them. Nonetheless, despite looking tired and a little shaken, they greeted me warmly and thanked me for coming.

Six days earlier, Pema had been found unresponsive by her uncle early in the morning in her room. The family, not knowing what might have caused the condition, rushed her to the nearest hospital with an ICU facility, in a nearby Indian city, which was an hour-and-a-half drive away. They realized later that Pema had ingested a high dose of a chemical causing neurotoxicity, which led to severe brain damage. Pema's uncle called to ask my opinion four days after the incident. When I asked for more information about Pema's condition, he told me that the head neurologist at the hospital had said there was nothing much they could do, and that Pema was "brain dead". The family was given an option to unhook the life support. However,

they also had another Tibetan medical doctor who had come to see Pema before me. The Tibetan doctor, after careful examination of Pema's condition, had told them to wait for at least two weeks before giving up on her.

Pema's family might not have been aware that Pema would have made a good candidate for organ donation if they had agreed to declare her brain dead. In such cases, if the doctor saw that she could not breathe on her own after being disconnected from her ventilator, she would be legally "brain dead". Pema would be then hooked up back to her ventilator to keep her organs fresh for transplant (Teresi 2012). I was curious to understand what made the two doctors decide on how to advise Pema's family.

The head neurologist was surprisingly open about talking to me when I reached him over the phone. He said he was swamped with meetings when I called him but agreed to a conference call the next day.

"I hope you know the patient's condition is irreversible," he said as we began our conversation the following day. I asked him what he meant by Pema's condition being irreversible.

"You mean she is untreatable or there is no point in treating her?"

"We could continue to treat and observe her but even if she regains consciousness, she would never be the same as before."

I started to wonder about the extent of Pema's brain damage. "How do you explain that?"

"See, the patient's cerebral cortex [responsible for higher thought processes including decision making, speech, social interaction, and so on] is significantly damaged. She is not aware of herself and her surroundings. The impact is such that it could be very hard to reverse the situation. She could never be a complete person."

“I spoke to Pema’s family and they are wondering if you could continue with your observation of her and see how she does in the next few days?”

“We could certainly do that,” he responded. We decided to stay in touch before we hung up the phone.

Later that day, I went to the Men-Tsee-Khang clinic to meet with the Tibetan medical doctor to ask him about his analysis of Pema’s condition. When asked why he advised Pema’s family to continue to keep her under observation, the Tibetan doctor told me that even though Pema was unresponsive, her pulse<sup>22</sup> was firm and strong. And, as if to emphasize Pema’s mental agility, he added, “She was full of emotion. She got all teared up when I was talking to her parents. Her consciousness was intact.” Pema’s parents later corroborated the Tibetan doctor’s assertion that her eyes had welled up with tears when they were speaking to the Tibetan doctor.

It was interesting to see that while Pema was lying in the ICU unable to intervene in what was being thought of her and planned for her, the doctors were directing life-and-death decisions for her – and with distinctly different lenses on her state of consciousness. Whilst the Indian neurologist had the “brain” as a key marker in determining Pema’s mortality, arguing that Pema could never be the *person* that she used to be; the Tibetan doctor, on the other hand, had her “consciousness” as a primary reference in contesting his view that she was very much conscious and alive.

The neurologist answered my call with enthusiasm when I called him exactly two weeks after Pema was admitted to the ICU. He told me that Pema had regained partial awareness and

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<sup>22</sup> Tibetan doctors use pulse reading as one of the primary modes of making a diagnosis (other diagnosis techniques are urine analysis, observing, examining and touching different parts of the body, and talking to patients). Tibetan doctors read patients’ radial artery of both hands using each of their six fingers (pointer, middle, and ring) as the medium to decipher functions of internal organs and other related illnesses. I elucidate further on the Tibetan medicine mode of diagnosis in Chapter 4. (Also see Tidwell’s ethnographic work on how Tibetan doctors’ address and treat cancer via pulse and urine analysis, 2018: 376-410; Gonpo 1984.)

part of her damaged brain had started to heal showing good signs of recovery. He also said that all her vital signs, including blood pressure, respiration, pulse, and body temperature, were stable and normal. Most importantly, he said, they had not noticed any seizures. The neurologist thought Pema's recovery was nothing less than a miracle and that he had high hopes for Pema's recovery. Pema did recover swiftly in the following days: she was taken off the ventilator, was aware of her surroundings. Within a week, the neurologist felt she was ready to go home. Pema was discharged in a stable condition a little more than three weeks after she had been admitted with little hope of recovery. Other than some difficulty in walking and maintaining balance, Pema has, since then, fully recovered.

Pema's case is fascinating not only because of the way it animates the existing conundrum relating to death, but also because it adds another layer for us to consider. The Tibetan doctor, besides being cognizant of Pema's unresponsive state, was using consciousness as a point of reference that is distinctive from the way death is conceived in neurocentric death (Laureys 2005). Understanding this consciousness-centric approach is critical to this research because of a recurring pattern throughout the course of my fieldwork where caregivers—Tibetan medical doctors (TMDs), Tibetan Buddhist monks (TBMs), and family members (FMs)—held the collective goal of caring for a dying person's consciousness. Likewise, I witnessed that consciousness plays a key role in drawing the line between life and death. For the caregivers, a person is alive as long as consciousness has not left the body. It was interesting to observe with all the aforementioned stakeholders (TBDs, TBMs and FMs) that when a person's physical body starts to break down, the consciousness is the entity that is perceived to need the utmost care, albeit the stakeholders employ different methods to do so. Nonetheless, before I present the way death is conceived and employed in Tibetan Buddhist community life, I think it is important to



get a sense of how the conception of death has evolved in modern biomedicine and why considerations about death have ended up being so contentious.

### **Cardiorespiratory to Neurocentric Death**

The way we understand and treat death speaks volumes about our relationship to death. The fact is, that despite a plethora of scholarship on death and dying (Beecher 1970; Becker 1973; Kaufman 2005; Laureys 2005; Braswell 2014; Norwood 2009; Bishop 2011; Gawande 2014 to among others), death is still poorly understood with a lack of consensus across disciplines. Interestingly, the debate surrounding a clearer definition of death has not changed since it started more than half a century ago. French neurologists, Mollaret and Goulon (1959) question if we even have a right to terminate treatment employing criteria that pretend to understand the boundary between life and death. Likewise, Henry K. Beecher, a pioneering medical ethicist and chairperson of an Ad Hoc Committee of the Harvard Medical School convened to examine the issue of irreversible coma, saying, “Only a very bold man, I think, would attempt to define death” (1970:471).

The perplexing nature of defining death can be traced to modern technology, for the concept of death has continued to evolve with progress in technology, particularly with the invention of the positive pressure mechanical ventilator and electroencephalogram (EEG) in the 1950s (Beecher 1970; Laureys 2005). There is a certain irony in a dying/dead person’s life being sustained by artificial respiratory support, with an EEG simultaneously pronouncing that person dead. Biomedicine’s attempt to determine death has never been more contested than today, despite a continuous endeavor to master the definition of death under the guise of technology and law. Dick Teresi, a notable science journalist, argued that rather than illuminating death, modern technology has “only expanded the breadth of our ignorance” (2012:4). Haider Warraich, a

cardiologist at Duke University Medical Center, in his effort to articulate how *modern* biomedicine has created a *modern* death and changed the end of life, writes:

Not only have biomedical advances changed the ecology, epidemiology, and economics of death, but the very ethos of death—in the most abstract possible sense—has changed. Far from being clearer, the line between life and death has become far more blurry. (2017: 9).

The aforementioned climate in the care of the dying has given birth to divisions between the cardiovascular system, the respiratory system, and brain, where a dying person, like Pema, could be viewed as dead or *almost* dead while the rest of her body is circulating and functioning normally. In this context, it is crucial to be aware that the conception of “consciousness” is fundamentally different in the Tibetan Buddhist cultural model compared to biomedicine because consciousness is not conceived as being tantamount to the organ of the brain (Varela 1997). This division has thus paved the way for both conceptual and practical shifts where neurocentric-death superseded the traditional approach of employing cardiorespiratory cessation as a primary marker in determining death. However, it is interesting to note that the division between cardiorespiratory and brain death, when viewed against the background of a broader debate of biological and socio-cultural understanding of death, clarifies the historical and theoretical perspectives, as well as underlying forces that led to the current contentious understandings of death.

### **Historical and Theoretical Background**

Despite the modern Western cultural reticence about engaging in conversation related to death or ostracizing dying people, philosophers and anthropologists have embraced the study of death with open arms (Becker 1973; Bloch & Parry 1982; Robben 2004; Halifax 2008; Jacobsen

2013; Thompson 2015). Anthropological studies, in particular, have shown that the way humans understand death and deal with dying reflect particular cultural worldviews and practices (Huntington & Metcalf 1979; Fabian 1973). Nevertheless, anthropologists have critiqued the ‘exoticization’ and ‘parochialization’ of death and called on the discipline to engage in cross-cultural analysis, which is the strength of anthropological investigation (Fabian 1973; Palgi & Abramovitch 1984).

Throughout human history, death has been known by two obvious oxymoronic characteristics: as primitive and as universal. Death is still unfamiliar territory and is viewed with utmost dread and fear, and it still encounters incredible differences in responses across cultures. Richard Huntington and Peter Metcalf (1979) made similar remarks about the human response to death in their introductory chapter in a monograph dedicated to a cross-cultural examination of death rituals. Since then, over the past four decades, scholars from varied disciplines, specifically anthropologists and bioethicists, have expanded the inquiry into the “mystery” of death and dying. This inquiry, as observed by numerous scholars (e.g. Kaufman and Morgan 2005; Lock 2002; van Brussel and Carpentier 2014; Braswell 2014; Bishop 2011; Lamb 1985; Beecher 1970), has added an additional layer of complexity – that of the dichotomization of biological and socio-cultural approaches to death.

### **Biological and Socio-cultural Death**

Death has been universally considered as an event of social significance, and every known culture has devised rules and norms for defining death as the final rite of passage, and for dealing with its consequences (Riley 1983). However, changes in social organization and cultural practices during the last two centuries have generated an ongoing dispute regarding the conception of death in the sphere of academia as well as amongst the general public (Lock 2002;

Kaufman & Morgan 2005). This debate has been constructed by a fundamental dichotomy: the difference between biological and social death—also known as death of the organism and death of the person (Braswell 2014). Consequently, this contestation has challenged the authority of biomedicine in medicalizing death as well as in deconstructing the way death is defined.

In the early twentieth century scholars such as Robert Hertz and Arnold van Gennep studied societies that do not view death as an “event or instantaneous” (Huntington & Metcalf 1979). Likewise, social thinkers and cultural analysts have contended that death is never independent of its cultural milieu; rather, it is strongly attached to specific social, cultural, and historical circumstances (Jacobson 2013; Gross 2003; Lock 2002). The cultural practices associated with death reveal fundamental social and cultural beliefs. Hertz, for example, in his seminal work on funeral rituals of the Dayak of Borneo in Indonesia, pointed out the way people would recognize a period when the dead person is neither alive nor dead. Hertz referred to this period as an “intermediary period,” and that the end of this state is celebrated by a “great feast” (1960: 54). Nevertheless, the concept of social death has gradually been overshadowed by the redefinition of death—based on the brain—advocated by medicine and law (Baron et al. 2006; Lock 2002).

The neurological determination of death (NDD) primarily came into the discussion when Mollaret and Goulen published their influential work in 1959, coining the term “*coma depasse*” which means “a state beyond coma” (Mollaret & Goulon 1959). Initially intended to define the futility of care in such cases, the introduction of organ transplantation inexorably led to linking the issues of “brain death, with organ procurement, and transplantation which has continued into current medical practice” (Baron et al. 2006: 603).

In August 1968, the Ad Hoc Committee of the Harvard Medical School published a

report, proposing an irreversible coma as the “new criterion for death” (85). The report justified this new criterion by asserting that only the introduction of mechanical ventilation was able to sustain respiration and heartbeat in irreversibly comatose persons, even after the cessation of whole brain function (Braswell 2014). The Ad Hoc report, however, led to confusion, as even though brain function could not be resumed by any medical means, there was no procedure to withdraw treatment. The Committee—in response to this confusion—proposed to categorize such patients as “brain dead.” This proposal would not only make it possible to remove “medically ineffective life-sustaining treatment, but also make them an organ donor candidate” (1968:87).

Nevertheless, the Ad Hoc Report was constantly scrutinized. The conference of Medical Royal Colleges and their Faculties in the UK published a statement focused on Mohandas and Chou’s emphasis on the importance of irreversible loss of brainstem function. This later led to the formal adaptation of the brainstem formulation of “brain death” in 1995 (Baron et al. 2006). Despite these numerous guidelines, the conflict between whole-brain death and brainstem death has not been resolved.

A point of departure for a formulation of socio-cultural death is the pivotal work of French sociologist Robert Hertz (Braswell 2014). First published in 1906, Hertz asserts in his essay “The Collective Representation of Death” that death dismantles both the individual’s “visible body life” and “social being” (1960:77). This dismantling causes the deceased person’s community to enter a “mortuary state” similar to the deceased’s own. By engaging in mourning, the community members detach the deceased person’s social substance from his or her physical form (Braswell 2014). In so doing, the individual is able to transit into the afterlife, while the community members are able to come back to the “world of the living” (Hertz 1960:75). Death

is therefore not an isolated biological event, but rather a social process that concludes with the rebirth of the deceased person as well as the community. Hence, the death of the person must be comprehended as a “fluid concept” that is structured in “social practices of recognition” (Braswell 2014:59).

Hertz further argue that the terror inspired by the corpse does not arise from the mere observation of the changes that happen to the body. For Hertz, such a simplistic explanation of death is not adequate because a death in a particular society can arouse extremely different emotions and variable intensities based on the social status of the deceased. For example, the death of a person of high social ranking or chief status could raise true panic among the community; whereas the death of a stranger, a slave, or a child might hardly be noticed, with no emotion or ritual (1960: 76). Moreover, the social aspects of death are reflected in how the dead body is treated. For instance, children who are not yet considered full social beings, are denied a secondary burial. Thus, for the death of children, there is no reason to go through the extended pain of returning them to the spirit world, to which they are still partly attached (Hertz 1960:84). The death of the person, then, cannot be related simply to physiological phenomena. And according to Hertz, “To the organic event is added a complex mass of beliefs, emotions and activities which give it a distinct character” (27).

Contrary to Hertz, there is an assumption in contemporary Western culture that death and dying are, of course, biological phenomena; associated with the “cessation of heartbeat and breathing followed by ongoing process of disintegration” (van Brussel and Carpentier 2014:2). However, as discussed earlier, the conception of biological death is both contested and evolving. It is important to note that these attempts to specify criteria of death are shaped by legal concerns more than anthropological interest.

David Lamb, in his influential book, *Death, Brainstem, and Ethics* (1984), emphasizes that in order to systematically analyze an account of death in biomedicine, it is necessary to differentiate between “systematic death” (or death as traditionally understood) and “brain death” (4). Systematic death, here, refers to irreversible cessation of cardiorespiratory function, whereas brain death refers to the total irreversible dysfunction of neuronal components that encompass cerebral hemispheres, brainstem, and cerebellum (Lamb 1984:4; Korein 1978). According to Lamb, cardiorespiratory arrest is only a mechanism for causing brain death.

Brain death acquired world-wide recognition only after being proposed by the 1968 Report of the Ad Hoc Committee of the Harvard Medical School. The Ad Hoc Report laid out four conditions as criteria of brain death: 1) absence of cerebral responsiveness; 2) absence of induced or spontaneous movement; 3) absence of spontaneous respiration - requiring the use of the respirator; and 4) absence of the brainstem and deep tendon reflexes (Lamb 1984: 53). The realization of the importance of “brainstem death” following the Ad Hoc Report was felt gradually. Referring to the brainstem as the essential component or “physiological kernel” of the brain, Lamb expounds on the relationship between brainstem and brain death:

The brainstem contains (in its upper part) crucial centers responsible for generating the capacity for consciousness. In its lower part, it contains the respiratory center. It is death of the brainstem (nearly always the result of increased intracranial pressure) that produces the crucial signs (apneic coma), which doctors detect at the bedside, when they diagnose brain death. (1984: 5).

In the context of brain death, the death of the brainstem, therefore, became synonymous with the death of the individual. Lamb, however, makes a distinction between brainstem death and a persistent vegetative state (PVS). He contends that a substantial brain impairment condition is

largely restricted to the cerebral hemisphere, sparing most of the brainstem, especially the capacity to breathe. Nevertheless, the conflict between whole brain death and brainstem death still continues. The Uniform Declaration of Death Act (UDDA) was drafted in 1981 by the President's Commission for a study on brain death and was shortly approved by the American Medical Association as well as the American Bar Association. The Act stated that "An individual who has sustained irreversible cessation of all functions of the entire brain including the brainstem, is dead" (Baron et al. 2006: 605).

Steven Laureys, an acclaimed researcher in the field of neurology of consciousness and the head of the Coma Science Group, affirmed that the most accepted definition of death is the "permanent cessation of the critical functions of the organism as a whole." For Laureys, "Critical functions are those without which the organism as a whole cannot function: control of respiration and circulation, neuroendocrine and homeostatic regulation, and consciousness" (2005: 900). It is interesting to note that Laureys has 'consciousness' as one of the criteria in determining death. However, it is pertinent to understand that the consciousness that Laureys is referring to is applied in the context of the nervous system where the brain's higher functions in the neocortex are interpreted as consciousness. Nonetheless, Laureys also recognizes the problematic nature of assessing the state of consciousness in pronouncing brain death by stating "Clinical testing for absence of consciousness is much more problematic than testing for absence of wakefulness, brainstem reflexes and apnoea in whole brain or brainstem death" (905).

When I asked the Tibetan doctor what he meant by Pema being conscious, he told me Pema, as a person, was consciously aware of the situation, her condition, and had a desire to get better. The Tibetan doctor gave an impression that Pema's emotional response to her parents' suffering, and her desire to get better, could motivate her to pull herself out of her dire condition.



Francisco Varela, a renowned neuroscientist and a strong proponent of an interdisciplinary approach to the study of consciousness, in his dialogue with the Dalai Lama on the importance of examining the relationship between self and consciousness in Buddhism, said:

First of all, the analysis has to do with the self as agent and the self as experiencer. In this sense it's very important. But now let us look to the flow of our experience: feelings of sadness and so forth arise in response to certain experiences. Then certain desires arise in our consciousness. From such desires the motivation to act may arise, and together with this motivation to act comes a sense of self, of 'I'. (1997: 113).

Informed by complex understanding of mind in Tibetan Buddhist culture, the Tibetan doctor was perhaps looking at Pema's consciousness beyond her neural capacity; and such an approach could cause disagreement in diagnosing a patient when brain and consciousness are viewed as connected, but not the same. Moreover, the Tibetan Buddhist interpretation of subtle and extremely subtle consciousness, on which I have elaborated further in the previous chapter, transcends the more agreed upon notion of biological death.<sup>23</sup>

### **The Problem with Viewing Death as a Biological Event**

Given that a disintegration of a person impacts the person's physical body, psychological mind, and sociocultural milieu, one cannot dismiss any of these components while caring for a dying patient. This is what Jeffrey Bishop, a physician and moral philosopher, argues in caring for the dying. Focused on contemporary medical practice, Bishop proposes a "biopsychosociospiritual" model asserting it as "comprehensive" care: "It is holistic, covering the whole of human thriving. It is about total care, and in this sense, it is totalizing (2011: 251). In such a scenario, an understanding of death solely as an isolated biological event denies death

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<sup>23</sup> For work elaborating on the topic of human consciousness in Tibetan Buddhist psychology, see Thompson 2015.

as being a dynamic social process and negates the holistic understanding of death (Braswell 2014). Bioethicists Harold Braswell (2014) and Bishop (2011) have observed that the omission of a dynamic social understanding of death has shown to be highly damaging to patients from the bioethical standpoint. Furthermore, recent anthropological scholarship has illustrated how focusing solely on the biological interpretation of death not only creates confusion but also makes little sense in other cultural settings. For example, ethnographic studies such as Margaret Lock's work in examining brain death cross-culturally in the US and Japan and Tanya Zivkovic's study of a Tibetan Buddhist understanding of death in northeast India showcase the complexity of the debate surrounding biological and sociocultural conceptions of death.

Margaret Lock explores the manner in which advances in medical instruments have enforced a reassessment of the recognized boundaries between life and death and how these debates mirror strong "social values and political interests" (2002: 2). She investigates why a highly technologically developed nation like Japan expresses strong resistance to brain death as equivalent to human death in contrast to North America or most of Europe. Even though many of Lock's informants relate their reservations to brain death to being "subjected to abuses of medical power" rather than to their culture (6), she noted that death in Japan signifies more than the destruction of individual bodies: "It is above all a familial and social occasion" (8). For the Japanese, she asserted, it is unacceptable to ascribe death to a specific moment. Dying is generally perceived as a process, and thus, cannot be "isolated as a moment" (8).

Relating to "brain death," Lock makes a contentious claim that organ procurement, a euphemism for organ harvesting, is largely responsible for the redefinition of death, giving birth to a "new" brain death. She asserts that if it were not for technological development used in organ transplant, that the "brain-dead" definition of death might not exist. She writes: "A 'living

cadaver,' as the brain-dead were first called, is created by an accident and sustained by medical technology" (1). In essence, she argues that organ transplants are institutionalized and commoditized by the collaborative work of modern medical technology and its associated legal framework. The definition of death focused entirely on the activity of the brain is a product of the need to provide for a legally regulated procedure which facilitates organ transplant. She contests that when the death of individual bodies is made into a measurable biological event, employing specific parts of the body (specifically in ICUs) that the social importance of death is naturally minimized.

The importance of social death is emphasized by a host of researchers, demonstrating how culturally relevant practices such as death rites, mourning, certain beliefs, etc., play an important role in dealing with the inevitable nature of death (Becker 1973; Hertz 1960; Huntington & Metcalf 1979). Moreover, social death negates the uncertain nature of physical death by obscuring the divergence between the inevitable process of biological death and the social recognition of the end of life, in a process that is carefully orchestrated (Lock 2002). Arguing that death can never be "divorced from culture," Lock writes: "Death is not a self-evident phenomenon. The margins between the life and death are socially and culturally constructed, mobile, multiple, and open to dispute and reformulation (2002: 11-12).

Pursuant to her assessment and presentation of the variation in understandings of death and organ transplants, Lock compares Japan and North America. Based on her ethnographic study and vignettes comprised of patient cases, newspaper articles, and meta-analysis of studies, she questions why Japanese responses to new "brain" death are remarkably complex and elude any simple explanation; whereas this definition is accepted in the West with little public debate. The concept of considering a living body as a dead person because of brain death might be

accepted in the West, but this would be a radical shift from the traditional understanding of death in Japan and would be hard for the average Japanese person to accept. Furthermore, Lock explicates that the “seductive metaphor” of the “gift of life” could make sense in the West but that it loses its meaning in Japan as Japanese culture does not have an abstract tradition of giving anything of value to someone you don’t know.

Another important difference is the institutionalization and legitimization of brain death as end of life in the West as there is no objection from legal and religious institutions. It certainly is instrumental in the routine procurement of organs across North America and much of Europe. This is not the case in Japan. Even though the Japanese are technologically highly developed and are adept at dealing with the technological difficulties of organ transplant there is a strong influence of Buddhist philosophy.<sup>24</sup> For example, in the Buddhist tradition, it is believed that even after complete cessation of brain and cardiac function, the person remains in the process of dying; and in some cases, deceased persons are able to transmogrify through reincarnation (Zivkovic 2014; Thompson 2015).

Tanya Zivkovic’s ethnographic study relates the social life (or a social death) of a deceased Tibetan Buddhist lama and his relationship with his faithful devotees in Darjeeling, India. Zivkovic follows the life course of a spiritually acclaimed Tibetan lama, Kenchen Sangay Tenzin and his young reincarnated successor, Tenzin Kunga Gyaltzen Rinpoche. Highlighting the potential contradiction between biological and cultural interpretation of life and death from her study of these lamas, Zivkovic calls for greater critical attention to culturally specific understandings of life and death because the acceptance that our life courses are 'natural' and “that biology determines our experience of death has little relevance to the life histories of

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<sup>24</sup> See Ozawa de-Silva (2006) in her work on the influence of Buddhism in Japanese worldview.

eminent Tibetan Buddhist lamas” (2014: 172-173). Zivkovic argues that the life histories for these lamas do not cease with biological death; rather the social life of Buddhist lamas continue through the media of supranormal activities, such as relics, reincarnation, bodily transmogrification, and hagiography.

These supranormal activities at the time of death—production of holy relics, postponing the decomposition of their bodies, and reincarnating into new body forms—facilitate both the extension of the lamas’ biographical processes and the lamas’ interaction with their devotees. For these Buddhist lamas, understanding death and mastering control over the process of dying holds the key to assessing spiritual achievement as illustrated through one of Zivkovic’s informant’s remarks: "It is after death that we can truly know a lama and their ability" (175).

In the context of the way in which the biographical process of a Tibetan lama is conceived and practiced in the posthumous life of that lama, Zivkovic claims that it challenges the linear life story – from childhood to old age and death. Tibetan lamas—for whom death is not an end but a continuum of life—are therefore, not confined to the biological interpretation of death that rests on the brain death or physical destruction of a person.

## **TIBETAN BUDDHIST NOTION OF DEATH**

*Death is a natural phenomenon of the world; everything born will eventually die.*  
– Damdul, Tibetan lay Practitioner

I noticed during my fieldwork that although the subtlety with which death was articulated varies among Tibetans, one of the most common conceptions of death was: “Death is a natural phenomenon of the world; everything born will eventually die” (Tib. *'chi ye ni 'jig rten gyi chos nyid red skyes ba thams cad 'chi rgyu red*). The dictum on death might sound rather banal but linguistically and symbolically, it carries a strong and persuasive meaning. To illustrate, the two

middle syllables “*jig rten*,” though generally understood as “world,” is a composite phrase that literally means “disintegrate and basis.” Hence, the tenet of Tibetan Buddhist cosmology that everything that arises, or is part of the base of existence, will eventually disappear/collapse, informs the way that life and death are conceived. Likewise, to expound on what Geshe Samten related previously, the fact that everything that integrates—including life and everything in nature—has to disintegrate, helps to illuminate the Buddhist concept of impermanence: nothing is permanent, and everything is in a constant state of flux. This cultural worldview offers a firm foundation to build an explanatory model for understanding death using multiple perspectives. Furthermore, the mechanism of this foundational ground of viewing death as an intrinsically natural phenomena of the world draws upon Buddhist psycho-philosophical and medical conceptualizations.

In the *rgyud bzhi* (the Four Tantras), the canonical root text of Tibetan medicine, a direct connection is drawn between birth and death in the spectrum of experience in human life. The medical text states that a mother cannot conceive, and that nothing can come into life without the support of consciousness (2015: 46). And at the other end of the spectrum, no one is considered dead until the consciousness leaves the body (also see Varela 1997). Reflecting on how the Tibetan doctor examined Pema in the ICU, I observed throughout my fieldwork that the aforesaid cultural model of assigning the most importance to consciousness to determine life or death is the greatest factor that informs caregivers while caring for the dying. The Dalai Lama, in his interaction with Western scientists and philosophers, stresses that death in the Buddhist view is not a death of a specific organ as in modern biomedicine; rather it is death of the entire person. He said, “According to Buddhism, the definition of death has to be understood in contrast to the

definition of life. Life is defined as the basis for consciousness. As soon as the body is no longer able to support consciousness, there is death” (Varela 1997: 141).

### **Bardo: Death as a “Moment of Transition”**

One of my interlocutors told me rather casually yet profoundly, that “Death is analogous to going where you came from. It’s like going back home.” For Tibetan Buddhists, death is viewed more as a state of transition, which they refer to as a *bardo*, literally meaning a gap between two things or an interval. They thus view death as not as a *dead-end*, but rather as a *transitional moment* between two of the six intervals or *bardos* that form the cycle of existence (Thompson, 2015: 285).

These six bardos begin with the “bardo of this life” (*skye gnas bardo*), which spans from the moment of birth to the start of active dying. Within the *bardo* of this life is another bardo – the “bardo of dream” (*rmi lam bardo*), that starts at the beginning of sleep, comprising dreaming and deep sleep and concluding with waking up; and the “bardo of meditation,” (*bsam gtan bardo*) which is the moment when the mind takes a time-out in meditative immersion. The “bardo of dying,” (*chi khai bardo*) begins where the “bardo of this life” ends, starting with active dying and concluding at the moment of death. Subsequently, there is the “luminous bardo or *dharmata*” (*chos nyid bardo*) that occurs during the after-death experience of the “clear-light” or “ground luminosity,” which is considered the ultimate nature of mind as pure awareness, concomitant to a time deemed clinical death in biomedicine. This is also the moment the Tibetan Buddhist practitioners recognize as the moment of profound peace and pristine awareness, a perfect time to enter into the state of *thugs dam*. However, they issue a caveat that one who has not practiced during this life of lived experience will not recognize this stainless moment of awareness and can instead enter into a state of delusion. Finally, the “bardo of becoming” (*srid*

*pa bardo*) is the time after the “luminous bardo or *dharmata*” when the subtle consciousness wanders in search of a new physical embodied form until it enters the womb of its future mother in that form, and starts the whole cycle again (Thompson, 2015: 285). With such expansive guidelines about death and dying, Tibetans seem to have inherited a cultural buffer of not having to conform to the binary states of being either dead or alive—the concept of the bardo provides an option to conceptually choose an in-between state, even without an in-depth knowledge of the “pristine awareness” moment.

Against the background of contemporary Western culture where death is feared, avoided, and often viewed as mysterious, and death being a state from which no one can come back to report, the centuries-old Tibetan Buddhist view of death as situated in their worldview is riveting and affirming. However, it was not always the case in the West that discussion of death provoked a gaze as if staring directly into the blazing sun. Seneca, a Roman Stoic philosopher famously said, “He lives badly who does not know how to die well,” and posed an important question to the Roman public, “What’s to be feared in returning to where you came from?” Similarly, Philippe Aries, a French medievalist and historian, in his seminal work on attitudes toward death in the West in the medieval era, argues that people of the time not only viewed death as normal, but were acutely aware of their own death, accepted it, and were prepared for it (1974).

Having said that, as I mentioned earlier, the fascinating aspect of a Tibetan Buddhist cultural death model is the way in which death and dying is understood from a multi-perspective approach—philosophical, biological, psychological, social, and spiritual—and employed as a moral compass in transforming one’s behavior, as well as how to view oneself, others, and the world. This model is similar to what Bishop posited to be adopted in biomedical practice where “total care” could be provided to a patient via a “biopsychosociospiritual” model (2011: 251).



For Tibetans, their model of death is not only about caring for the dying, but also serves as a psychological adaptation tool in crafting their view of their next life via living well and preparing to die well in this life.

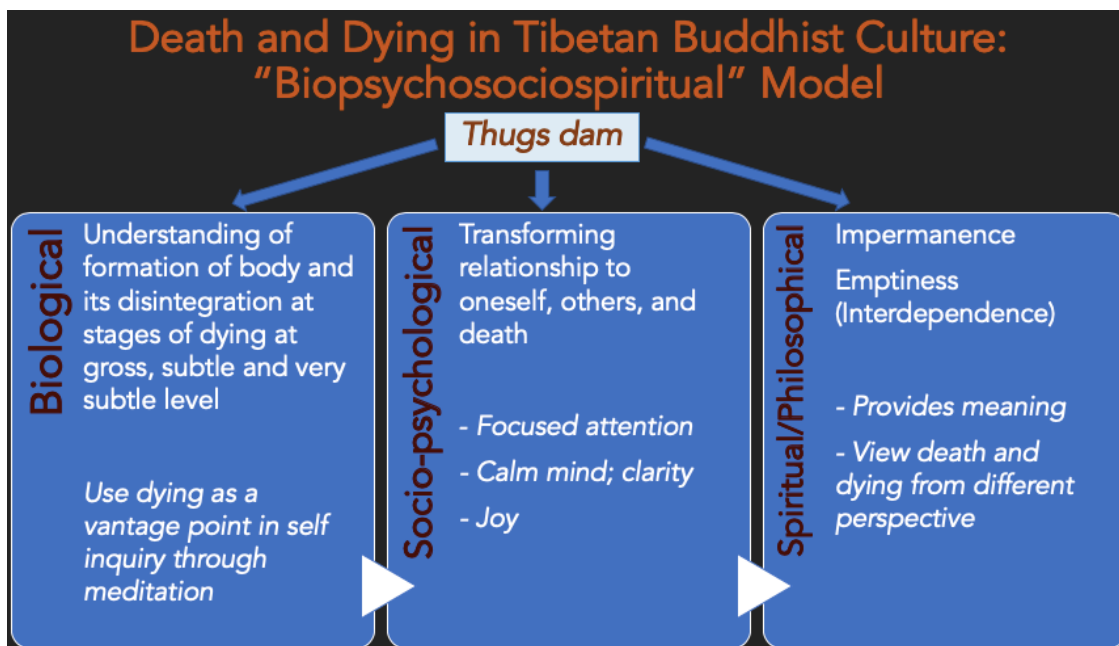


Figure 1: Tibetan Buddhist Death Model: The "Biopsychosociospiritual" Model.

## HOW DO WE RESPOND TO DEATH?

*Death will always remain a mystery; nevertheless, the cross-cultural investigation of death will continue to provide insights into how humans cope with that mystery.*  
– Henry Abramovitch. 2001. Anthropology of Death.

Western contemporary culture has chosen to look the other way or treat death as the "elephant in the room" but if we pause to look at death, it is quite an interesting human phenomenon. We have complete certainty that everyone will die, but a caveat to this is the complete uncertainty as to where and when one might die, or about what (if anything) comes next. Of course, this has caused a sense of fear and helplessness among us; and in our response to this, we have come up with a myriad ways to either make peace with death, confront death, or at

times, endeavor to conquer death (Kubler-Ross 1969; Huntington & Peter 1979; Green 2008; Bishop 2011). The cultural anthropologist Ernest Becker, in his acclaimed book, *The Denial of Death* (1973), makes a provocative argument that humans are driven “crazy” by the idea of being mortal. Becker asserts that humans are terrified of death and thus have resorted to denying and keeping death unconscious. Becker, in fact, attributes this torment around the concept of death as the cause for developing everything that is culture in human societies. He writes:

Everything that man does in a symbolic world is an attempt to deny and overcome his grotesque fate. He literally drives himself into a blind obliviousness with social games, psychological tricks, personal preoccupations so far removed from the reality of his situation that they are forms of madness—agreed madness, shared madness, disguised and dignified madness, but madness all the same. (1973: 27).

### **Terror Management Theory: Mortality Salience**

Becker’s hypothesis, though, initially ridiculed by academics, gained ground as an important anthropological theory known as “Terror Management Theory” with an impressive work and series of publications related to “mortality salience” by Jeff Greenberg, Thomas Pyszczynski, and Sheldon Solomon, particularly in the mid-nineties (Teresi 2012). Dick Teresi, in his conversation with Solomon while doing research for his book, *The Undead*, (2012) reported that Solomon and his colleagues started their study questionnaire with these directions: “Please describe the emotions the thought of your own death arouses in you. Jot down, as specifically as you can, what you think will happen to you physically as you die and once you are physically dead” (2012: 8). Solomon and colleagues found intriguing results where groups who were exposed to “mortality salience” engaged in behavior such as berating people who did not share their worldviews, trying to convert them into their system of beliefs or even killing

them. For instance, their study reported that judges subjected to the experiment were much harsher with their judgement: “The judges who had been reminded of their mortality set bails that were nine times as high [as the control group]” (Teresi 2012: 9).

In one of their influential studies, Solomon and colleagues posited that humans possess “dual-component cultural anxiety buffer: worldview and self-esteem” (1991: 93). These two buffers, according to Solomon and colleagues, help an individual to lessen the anxiety about death by maintaining meaning provided by a cultural worldview and acquiring self-esteem by living up to the standard of this worldview. However, Teresi recounted Solomon saying that cultural buffers did not necessarily work for everyone, identifying associated maladaptive practices in dealing with death that were due to a lack of effective cultural symbols.

Rachel Menzies, a clinical psychologist, through her interesting work in associating salience mortality with an array of mental health issues (2017) asserts that a fear of death can generate a feeling of “powerlessness, loneliness, and meaninglessness,” and for some individuals, may seriously weaken their “experience of happiness or peace” (Menzies 2018:1).

One of the most glaring reasons for death being feared and avoided, according to Philipp Aries, is its obscure nature and the rupture that it brings into an individual’s life (Aries 1974). Others have related that the fear and avoidance of death is as a result of death being stripped of its religious perspective that renders specific values and meanings. For instance, Shai Lavi, in his study of euthanasia in the United States in *The Modern Art of Dying* (2005), argues that with the technical search for mastery over death, the mode of dying has shifted from a "work of art to a product of technique" (4). According to Lavi, since the end of the nineteenth-century, death and dying in the West have been defined in relation to medicine, not religion. For Haider Warraich,

modern death has become “secular, sterile, and singular” (2017: 8). In understanding death, Warraich emphasizes the importance of knowing how we are responding to death:

Perhaps the most primitive aspect of death is how we respond to it, how we spend most of our lives imagining it away, how we fear it as some sort of unnatural schism in space-time. Every time we talk about death, the food seems terrible, the weather seems dour, the mood sullen. Every time we think about death, we get so depressed we can't hold a meaningful thought in our heads. Many families talk about death only after their loved one is in the ICU, hooked up to more gadgets than Iron man. (8).

### **Death: Collective Cultural Reference**

In contrast, Tibetan Buddhist culture seems to have taken a different approach to being reminded of mortality, arguably a much more adaptive coping mechanism. Tibetans see death as a reality of life that is pertinent in every step of our walk through life. Whereas a lay Tibetan would tell me that death serves as a potent reminder to lead a morally ethical life, Tibetan doctors often shared with me how their philosophical understanding of death aids them in caring for the dying. Buddhist practitioners, in turn, told me how their nuanced psycho-philosophical knowledge of death and dying affords a potential vantage point for investigating the true self. In that light, Tibetans that I interviewed and observed do not make an attempt to conquer or tame death, nor eschew death, but they endeavor to change their relationship with death vis-à-vis their different capacities based on their education and practice of Buddhist philosophy and psychology.

For example, based on the survey study I conducted, 86 percent of monks, 82 percent of Tibetan medical doctors, and 78 percent of lay Tibetans I sampled, although fearful of death, see death as a vital facet of life – reminders of which help to motivate them to lead an ethical life and

thus secure a better next life. When I asked a follow-up question of why they fear death, the majority of them responded by saying that they do not feel prepared enough for the next life. Some responders told me they were scared of the pain and suffering that they might experience while dying; and some said they fear what might happen at the time of death. Nonetheless, we can extrapolate these results based on the average responses that their fear of death was more about how they would fare in the next life rather than the death itself. Likewise, most of the responders (91% monastic and 84% laypeople) agreed that death is an opportune moment for spiritual development.

I found that, in general, death plays a role as a collective cultural reference for Tibetans. Importantly, the relatability between Tibetan medical doctors and Buddhist monks with regard to their conceptions of death and caring for the dying was critical for my research. These two stakeholders would often complement each other, and at times, when conflict arose while caring for dying people, they would collaborate in negotiating caring for the dying with the surrounding family members.

### **Death as a Psychological Adaptation Cultural Tool**

The intersection between Tibetan medicine and Buddhist psycho-philosophy has served Tibetans well in gaining access to the understanding of the mind and its synergistic relationship to the body (Clifford 1996; Tidwell 2017). The intricate relationship between Tibetan medicine and Buddhist psychology and philosophy cannot be emphasized enough if we look at the etiology of illness in Tibetan medicine and the root cause of all suffering in Tibetan Buddhism. While Tibetan medicine attributes the root cause of illness to an “ignorant mind that fails to recognize the absence of [an intrinsic] self” (Gonpo, 2015: 96), Tibetan Buddhism links individuals’ default mode of being obsessively focused on a permanent, independent, autopoietic

concept of “self” as a cause of suffering (Dalai Lama, 1997:18). In essence, both these disciplines see the ignorant mind that misperceives a self as the root cause of all suffering; and hence, the most effective remedy is to engage in contemplative practice in order to investigate the real self or ultimate reality. In pursuance of self-inquiry, the Tibetan Buddhist cultural model of death is employed as one of the main psychological adaptation tools.

Charles Taylor, a philosopher known for his seminal work on reimagining identity and morality for a secular age, succinctly presents the divergence between Buddhism and other major world religions in dealing with death by highlighting differences in the concept of an individual identity. Taylor makes a case that the Buddhist approach of familiarizing oneself with the (mis)perception of a self in order to transcend the self has strong impact on the way death is engaged with among Buddhists. On the other hand, in Christianity, Judaism, and Islam, the goal of transforming one’s relationship to God comes into play, and hence, the importance of being intimate with God. “Death must not separate us from God” (Varela 1997: 133). As discussed earlier, we all deal with death differently informed by our cultural worldviews; and Tibetans, being culturally invested in examining the function and mechanism of mind in order to comprehend self, has realized that the nature of the mind at the time of death is most fertile ground to engage in deep meditation (Dorjee 2007).

### **Death as a Moral Supervisor**

Death for Tibetans in south India is like an invisible authority of law; and each time they catch themselves engaging in behaviors guided by greed, attachment or anger, they get imaginary police citations to retract or to be more cautious the next time. Death was often used as a moral reminder, such as, “Have you forgotten you are going to die?” when someone was either too excited, saddened or irrational, so much so that that it has become a sort of dictum.

Interestingly, this tactic has been coopted by a popular sociomoral startup app company called [WeCroak](#) in America. Inspired by a Bhutanese Buddhist folk saying: “To be a happy person, one must contemplate death five times daily,” the WeCroak app invites their clientele with a provocative bold line on their main page: “Find happiness by contemplating your mortality.” The app sends out five invitations daily to their subscribers, comprised of quotes about death by poets, philosophers, and notable thinkers, to pause and think about death. This is a different and novel strategy to deal with one’s mortality as compared to what Solomon and Menzies have reported in their Terror Management Theory studies. Instead of being terrorized or reacting indifferently toward death, the WeCroak app encourages its members to find happiness in the awareness of mortality.

Unlike contemporary Western culture, death in Buddhist culture is respected and incorporated into a societal endeavor to encourage behavior conducive to happiness at both individual and communal levels. Interestingly, when the notion of viewing death as being part and parcel of our existence; and when consciousness as a key player at the time of death is juxtaposed with the Buddhist concept of reincarnation, engagement with death becomes more of a commitment and practice-based endeavor.

### **Death as a Means to Attain a Better Life**

Dawa surprised me with her poise and calmness when she spoke to me about her father who had died five days earlier. “Despite a difficult last few weeks,” she said, “he died the way he had wanted to die. He did not talk much during the last few days before he died; he was having problems breathing and was in pain, but on the day he died, he was awake early in the morning, and asked me to read from the *bardo tödrol chenmo*, [the Tibetan Book of the Dead]. Other family members joined us. Every now and then, he looked uncomfortable, but overall, he seemed

like he was at peace. He laid there, eyes closed, would nod at certain words I was reading; and around noon, or a little later, I think, he left his body.”

Dawa’s seventy-six-year-old father had lived a relatively healthy life, despite the diabetes. (He developed diabetes in his fifties and in his final days his heart gave up on him due to congestive heart failure.) She told me her father used to be a hot-headed man until he retired from the army more than fifteen years ago and became a dedicated practitioner. “He became a different person,” she added. She said her father became more philosophical about life and spent lots of time in spiritual practice, such as reading Buddhist texts, including the Tibetan Book of the Dead, doing prostrations, and listening to teachings by the Dalai Lama and other teachers. I sat there, on the front porch in the late evening of a southern India summer, battling occasional mosquito attacks, listening to Dawa with awe as she spoke about her late father and how she helped him through the last phase of his life. I wanted to know more about her relationship with her father and what she had learned from her experience.

Dawa was in her early thirties and had moved to North America almost a decade ago and I was curious to know how she was able to maintain her relationship with her late father, and most of all, how she was able to do what she did during the last few hours of her father’s life. Until then, I had not met any young lay Tibetan who showed much familiarity with the *Tibetan Book of the Dead* text. I had personally been introduced to the text only a few years previously largely due to my research and I had never felt the need to read the text to enrich my spiritual life. When I asked Dawa how she was able to assist her father when he was dying, particularly staying calm and reading the Tibetan Book of the Dead, she surprised me by saying she was not calm.



“I was nervous for him but reading a particular chapter from the text about the nature of consciousness and how it would change through the course of dying helped me as much as it might have helped my father.”

“How long have you been reading the text, and what made you read it?” I asked.

“I had seen my father reading it and he would tell all of us [siblings] to read it too, but it was only when I had a chance to sit in a teaching of a Tibetan rinpoche who explained the importance and benefit of reading the text, both for this life and the next life, that I started to read it.”

“Were you able to learn much about your father’s spiritual practice since you live abroad?”

“Yes, I was far away but I would come home every winter to go to Bodh Gaya for pilgrimage. He also had another Buddhist text that he would bring with him all the time. The text is about finding your spiritual teacher, familiarizing yourself with your mind, and engaging in preliminary practices that would help to be focused at the time of death.”

“Have you read the text?”

“Yes, I have. It helps to structure my practice.”

Dawa’s mother who had been coming around to make sure the mosquito repellent coil she had fixed under the table was intact, came back this time with a text in her hand, and said, “This is the text Dawa is talking about. It is called *Kunzang Lamé Shelung* [*kun bzang bla ma'i zhal lung*].”

*Kunzang Lamé Shelung* was another important Tibetan Buddhist text I had become aware of while in the field. The text is translated as *Words of my Perfect Teacher* with a subtitle: *A Guide to the Preliminaries for the Heart-essence of the Vast Expanse from the Great Perfection*

(1994). The text is authored by Patrul Rinpoche, a highly revered Buddhist teacher and scholar of the nineteenth century. Patrul Rinpoche, though technically belonging to the Nyingma School of Buddhism,<sup>25</sup> was known for his non-sectarian work, as attested by Dilgo Khyentse Rinpoche in his Foreword to the translation of the book, “[This book] sets out the paths of the four main schools of Tibetan Buddhism without any conflict between them” (1994: xxvii).

The popularity of *Words of my Perfect Teacher* is its relatability across the community members owing to the style in which it was written that “could speak as easily to rough nomads and villagers as to lamas and monks” (1994: xxxi). Patrul Rinpoche maintained that the purpose of writing the text was primarily to share oral instructions he received from his teacher, benefitting anyone via examining their mind and setting out on the right path. The text offers a “detailed guide to the methods by which an ordinary person can transform his or her consciousness and set off on the path to Buddhahood, the state of awakening and freedom” (1994: xxxi).

I had no idea that my mother, who had decided to become a Buddhist nun a decade prior to the time she died in 2016, during my fieldwork, had her own preliminary practices of preparing for her final test at the time of death. Along with other Buddhist ritual artifacts, I saw the aforementioned text when I was clearing her rented apartment after her death. I feel sad that I did not get to talk to her about her practice and learn from her, but it was helpful to go through her religious items and the text, and to talk to people who were going through a similar trajectory. At least, it gave me a point of reference to imagine what she was practicing and experiencing.

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<sup>25</sup> The Nyingma school is the oldest lineage tradition of the four major schools of Tibetan Buddhism. The other three lineage traditions are Kagyu, Sakya, and Gelug. Nyingma literally means ancient, for it is founded on the first translations of Buddhist scriptures from Sanskrit to Tibetan in the eighth century.

When I asked Dawa if she remembered any conversation during her father's last moments that had impacted her life or spiritual practice, she told me that her father told her to continue to studying Buddhist texts and to be a kind person. "You would die well if you knew you had done enough for your next life," she said, "that speaks to me deeply."

For Tibetan Buddhist practitioners, both monastics and laypeople, leading a moral-ethical life informed by one's awareness of inevitable death is critical because this determines how one does and it determines the quality of one's next life. However, some practitioners go deeper into studying the nuanced mechanics of the mind and its impacts at the time of dying. In so doing, they work toward using different states of consciousness to amplify their meditation. As one of the practitioners told me, "Death is an opportune moment for spiritual development."

### **Death as a Means to Unmask Ultimate Reality**

Interestingly, for some Tibetan Buddhist practitioners that I interviewed, the functionality of death goes beyond supervising their daily behavior or making sure that they die peacefully so as to make a smooth transition to the next life. These practitioners would tell me that studying and familiarizing oneself with the process of dying actually renders a most fertile avenue to investigate the real nature of the existence of the self. In that endeavor, it presents both the epistemological and ontological modes of inquiry – the means of knowing the real 'self,' and the creation of a 'self' that aids to generate resilience and cultivate compassion.

Tibetans use the term *snying stobs*, literally meaning heart and power or heart-power, which they articulate as the "power of resilience supported by a compassionate heart." I have discussed the way in which the stages of dying are applied by practitioners in more detail in the previous chapter; but as I discussed the different stages of bardo at length earlier, let me briefly shed light on the specific *bardo* that these practitioners see as the most potent period to engage in

meditation in investigating the self. To reiterate, the luminous bardo (*chos nyid bardo*) involving the after-death experience of the clear-light or ground luminosity is considered to be the ultimate nature of mind as pure awareness. This state also parallels the period classified as clinical death in biomedicine, which is not something that everyone might realize. One needs to have experienced this practice during one's life through simulating the dying process, in order to gain familiarity and to be able to remain calm and focused so as to realize the moment of "pristine awareness" when death actually occurs (which I have elaborated in the last chapter).

According to Buddhist practitioners, meditating inside the moment of pristine awareness, whether during simulated or actual dying processes, one can develop a state of mind that transcends the self and connects to the universe. Such a "self" in Tibetan Buddhist culture is considered as the "confident self," and instead of carrying feelings of attachment, hatred or xenophobia, one experiences love, joy and compassion. This makes sense because as Gen Phuntsok, my field supervisor would say, "When one only thinks about others and does things for others, there is no need to feel insecure, jealous or be attached to something." Not every practitioner admits to a practice of simulating the dying process owing to its association with highest tantric yoga practice that is considered sacred. However, some practitioners do admit to it in order to guide and encourage other practitioners. For instance, in recent times, the Dalai Lama has often made remarks about his practice of dying five to six times a day.

Nonetheless, it is evident that in Tibetan culture, the hypothesis about death is contingent on how one conducts one's life and what level of spiritual practice one engages in. This determines the kind of death one can have, if not foreseeing the kind of rebirth one would secure. This hypothesis is well supported every time someone like Lobsang Nyima Rinpoche (who stayed in *thugs dam* riding on his clear-light awareness after clinical death for eighteen days,

which I will elucidate in the next Chapter), or Dawa's father and many others die in harmony with their death and not in conflict with it.

## **HOW CAN WE DIE?**

One question that I asked all my interlocutors during fieldwork, with the caveat that they could skip the question if they felt uncomfortable, was: "How do you wish to die?" None of them skipped the question; but answers varied from "I want to die peacefully without pain," "I want to die with a feeling that I have done everything I could and without any regret," "I want to die with compassion in my heart," "I want to die without any fear, and a feeling like I'm sleeping in my mother's lap," to "I want to die feeling ready and confident for my next life."

It is interesting that almost none of my interlocutors mentioned anything about a wish to die at home with family members. Perhaps it is assumed among them that they would die at home. Or, perhaps it does not matter when and where they die, particularly for initiated Buddhist practitioners. A monk told me that it is all about our mind at the time of death. A Tibetan medical doctor whose two-year old daughter died due to complications related to congenital heart disease, said, "It was not easy to see my daughter subjected to all the tubes and hundreds of needle-punctures on the back of her delicate hand, but one needs to be prepared to die well, no matter when and where."

However, the same question might garner quite a different response among communities in Western culture. Modern culture where death is best avoided or controlled as if it is unavoidable (Neumann 2016; Nuland 1994) does little to aid individuals in forming any kind of relationship and familiarity with death. Medical school, one of the main pertinent institutions, has done little to repair this culturally maladaptive model – not much has changed since the

eighties in terms of how little is taught to medical students about death and dying and how to care for the dying (Gawande 2014; Swanson & Cooper 2005). Philippe Aries shows that people in the West used to accept death and were prepared for their time (1974: 11-14), but modern death has acquired way too many complexities that leave little room for individuals' preference to forecast ways they want to die (Warraich 2017: 46).

### **Tibetan Cultural Models of Ways of Dying**

The Tibetan refugee population that I studied showed a radically different approach. They not only seemed to have a collective understanding of the importance of familiarizing themselves with death closely, but also to have a specific cultural model of ways of dying depending upon how developed individuals are in their spiritual practices.

For instance, Gen Phuntsok told me that the way one dies is directly related to one's past and future. *Past* because the dying person's behavioral action and mental habits while alive will determine the way person dies; and *future* because the way in which a person dies and the mental state at the moment of death will have a strong impact on the person's rebirth. With regard to different ways in which a person might die, he explained that (1) a beginning practitioner who applies death simply to remind herself of impermanence and thus engage in ethical behavior could potentially die without remorse but still be fearful; (2) an intermediate practitioner who, besides living an ethical life, has studied the nature of her mind and how her mind and body would go through changes at the time of dying and has done all the preliminary practices, could potentially die without any remorse and fear; and (3) an adept practitioner who has led an ethical life governed by love and compassion, mastered her understanding of the nature of mind and changes her mind and body will go through at the time of dying, and has simulated the

process of dying to gain a lived experience and knows how to transit through each bardo could die confidently with love and joy.

## **CONCLUSION**

The Tibetan Buddhist worldview with regard to death is strikingly different from contemporary Western culture not only in terms of how death is conceived (Dorjee 2007), but also in the way life and death are determined (Gonpo 2015).

It might sound counterintuitive to consciously think about death, and even more so, to study and get accustomed to death and the process of dying in great detail and invest time to contemplate on such an understanding. Sigmund Freud makes an interesting analysis of the contradictory relationship between our conception of death and our behavior. To illustrate, he writes: "...that death was natural, undeniable, and unavoidable. In reality, however, we were accustomed to behave as if it were otherwise...It is indeed impossible to imagine our own death; and whenever we attempt to do so we can perceive that we are in fact still present as spectators" (1915: 289). Freud argues that at a subconscious level we cannot relate to our mortality and believe that we are immortal. As Donald Lopez points out, Freud's assertion could be based on his understanding that mental functions cease at death (2011: 7). Nevertheless, for Tibetans, the Buddhist concept of reincarnation provides a cultural buffer to prevent or reconcile this potential gap between an understanding of death and enacting behavior surrounding death. I will explain the mechanism of reincarnation in Chapter 3.

Contrary to what Solomon and colleagues and Menzies' studies of how the death reminder brings out negative emotions or exacerbates mental illness, the Tibetan coping mechanisms of dealing with death positively and using it as a sociomoral reference point

promises benefit at both an individual and societal level. Likewise, if we take into consideration the correlation between the conception of death and care of the dying (Gawande 2014, Swanson & Cooper 2005), the contemporary biomedical attitude of viewing death as a failure and trying to conquer death via technology and law could profit from borrowing a conceptual framework from the Tibetan tradition of treating death as part of life.

In the same vein, articulating death under the holistic purview of biological, sociocultural, psychological, and spiritual mores could only make it easier and beneficial for all stakeholders—physicians, patients, and family members—in the sphere of end-of-life care. The intimate intersection between Tibetan medicine and Buddhist psycho-philosophical elements in caring for terminal patients necessitates a biopsychosociospiritual approach. Moreover, the Tibetan Buddhist practice of mimicking the dying process while alive and choosing to stay in *thugs dam* meditation during the moments and the transition thereafter, produces effects similar to the results of psychedelic studies reported by Pollan and researchers at NYU and Johns Hopkins – a sense of interconnectedness, profound joy and love, and importantly, a whole new concept of self and one’s relationship to others.

In 2007, when Lobsang Nyima Rinpoche stayed in *thugs dam*, the Dalai Lama made his spiritual achievement accessible to a wider population beyond the confines of the monastic community by inviting a team of scientists to study it, knowing such a practice could have a broader social benefit. The ongoing neuroscientific and phenomenological collaborative study between Tibetan institutions (comprised of medical and monastic institutes) in India and the Center for Healthy Minds at the University of Wisconsin-Madison is one of the projects that he initiated. Akin to how Tibetan practitioners use death as a vantage point in their spiritual endeavor, I have used *thugs dam* as an anchor for this dissertation in my effort to present how



Tibetans work toward facilitating an “ideal” death for themselves and others. I did so because I propose that *thugs dam* not only animates core Buddhist concepts, it exemplifies the way death and dying is assumed to be approached in Tibetan Buddhist culture.

## CHAPTER 3

### CARE FOR DYING: THE LOCUS OF INTERSECTION BETWEEN TIBETAN MEDICINE AND BUDDHISM

*What is most important to people who are closer to death: comfort; feeling unburdened and unburdening to those they love; existential peace; and a sense of wonderment and spirituality.*

- Bruce (BJ) Miller

#### INTRODUCTION

An elderly man with a thick file in one hand and a phone in the other approached me and asked, “What do you think about the senior doctor at the clinic?” “I heard from other patients and also read in the local newspaper that the senior doctor is known for treating cancer patients,” he continued. I was startled by his questions for I was engrossed in my thoughts, observing the rush of patients gathered at a small clinic to consult with Tibetan doctors. Regaining my composure, I barely managed to echo what he said, “Yes, that is what I have heard.”

It was an early November morning and a stream of patients—mostly local Indians—stretched outside the main gate of a Men-Tsee-Khang<sup>26</sup> (MTK) Tibetan Medical Branch Clinic in Bangalore, the capital of India’s southern Karnataka state. I arrived in Bangalore the night before from Mundgod—my primary field site and 236 miles northwest of Bangalore—to observe and interview Tibetan doctors at the MTK Clinic. I had my first interview appointment scheduled with the senior doctor during the lunch break, so I had plenty of time to *hang* around and observe people. I found a spot outside the clinic, next to a pharmacy to sit and watch people’s reaction as

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<sup>26</sup> Men-Tsee-Khang is one of the many major Tibetan cultural Institutions, reestablished in India in 1961 with a sole objective to preserve, promote, and practice Tibetan medicine and astrology. Men-Tsee-Khang, in Tibetan, literally means House of Medicine and Astrology.

**Note:** All the names for my informants are used by consent unless otherwise specified.

they come out of doctors' consultation rooms while enjoying the aroma of Tibetan herbal formulas permeated in the air.

The man who inquired about the senior doctor was with his family, whom he introduced to me as his wife and brother. I saw them earlier, talking anxiously to each other and the man standing with a thick file that looked like a medical report in his hand. He appeared restless and worried. I learned that he and his wife had convinced his brother, who was diagnosed with terminal lung cancer, to see a Tibetan doctor. The brother, I was told, had tried treatments at other hospitals under various doctors; his last oncologist had given him a poor prognosis and made him aware of his limited time to live.

"No more than 3 to 4 months," the brother told me without much emotion when I asked if his doctor had specified any time. He looked frail, short of breath, and had dark lines around his eyes and kept on rubbing his knees as if he was massaging them.

While waiting outside for my interview, I wondered how Tibetan doctors navigate their role when they see patients who are aware of their terminal illness conditions yet still seek their help. What makes many patients diagnosed with terminal illness, some even close to dying, see Tibetan doctors? One way to look at terminal patients pursuing Tibetan medicine could be that patients are looking for something different and better than the mainstream (biomedicine) healthcare. Care for terminal patients, in general, in the mainstream medical practice has been viewed as severely ill-equipped in recent years (Neumann 2016; Gawande 2014; Lavi 2005; Kaufman 2005); and a quick literature research shows the dismal condition of palliative care in India. According to the latest index developed by the Economist Intelligence Unit, the quality of death in India is among the worst in 80 countries that were measured (2015: 16). Bruce J. Miller, who is executive director of the Zen Hospital Project and an assistant clinical professor of

medicine at the University of California, San Francisco, has called for paradigm shift in providing care for terminal patients. According to Miller, there is a strong need to connect medicine, art, and spirituality in caring for terminal patients.<sup>27</sup>

Nonetheless, I was eager to speak to Dr. Dorjee Rabten, who over the years, had earned name for himself for treating cancer patients. Also, with more than thirty-five years of clinical experience and active involvement in numerous research and public health projects related to Tibetan medicine, he is highly respected among his colleagues.

After an hour wait, the clinic attendant called the family into the consultation room, and twenty or thirty minutes later, I saw the family coming out of the clinic after consulting with the doctor, looking a little more cheerful than before. I wanted to ask them, especially the brother, about his experience of seeing a Tibetan doctor but I choose not to ask. They collected their (herbal) medicines from the pharmacy counter and I wished them well as they left.

When the receptionist escorted me to Dr. Rabten's consultation room, he was finishing with his last morning patient. He took time to advise the patient about her diet and lifestyle while taking my hand, directing me to sit on the chair across the table. The consultation room was small with the major part of the space taken up by a large office table and chairs. I noticed extra chairs in all the MTK clinics, accommodating family members who accompanied patients. Two sides of the wall were covered with *thangka*, traditional Tibetan scroll paintings depicting Medicine Buddha and Avalokiteshvara, the embodiment of compassion of Buddha. As we started to talk, I could not help mentioning the cancer patient I encountered earlier and asked his view in order to get his perspective while it was still fresh in his memory.

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<sup>27</sup> See Miller's TED talk that generated huge interest in re-thinking end-of-life care: TED Ideas worth spreading. (March 2015). What really matters at the end of life. BJ Miller. [https://www.ted.com/talks/bj\\_miller\\_what\\_really\\_matters\\_at\\_the\\_end\\_of\\_life?language=en](https://www.ted.com/talks/bj_miller_what_really_matters_at_the_end_of_life?language=en)

Dr. Rabten readjusted his rolling-chair, pulled himself little closer to the edge of the table and said, “It is hard to say in terms of treating [cancer] in a patient like him, but it is crucial to take care of the mental state of a dying person so that the person may die peacefully; and the person’s consciousness passes swiftly into the next life if someone believes in rebirth.” “It helps to view death as a continuation of life,” he said.

When I asked him to elaborate further, he responded instantly, demonstrating the integral connection between Tibetan medical practice and Buddhism: “Unlike other cultures, Tibetan culture has a deep belief in reincarnation...and that belief is central to our understanding of death and to the care for dying patients.” His explanation demonstrated the perspective of an integral connection between Tibetan medicine practice and Buddhism.

Dr. Rabten’s comments elucidate three interrelated features of care for dying patients in Tibetan Buddhist culture: (1) the facilitation of a peaceful or “good” death by protecting a dying person’s mental state, (2) the Buddhist notion of reincarnation, and (3) the interpenetration of Tibetan medicine and Buddhism. This chapter examines how these features lend Tibetan medical doctors a distinct lens for viewing death and dying and the way they care for dying persons. Furthermore, this chapter explains how caring for a dying person provides a nexus for integrating Tibetan medical and Buddhist practice. Hence, the chapter sheds light on the two overarching questions of this dissertation: (1) how does end-of-life care in Tibetan medical practice necessitate the integration of medicine and Buddhist philosophy and psychology; and (2) how does the integration of medicine and religion stimulate a paradigm shift in caring for dying patients and their family members?

Based on my ethnographic data, I show how Tibetan doctors employ this intersection between medicine and religion in their understanding of the human body in the relationship

between body and mind, and death and dying; and how they care for dying patients. Specifically, I discuss how reincarnation, one of the fundamental cultural concepts related to death, shapes Tibetan doctors' attitudes toward death and the care for dying patients.



Figure 6: Dr. Rabten in his consultation room and the Patient Waiting room at Bangalore MTK Clinic

## THE INTERSECTION OF MEDICINE AND RELIGION

*Though we have made technological advances, they often remain unused when it comes to dealing with the dying and dead, so cultural factors—philosophy, ethics, economics, religion—cannot be ignored.*  
 – Dick Teresi (2012: 4)

The intersection between medicine and religion, as observed in Tibetan medical practice, is not an isolated case. In Euro-American history, the association between medicine and religion is reflected both in complex biological and philosophical intersections and the historical establishment of hospitals (Cadge 2012; Garrett 2008). For instance, the work of Plato and Aristotle had a strong influence on Greek medicine; and the study of human science (biology) in Europe until the eighteenth century (Grant 2004). Social historians and anthropologists such as

Phillip Aries (1974) and Joan Halifax (2008) have demonstrated in their seminal work how religion and medicine inform each other, specifically in issues related to death. Phillip Aries illustrates the scene around a dying person prepared for his impending death supported by his Christian practice and physicians until the beginning of the nineteenth century. He writes: "...death was a ritual organized by dying person himself, who presided over it and knew its protocol. Should he forgot or cheat, it was up to those present, the doctor or the priest, to recall him to a routine which was both Christian and customary" (1974: 11-12).

Joan Halifax, in her powerful book, *Being with Dying...*(2008), accentuates the role of a dying person's psychological and spiritual issues. She says:

One thing that continually concerned me was the marginalization of people who were dying, the fear and loneliness that dying people experienced, and the shame and guilt that touched physicians, nurses....I sensed that spiritual care could reduce fear, stress, the need for certain medications and expensive interventions, lawsuits, and the time doctors and nurses must spend reassuring people, as well as benefit professional and family caregivers, helping them to come to terms with suffering, death, loss, grief, and meaning. (2008: 5).

Further, academic research on the link between medicine and religion has exponentially increased since 1990 (Cadge 2012). Likewise, in recent years, university centers such as the Earl E. Bakken Center for Spirituality and Healing at the University of Minnesota, the George Washington Institute for Spirituality and Health, and the Center for Spirituality, Theology, and Health at Duke University have been established to initiate research and educate healthcare providers. These centers employ an interdisciplinary perspective in creating awareness about the intrinsic connection between health, religion, and spirituality.

Wendy Cadge, in her book, *“Paging God: Religion in the Halls of Medicine,”* demonstrates the presence of religion and spirituality in formally secular hospitals in America. Based on her ethnographic study of seventeen leading secular academic hospitals, Cadge shows the role of religion and spirituality in the form of chaplains saying prayers at the time of patients’ death, talking to patients and family members, and medical staff providing space for patients in the medical ICU. However, she pointed out the invisibility of religion despite its noticeable role in these hospitals. Cadge observes that even though a chaplain’s presence is evident in these hospitals, their prayers, chapels, and meditation rooms are devoid of any specific religious or spiritual symbols. With outwardly neutral and symbol-free chapels, and the chaplains’ role focuses on hope and wholeness. The presence of religion and spirituality in “hospitals seem almost devoid of content and conspicuously absent,” Cadge writes (2012: 15). Despite the fact that the religion has become an unspoken and invisible component of intervention at many academic hospitals, the need for spirituality, especially, patient’s mental well-being, has been increasingly recognized (Dormois 2014; Kubler-Ross 1997).

An internal medicine physician, Dr. John Dormois, at the age of 65, went back to Yale Divinity school to study theology after more than three decades of practice. He relates his decision to go back to school to prepare himself to be a better physician – a physician who can care for patients with empathy and compassion. Dr. Dormois underscores the importance of addressing patient’s “spiritual/existential issues that reflect the person with illness rather than simply the account of the body” (2014: 198). For him, the intersection between medicine and religion is crucial for patients at the end of their life.

As I approached the end of my divinity school education, it became apparent to me that the best venue to embody the virtues of empathy and compassion was in palliative care. It



is the place where the tension between curative care and comforting care is most obvious. In order to resolve this issue, spiritual and existential issues must be addressed...My thesis is that palliative medicine provides a way to bend the curve back from a purely bodily view of illness and suffering, allowing the spiritual and existential to ascend to equality with the material. (2014: 199).

### **The Integration of Tibetan Medicine and Buddhism**

As illustrated in this chapter, the link between medicine and religion is an important facet of Buddhist culture—both for Tibetan doctors and patients—even though it found its footing in academic discourse only in recent years (Garrett 2008). In *Tibetan Buddhist Medicine and Psychiatry: Diamond Healing* (1984), Terry Clifford articulates the exclusivity of Tibetan medicine by highlighting the integral relationship between Tibetan medicine and Buddhism. She writes:

It is precisely this spiritual and philosophical core that makes Tibetan medicine so unique. Indeed, there is no other medical tradition in the world that is so coherently developed in terms of a philosophy and metaphysics. The relationship between Buddhism and healing is innate and extraordinary (1984: 5).

Moreover, the articulation of mind and its relationship to body is so nuanced that it lends a unique lens to Tibetan Medicine in its epistemology of body, health, and illness. Scholars like Allan Wallace went as far as contending that Buddhism is more a science than religion owing to its systematic knowledge about mind and its relationship to environment (2003).

More recently, in *The Enlightened Gene...*, Arrie Eisen and Yungdrung Konchok explore the remarkable ways in which the integration of Buddhism and biological science could change our understanding of life and how we live it (2017). However, besides philosophical and

historical analysis of the intersection of Tibetan medicine and Buddhism (e.g., Gyatso 2015; Garrett 2008), there is a lack of study that examines the link between theory and praxis pertaining to the role of Buddhism in Tibetan medicine.<sup>28</sup> This chapter aims to fill that lacuna in the literature by illustrating how Tibetan medicine and Buddhism intersects by specifically looking at the way Tibetan doctors care for dying patients.

During my fieldwork, I observed that the collaboration between Tibetan medical doctors and Buddhist practitioners is not only important in caring for the dying, but their integration is visible and continuously present. This interaction between Tibetan doctors and monks is present in the hospital setting as well as at the home. I observed that family members often seek advice from both Tibetan doctors and Buddhist practitioners as they care for the dying person.

### **Epistemological Framework: The Four Noble Truths**

One of the key components that link Tibetan medicine and Buddhism is the mutual acceptance of a primordial cause of illness and suffering. If we were to situate the etiological concept of Tibetan medicine in Buddhism, we could infer that the designation of mind as a key player is inspired by the theory of the Four Noble Truths (*bden pa bzhi*) in Buddhism. The Four Noble Truths are considered foundational teachings of Buddhism. It is often maintained that one cannot be a Buddhist practitioner without proper understanding of the Four Noble Truths (the XIV Dalai Lama 1997; Spiro 1970). The Four Noble Truths are enumerated as: (1) the truth of suffering; (2) the truth of the origin of suffering; (3) the truth of cessation of suffering; (4) the truth of the path leading to the cessation of suffering.

Heuristically, it is interesting to probe the uninterrupted inextricable link between Tibetan medicine and Buddhism. One way to look at this connection is the way the Four Noble Truths

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<sup>28</sup> See Tawni Tidwell's (2017) doctoral research where she examines the Tibetan medical diagnostic technique in treating cancer patient and the role of Buddhist practice.

are positioned in the conceptual framework of Tibetan medicine given the context in which it is applied. The fact that a patient is already suffering due to illness takes away the burden of conveying the First Truth of *suffering*; investigating the *origin* of suffering or Second Truth fits in naturally, for making a diagnosis of the cause of illness is necessary to prescribe any treatment; and the patient, longing for medical intervention, would comply with the *path* (treatment) that could *cease* the suffering, the Third and Fourth Noble Truths.<sup>29</sup>

The applicability of the Four Noble Truths in the conceptual structure of Tibetan medical practice facilitates the convergence of Tibetan medicine and Buddhism seamlessly, devoid of any conflict. Hence, the understanding of an untamed-mind as a general cause of illness and suffering and a tamed-mind as a source of human flourishing and happiness is deeply rooted in Tibetan medicine as well as in Buddhism (Phende 2014; Gonpo 2008 [1892]). Likewise, the role of mind becomes equally significant at the time of death because it is conceived among Tibetans that the mental state of a dying patient determines how one would die and what kind of rebirth one might have. In my survey study focused on validating the conception of death and dying and care for dying conducted during my fieldwork, 94 percent of Tibetan doctors responded strongly to the importance of facilitating a peaceful mind for a dying person, and its association to the smooth transition of consciousness to the next life.

## **REINCARNATION: THE SYMBOL OF HOPE**

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<sup>29</sup> The intersection between the principal teaching of Buddha and the etiology in Tibetan medicine is clearly explicated in the book, *Mind Science: An East-West Dialogue* (1991), based on a symposium at Harvard Medical School: “The teaching on the Four Noble Truths was the Buddha’s first. Like a medical analysis, these truths express his diagnosis and prognosis of all life, and especially the human condition, and provide a methodical therapy of suffering. They are called “noble” because they are understood to be true for a “noble” person, one who has awoken from the sleep of selfishness. Enumerated, they are the truth of suffering—the inevitable experience of the egocentric being; origination—how ignorance, greed, and hate combine with evolution to cause the suffering; cessation—how freedom from suffering is possible; and the path—the way to achieve that freedom by counteracting the cause of suffering” (123).

The concept of reincarnation in Tibetan culture does more than to challenge the contemporary norm in the West that life ends at death or to merely provide a mental comfort to a dying person thinking there is a *next* life waiting for her. Rather, reincarnation is a complex conceptual framework with multiple layers of interpretations that inform the moral ethical life, as well as constructing a life course that provides a scope of continuity through many lives in one's spiritual development (Zivkovic 2014).

Having said that, reincarnation does not provide immunity toward fear of death if one is not prepared for the next life. Tibetans, in general, admit to being fearful of death. Most of my informants said they were afraid of death and when I asked for reasons, they said they felt like they were not prepared for the next life. In translation to the *Tibetan Book of the Dead*, Robert Thurman (1994) rationalizes the need of preparing for the next life by arguing that going to sleep “will not prevent tomorrow's challenges. So, we prepare for tomorrow as best as we can. [Hence] the better we are prepared, the more happily we fall asleep” (26). Thurman is making a strong case that just like we can sleep peacefully if tomorrow is better prepared, we will die peacefully if we are better prepared for the next life.

Likewise, reincarnation in Tibetan Buddhist culture does not imply transmission of an indestructible consciousness or a soul, but rather a consciousness, more in the form of information, that transfers from one life to the next life, carrying along with it a karmic imprint that is needed for and shapes aspects of the next life. This mechanism of carrying forward karmic information from one life to another is based on one of the core Buddhist concepts, called karma (Tib. *las*) – the theory of cause and effect (Thurman 1994).

According to karmic theory, whatever good or bad behavior—body, mind, and speech—one engages in, he or she faces the result in this life or the next life. Robert Thurman argues that

the theory of karma and its impact on rebirth could be concomitant to the Darwinian idea of evolution and refers to this mechanism as “evolutionary action” (28). Thurman makes a case that individuals engaging in haphazard behavior can have a random rebirth; however, once individuals are aware of the cause-and-effect process, “they can purposively affect their evolution through choices of actions and thoughts” (28). Thurman’s interpretation of karmic theory also speaks to how individuals would respond to the inevitability of their death.

Reincarnation in Tibetan is *yang srid*, which literally means “to come again into existence.” For the majority of Tibetans, to be reborn as a human (out of six realms of gods, demi-gods, animals, hungry ghosts, and hells) is the most aspired realm, for only in the realm of humans can one engage in spiritual practice. Tibetans believe that human realm is the most fertile avenue to study and practice Buddhism, and eventually, be free of the cycle of birth, death, and rebirth (Thurman 1994).

Melford Spiro’s study of Buddhist practice in Burma illustrates these two different approaches in Buddhism—to improve karmic imprint for a better rebirth and the cessation of rebirth itself—under the concepts of Kammatic (earning merit) and Nibbanic Buddhism (extinction of karma to be free from cycle of birth and death (1970: 92). Although both aspirations—good rebirth and free from rebirth—motivate people to engage in moral ethical behavior, they require different action. Spiro supports his analysis by saying:

Hence, in Nibbanic Buddhism salvation is achieved, not by works (and certainly not by faith), but only by knowledge (*panna*); and since meditation alone produces the knowledge requisite for salvation, meditation is the soteriological act of Nibbanic Buddhism. Any other kind of action, even moral action, is subversive of salvation, for morality produces karma, which in turn causes rebirth. (1970: 93).

The juxtaposition of a good rebirth and an aspiration to be free from the cycle of existence presents an interesting point of reference in understanding how Tibetans conceive any human action as possessing an immediate and ultimate goal, specifically in Tibetan medical practice. For instance, in the Four Tantras, the foundational text for Tibetan medicine, it is stated that a physician's act of assisting patients could earn fame and wealth, but the ultimate fruit is the spiritual benefits and, eventually, enlightenment (Gonpo 1984). Similarly, the conception of self in Tibetan Buddhism is based on thorough investigation of the difference between the independent self and the dependent self that is a result of numerous factors. The "dependent self" that is conceived as the real self is informed by understanding one of the key Buddhist principles called "dependent origination" (Dreyfus 1997).

### **Twelve Interdependent Links**

In his introduction to the most recent translation of *The Tibetan Book of the Dead* (Padmasambhava 2005), the Dalai Lama emphasized the notion of dependent origination in Buddhist philosophy. According to the principle of dependent origination, things do not exist independent of other factors; they exist "only in dependence on the aggregation of multiple causes and conditions" (xvi). The same mechanism of interdependence comes into play during death and rebirth. This cycle of existence, called *'khor ba* (Skt. Samsara), in which an individual is trapped in the continuity of being born, dead, and reborn, driven by the force of karmic tendencies and misconception of reality, is illuminated through twelve interdependent links.

Beginning with fundamental ignorance that induces a condition to develop certain susceptibilities generated by an individual's past actions (physical, mental, and speech), these propensities influence an individual's consciousness, which affects the interaction of an individual's psycho-physical aggregates and thereby, sensory fields. The aforementioned

condition generates contact, sensations, and then, attachment, grasping, and inclination toward rebirth. The next stage is fascinating as it shed light on the integration of ‘conditioned’ mind and parents’ genetic materials. The Dalai Lama expounds on this:

At this point there is an interaction with the genetic constituents of the parents and subsequent interaction with the environment, and then finally we have birth, aging and death, this cycle can be viewed as both illustrating the underlying processes of life, death and rebirth and as an illustration of the processes to be transformed on the path to liberation from suffering in cyclic existence (xvii).<sup>30</sup>

Adept practitioners aim to transcend the cycle of death and rebirth; and preferably “they endeavor to experience liberation from the illusory nature of the self and external phenomena” (Zivkovic 2014: 3).

“Some adept practitioners are able to direct their rebirth in terms of space and time based on their spiritual goals,” said one of my informants. These practitioners, unlike ordinary laypeople, use the opportunity of rebirth to carry forward their spiritual work and cultivate *byang chub ki sems* (Skt. *Bodhicitta*) There are many reincarnate Tibetan lamas but someone like the fourteenth Dalai Lama is the prime example of the aforementioned spiritual endeavor. In his seminal work of psychoanalytic explorations of *Tibetan Symbolic World* (1982), Robert A. Paul explicates the Tibetan cultural phenomenon of a reincarnate lama with a focus on the effective mechanisms of succession.

According to this [reincarnation] principle, which is an extension of the basic general Buddhist belief in reincarnation, a person, usually, an important lama, who is to be reincarnated, dies and, after the traditional forty-nine-day intermediate period between

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<sup>30</sup> See Tsong-kha-pa’s *The Great Treatise of the Stages of the Path to Enlightenment* (2000), for more detail on Twelve Interdependent Links or “The Twelve Factors of Dependent-Arising” (315-325).

lives, is conceived again as human embryo... Whatever it is that reincarnates enters a newly conceived child, whose body is about two years old, he maintains himself by means of various signs. Often his predecessor will have given some indication of where he intends to be reborn and how he may be recognized (40).

I distinctly remember my conversation with Gen Loden, one of the main attendants of Lobsang Nyima Rinpoche who stayed in *tukdam* in 2008. A day before I was to leave the monastery for Dharamsala after the completion of Rinpoche's *tukdam*, we had dinner together and he told me Lobsang Rinpoche's reincarnation would come soon. I was a little surprised by Gen Loden's confidence in his teacher's reincarnation, and could not help asking him, "Why do you think so?"

"When Rinpoche was quite ill and had to be in the hospital for more than a month, everyone was worried" he said. Gen Loden grew a little more serious and added:

Rinpoche was frail and exhausted most of the time when he came back from the hospital. One morning, we received an urgent message from the monastery office saying His Holiness the Dalai Lama would be coming to see Rinpoche. We were excited but a little nervous too. It was a surreal moment as we waited for His Holiness, and when he arrived, there was no entourage of security vehicles or staff as usual. His Holiness came all the way to Rinpoche's room. His Holiness sat on a chair right next to Rinpoche's bed, held his hand, and handed Rinpoche a cup of boiled warm water that I served him and told Rinpoche, 'You know you have done whatever you can as a good Buddhist practitioner and served your community. You should feel free to go, but I will be waiting for you.' That is the reason we all knew Rinpoche will come back soon. His Holiness asked him to; and also, all his students are here.



### Lobsang Nyima Rinpoche's Reincarnation

On the morning of December 10, 2017, a day before I left my field site in Mundgod, a monk friend of mine called me to inform me that there would be an informal enthronement ceremony of Tenzin Lobsang Nyima Rinpoche. He further told me Nyima Rinpoche is the reincarnate of Lobsang Rinpoche and I should come if I had time. I truly could not believe what I heard because I might have missed the ceremony if I had left a day before which I had originally planned. I was told that the reincarnate lama was born to a family in a small village in Spiti Valley of northern India and was identified when he was three-years old.

A large number of monks and laypeople had already lined up by the gate of a small monastery where the ceremony was to be held. Besides excited young monks, there were many senior monks gathered who used to be students of Nyima Rinpoche's predecessor. They were beaming with joy to welcome young Rinpoche. On the other side of the courtyard, there was a group of laypeople from Nyima Rinpoche's hometown who had come along with Rinpoche's family to pay respect and to send him off. Along with others, I got an opportunity to walk up to him and receive a blessing from him. After he returned my white *khata* ceremonial scarf,<sup>31</sup> I requested him to pat my head so that I can receive a corporeal blessing. I wondered, at that time, if he remembered anything of my engagement with his predecessor.

In the summer of 2018, I went back to my field site in Mundgod to collect follow-up data. It had been raining the whole morning and my lunch appointment with one of my interlocutors had just been cancelled. I was looking forward to some quiet time reading when a

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<sup>31</sup> *Khata* or *khatag* is ceremonial scarf used in Buddhist culture. It is usually made of white silk and symbolizes pure heart. *Khata* is presented to a spiritual teacher or others to show respect; or to express good wishes during ceremonial occasions including marriage, births, funerals, and the arrival and departure of guests.

monk showed up out of nowhere by the door. He asked, “Are you *amchi*<sup>32</sup> la?” When I said “yes,” he instantly asked if I could accompany him to see a patient. I picked up my raincoat and backpack in which I usually keep some common Tibetan herbal medicines and my blood pressure device. On our way, he told me that a rinpoche had fallen ill with high fever. As we approached the main gate of the house tucked under the lines of coconut and mango trees, nourished by heavy monsoon rain, I sensed a familiarity. I told the monk I had been here before; and once we got into the front yard of the house, it dawned on me that it was the place of Lobsang Nyima Rinpoche who stayed in *tukdam* a decade ago.

The monk escorted me through slippery steps to the first floor where young Rinpoche was sitting on a bed, calm and composed, and gracefully dressed in his monk robe. I recognized him instantly. He was sitting on the same bed on which Lobsang Rinpoche had lain motionless, for 18 days in the state of *tukdam*. A friendly large monk, who was Rinpoche’s main attendant, came in and introduced the young Rinpoche as Tenzin Lobsang Nyima, the reincarnation Lobsang Nyima Rinpoche. Tenzin Rinpoche was eight years old and had started his formal education at the monastery a year before. Once we were done with the medical consultation, I could not help myself from asking the Rinpoche attendant if I could ask couple of questions to Rinpoche. By this time, the attendant knew that I was one of the investigators who studied Rinpoche’s predecessor, Lobsang Rinpoche, when he was in *tukdam*.

“Rinpoche, you know you are sitting on the same bed where your predecessor, Lobsang Rinpoche stayed in *tukdam* ten years ago. Do you remember anything?” I asked.

“No, I do not,” he said.

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<sup>32</sup> “*Amchi*” is a commonly used Tibetan term for Tibetan physicians, mainly in Central Tibet and in the exile community. Although it is a Mongolian word, it has become synonymous with the original term, “*menpa*” within Central Tibetan populations.

“Do you usually sleep here?”

“I used to, but I don’t now because I dream about so many things, and I get scared.”

### **What does Reincarnation Entail?**

To reiterate, reincarnation is one of the key cultural concepts in Buddhism, and hence, one of the key themes in my dissertation. However, it is important to bear in mind that the concept of reincarnation is fluid and has been used differently across cultures (see Kramer 1988; Lifton and Olson 1974 for different philosophical interpretations). The theory of reincarnation often sounds esoteric and mysterious to many people and many, even Buddhist and Hindus, have trouble embracing it. Philosophers and anthropologists, and clinical researchers in recent times, have engaged this phenomenon in myriad ways.

For example, in the seventeenth century, a French philosopher, Blaise Pascal, came up with a concept called a wager (Lifton & Olson 1974: 34). He argued that “If there is no life [after death], and one doesn’t believe, then one has lost nothing. But if there really is such a thing, and one fails to gain admission through lack of belief, then all is lost” (p. 34). Pascal, therefore, contend that since there is everything to be gained by believing, and nothing to lose, one should make the wager and decide to believe in the afterlife. Moreover, in recent years, the scientific study of young children’s report of memories from previous lives at Division of Perceptual Studies at the University of Virginia has reported fascinating result where children’s memories were corroborated with factual information. One of the main researchers, Dr. Jim Tucker, explains that even though such cases are more common in cultures with a belief in reincarnation, they have found cases worldwide (2008, 2008, 2007; Keil & Tucker 2005). Pascal’s wager concept and studies on children’s memories from past lives are important in the context of this research because besides providing a potential psychological buffer in dealing with death, such

reasoning and finding raise questions about the underlying notions of belief in reincarnation. For instance, is there any relationship between the current life, death, and the next life? If there is, how are such cultural relationship manifest in social life, and the way people live and die?

The aforementioned questions are important because if the theory of reincarnation aids in rendering an alternative perspective about death—that death is not an end and consciousness moves onto next life—it also seems to contradict another fundamental Buddhist notion of absence of self or “emptiness.” Unlike the concept of “*atman*,” the idea of an indestructible soul in Hindu culture, the Buddhist strictly relies on “*anatman*,” no soul or independent consciousness (Kramer 1988). I had my own dilemma when I discussed this with others. I was ecstatic when I got an opportunity to talk to Geshe Dadul Namgyal relating to rebirth. Geshe Dadul is a prominent scholar in Tibetan Buddhism and one of the leading scholars in spearheading the dialogue between Tibetan Buddhist scholars and Western scientists. When I asked him how rebirth happens, he smiled and said, “This is a complicated topic, but let me try it.”

When one dies and takes rebirth, it is not the case that either something permanent continues to the next life, or that everything is discontinued and becomes nothing. It is not the case that there is no cause whatsoever or that there is anything brought about by the creator. Rather, rebirth takes place due to the aggregation of causes and conditions in the form of afflictive emotions and actions by them.

I told him I was still confused because how does one comprehend the concept that there is neither something permanent that is transmitted nor a discontinuation of everything. “How do you resolve that?” I asked. Geshe Dadul told me there are different analogies that are used to expound on all the key Buddhist concepts, and so with rebirth. He continued:

See, there are eight supporting examples to illustrate the theory of rebirth: 1) the example of the student learning from his master's instruction; 2) the example of a lamp being lit by another lamp; 3) the example of reflections appearing in a mirror; 4) the example of an embossed impression and design emerging from a seal; 5) the example of fire produced by a magnifying glass; 6) the example of a sprout growing from a seed; 7) the example of salivating from the mention of a sour taste, and 8) the example of an echo. Through these examples, one might arrive at an understanding of the concept of rebirth in Buddhism.

The reason for having multiple examples is that each of them does not stand on its own, but rather they support each other in clarifying the nuances of the concept itself.

### **Reincarnation in the Scope of Tibetan Medical Practice**

During my fieldwork, particularly while shadowing and participating as and with Tibetan doctors caring for dying patients, it was evident that the principle of reincarnation provides an additional conceptual lens for Tibetan doctors to have a better understanding their role and goals in caring for dying patients. I witnessed on numerous occasions that the perspective of rebirth helps Tibetan doctors to view death and physical disintegration with less fear and less anxiety, as well as provide confidence and composure while interacting with dying patients and family members. More importantly, woven through the following chapters, I argue that the concept of reincarnation gives a different, more practical, understanding of "hope." This is so because, hope can be misconstrued as "empty" hope relating to hoping for a cure or hoping for remission in terminal patients. Hope, in the context of reincarnation, helps bridge a relationship between this life, death, and the next life. Orienting from such a view, I propose, could infuse a dying patient with a hope and purpose that facilitate a more practical and realistic approach to death.

I have observed Tibetan doctors merging Buddhist concepts with signs of imminent death—physiological signs articulated in Tibetan medical theory similar to biomarkers in Western medicine using complex pulse and urine analysis, dreams, environmental cues—and herbal medical treatment as they work with family members and Buddhist practitioners in assisting dying patients. I will elaborate on these aspects of Tibetan medical practice in the next chapter.

### **Seeking Help from Tibetan Doctors and Monks**

When I asked Tsering, whose mother was suffering from advanced stomach cancer about her constant effort in seeking help from both Tibetan doctors and monks, she said, “The role of doctors and monks are like two legs of a body where one needs the other to be able to stand or walk.”

Tsering would often get teared up talking about her mother’s condition and the possible trajectory of her illness. She called me once with a tone of urgency saying that her mother’s condition had deteriorated into frequent vomiting and abnormal swelling in the legs. However, she was surprisingly calm when I reached her place; she told me she had invited a monk [who was reciting prayers inside] and her mother was doing better.

“Now, she [her mother] might respond better to medicines,” she remarked with a sense of accomplishment. She continued, “Earlier my mother felt relaxed and happy when monks recited prayers for her and her swelling [due to edema] subsided immensely and her appetite improved with Tibetan [herbal] medicines.”

Tsering’s action intrigued me because it exemplified her tacit engagement in taking care of her mother’s spiritual (mental) needs before addressing the physical need by taking advantage of religious and medical resources which were readily available in her cultural milieu.

Tsering also told me that she was, earlier, advised by a Tibetan doctor from a local Tibetan medical clinic that it is important to take care of her mother's state of mind. It could be thus argued that Tsering's action was motivated by the doctor's words, but the question is why she would see a Buddhist practitioner as someone to take care of her mother's mental state. Such tacit knowledge related to the assignment of different roles in caring for dying is important in understanding the dynamic of collaboration among different collaborators—family members, Tibetan doctors, and Buddhist practitioners—in caring for a dying person. However, in order to maintain our focus on Tibetan doctors' care for the dying, I will discuss how different actors collaborate despite their distinct roles in chapter 5.

### **The Importance of State of Mind**

“Calm mind,” said Doctor Tsewang Tamdin, when I asked about the one most important thing when he cares for dying patients.

“Could you tell me why you would focus on calm mind when there could be lot of other things happening at the time of death,” I asked, with little hesitation.

“See, usually, when I go to see patients, my role is to see how best to restore their health. But when I realize that a patient has not much scope of surviving, then, my role changes. I have to see how best to help a patient stay calm by supporting her mental state. If the patient is mentally calm, there would be much less, or perhaps no fear.”

Dr. Tamdin's remark of playing with how he cares based on the patient's condition, I think, is crucial because it reflects the fluidity of Tibetan doctors' role in caring for the dying. I observed or heard similar strategy in my interaction with Tibetan doctors all through my fieldwork. Such flexibility, strikingly different from Western medical model where the focus is to safe or prolong life at any cost (Gawande 2014), seems to be strongly contingent upon the

inextricable integration of Tibetan medicine and Buddhist thoughts. This unique feature of Tibetan medicine offers Tibetan doctors with lexicon that prepares them in conceptualizing their own role and in candidly conveying the need of hours for a patient as well. It is, however, critical for healthcare providers, as well as patients and family members, to be aware of what is happening as an attending doctor change the mode of care.

Although Dr. Tamdin's assertion of focusing on facilitating mental calmness rather than restoring (physical) health once a patient's death is imminent displays an idiosyncratic Tibetan medical strategy, it could possibly induce fear among patients and families. This is because a dying person and family members, if not properly engaged in the process of shifting the treatment, could easily lose trust in their physician (see Neumann 2016). For instance, despite hospice care's fundamental approach of providing comfort and compassionate care in assisting patients to die well, people often get scared and confused when hospice care is suggested (Smith and Himmel 2013). Such misunderstanding, in a way, is understandable considering the vulnerable situation death creates.

Atul Gawande, in his influential book, *Being Mortal: Medicine and What Matters in the End* (2014), makes a strong case about the adverse ramifications of a sheer poverty of language and honesty in conversing with dying people. It was, therefore, refreshing to observe and listen to a healthcare provider like Dr. Tamdin, who not only possesses a unique conception of caring for terminal patients, but uses that understanding to navigate care in the midst of a chaotic medical scene.

My relationship with Dr. Tamdin goes back many years. I did my internship under his supervision after I graduated from the MTK in 1997. He is known to be exceptionally kind and sensitive to his patients' needs; and with his vast clinical experience of over forty years, he is one



of the most experienced and sought-after Tibetan doctors outside Tibet. His popularity is such that patients from all over the world come to Dharamsala to see him with variety of health problems. I have seen people start queuing outside his residence early in the morning, around 3 am, to consult with him. From 6 am to 1 pm, except for a swift breakfast break, he gets completely taken over by a pool of patients.

It was during one of his busy mornings that I got a chance to shadow Dr. Tamdin. It was almost 9 am and he had moved his patient consults from his residence to a small consultation room in the main administration building, which is in the same compound. There was a long line of people with different backgrounds—Tibetans, local Indians, a few foreigners, monks, nuns, old and young—by the hallway outside the consultation room. Some were sitting and some standing. They were surprisingly quiet, but they did not look sad or anguished. Perhaps it is the ambience that does not intimidate them—no flashy lights, no beeping machine, no iodoform smell, and no doctors or nurses in uniforms. Or perhaps those in line simply have a joyful feeling that they are about to see Dr. Tamdin. Earlier when I was waiting by the reception area, I overheard patients conversing.

“I am so glad that Dr. Tamdin is in town. I heard he usually travels a lot,” said an elderly monk who had come all the way from Darjeeling, a town in the northeastern region of India. He put his hand around his abdomen and continued, “I have a chronic gastritis that has been troubling me all the time, and now it has developed into an ulcer despite trying different treatment modalities.”

A man in the mid-thirties standing next to the monk smiled, almost acknowledging his sentiments and said, “I got to town early today and came straight here. My in-laws who live here helped me to get a ‘consultation coupon.’”

An elderly woman, sitting close to them, spinning a well-used portable prayer wheel,<sup>33</sup> joined their conversation. “It has become even harder to get to see Dr. Tamdin since there are so many of you coming from outside,” related the elderly woman and chuckled lightly to herself. I was eager to engage in their light, yet informative conversation, but a staff member came over saying Dr. Tamdin was asking for me.

The consultation room was small, minimally furnished with a portable sink attached to a white metal water container, a long bench by the corner, a huge closet, and a portrait of the Dalai Lama on the wall right above Dr. Tamdin’s chair. Dr. Tamdin was talking to a male patient, who we shall call Kalsang. Kalsang appeared to be in his early-seventies and had been diagnosed with terminal liver cancer six months earlier. He looked weak and exhausted, but his voice was strong and engaging as he responded to Dr. Tamdin’s queries. Kalsang had come along with his daughter and son-in-law, who had come from the U.S. to take care of him. They said that they had just returned from Delhi a day before after consulting with a team of doctors—hepatologist and oncologist—there and the doctors said that there was not much they could do to help Kalsang’s condition. Dr. Tamdin took some time—at least 2-3 minutes checking the patient’s pulse (at the radial artery) in both wrists, one after another, and then, both hands together. He looked at Kalsang’s tongue and eyes briefly and with a little smile, he said, “You seemed anxious and it is understandable.”

Dr. Tamdin held Kalsang’s hand again, leaned a little closer this time, and asked, “Is there something that you are worried about other than your illness?”

I was little surprised by Dr. Tamdin’s question. I thought of course the patient would be worried about the fact that he did not have much time besides experiencing weakness, lack of

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<sup>33</sup> A handheld prayer wheel is mostly used by many Tibetan Buddhist practitioners by rotating it in one’s hand while reciting mantra to maintain their attention as well as to earn a merit to enhance the likelihood of enlightenment.

appetite, possibly pain, and a host of other symptoms. However, the conversation that followed helped everyone in the room to feel little less anxious and more assured of what everyone could do to help the patient.

“I am worried about my health, like what might happen, umm... and if I would get better,” said Kalsang. He thought for a few seconds and continued, “I am actually not sure, but I have been feeling low ever since I was told I have this disease.”

“Of course, your health condition is not good, but have you tried to think beyond that?” probed Dr. Tamdin. “Like did you think about what you can do now that you have this health condition, just like you would do with any other problem?”

With a quick glance toward his daughter, Kalsang said, “I am so glad my daughter is here, and her husband; and my granddaughter is here, too. I haven’t seen them for a long time.”

“So, you want to spend as much as time with your daughter and her family?”

“Yes,” said Kalsang, and he managed a smile for the first time since I saw him. “I don’t know how much time I have. It worries me thinking I might not be able to spend much time with them.”

“I don’t have to tell you this, but you know well we all could die any moment irrespective of our health condition. Even I don’t know how much time I have,” said Dr. Tamdin, bringing in the key Buddhist philosophical concept of impermanence. “If we all keep on worrying about when that *moment* [of death] might arrive, we might never be able to live fully.”

“I have always wished to go one more time to Bodh Gaya<sup>34</sup> on a pilgrimage with my daughter, and I am worried if I will get a chance.”

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<sup>34</sup> Bodh Gaya is one of the holiest Buddhist sites, in the state of Bihar, India. It is believed that Buddha (Gautama Siddhartha) got enlightened in Bodh Gaya, and thus Buddhist from all around the world visit the place on a pilgrimage.

Dr. Tamdin took a quick look at the bench where the patient's daughter and her husband were sitting (as if to get their attention) and then, turned his attention to the patient and said, "It is important that you do not get sucked ( *'thim pa*) into your illness. Similar to what we do usually to make best of our life, you should make best of your time with your daughter and her family." "I will write [prescribe] some medicines here to help you feel better and support your physical system."

Kalsang thanked Dr. Tamdin and said he would do his best. Before leaving, the patient's daughter asked if she could get a copy of my note, which I produced for her later in the afternoon. She said it would be helpful to have information about the conversation that happened during the consultation.

I was impressed to see that Dr. Tamdin had focused on the patient's mental wellbeing, and without being too explicit, he guided the patient to pay attention to something that transcends his physical disintegration. In the same vein, as Dr. Rabten pointed out earlier, a physician must take into consideration the importance of preparing the patient to die well and be better prepared for the next life. I realized that the overarching goal of a good reincarnation is fundamental in shaping the way Tibetan doctors interact and help dying patients and families and the way patients respond to their illness and doctors' advice.



Figure 7: Dr. Tsewang Tamdin seeing patients

The general consensus among Tibetans that the mental state at the time of dying is crucial in determining the quality of next life helps to generate a team where all the collaborators become equal partners in protecting the dying person's mind. However, such (tacit) assumption of protecting a dying person's mind could lead to adverse effect, especially among laypeople. For instance, the predominant act of protecting a person's mind, sometimes, comes into a play in a situation where family members go to an extent of force-feeding a dying person out of a sheer love and concern that the person dying with an empty-stomach might have negative impact on his or her mind. I remember a situation where family members could not stop feeding a dying person even though he coughed and threw up whatever they put in his mouth. A monk who was present came to the rescue by advising the dying person's relatives that if they keep on doing this, the dying person might develop a repulsive feeling toward food. The monk explained that such experience at the time of dying could cause the person to be reborn in a place with severe lack of food and could suffer immensely. The relatives were able to relate to that interpretation and they stopped feeding the dying person right away.

Whether serendipitously or through the influence of karma, a few months later, I ran into Kalsang's daughter and her husband in my primary field site, Mundgod Tibetan settlement in southern India. They were on a pilgrimage to all the major monasteries in the Tibetan settlements. The daughter told me they could not take her father to Bodhgaya as he had wished but he had died three months after seeing Dr. Tamdin, peacefully. She said her father became lot more positive after he met with Dr. Tamdin and it became much easier for him and everyone else.

One might argue that the Tibetan doctors' emphasis on mind is a natural process, an act that is enacted by default – that the focus on “mind” is an unconscious act that occurs by a sheer dint of being exposed to the Tibetan Buddhist cultural milieu. However, the theoretical concepts of Tibetan medicine that are based on Buddhist epistemology form an explicit field of Tibetan medical psychology and its intricate relationship to the human body. For Tibetan doctors (and Buddhist practitioners) to embody the coalescing of two distinct yet interconnected fields of Tibetan cultural knowledge, one needs to engage in rigorous practice to cultivate such qualities (Adams et al., 2013). The focus on mind is emphasized because of its direct or indirect impact on the human body and its environment.

### **The Interplay of Mind and Body**

On December 18, 2016, more than three-hundred Tibetan Buddhist scholars and Western scientists sat together in Drepung Monastic University's main prayer hall to engage in scientific discourse and to explore a common-ground between the two traditions. The conference was the natural extension of the work of the Emory-Tibet Science Initiative, an extensive educational program intended to teach science to Tibetan monastics. The eventual goal of the symposium was to build a bridge between two complementary systems (Buddhism and modern science) of

knowledge. It was during the panel on human development when the Dalai Lama looked at the moderator, indicating he had a question for the panelists. “I have a question for the scientists here,” he said. “Do you say that a woman will conceive as long as healthy sperm and egg [ovum] are present?”

The scientists exchanged glances and after a brief moment, one of them said, “Not necessarily.” The Dalai Lama chuckled and said, “In Tibetan Buddhist [tantric] practice and medicine, it is clearly stated that for a woman to successfully conceive, three factors have to be present, i.e., healthy sperm, ovum, and the support of a subtle consciousness.” The conference on “Bridging Buddhism and Science for Mutual Enrichment, was organized jointly by Emory-Tibet Partnership and the Dalai Lama Trust in collaboration with Drepung Monastery and the Library of Tibetan Works and Archives. I was able to attend the conference while I was there conducting my field research. A monk who was one of the panelists introduced me to a biologist who wanted to discuss the Tibetan medical understanding of the human body and its relationship to mind. We could not follow up on our discussion after the conference, but we spent an hour delving into whether mind is a separate entity or a by-product of the brain.<sup>35</sup>

The ontology of the human body in Tibetan medicine is interpreted distinctly different from that in Western discourse. Influenced by Tibetan Buddhist principles, the body, though conceived as an integration of psychophysical constituents, is viewed as a vessel for the mind (Padmasambhava 2005).<sup>36</sup> According to Buddhism, the aforementioned psychophysical constituents are referred to as *phung po nga* (translated as five aggregates or heaps; Skt.

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<sup>35</sup> See Varela et al. (1991) for an account of similar discussion that stemmed from a dialogue between neuroscientists and the Dalai Lama.

<sup>36</sup> See Tidwell 2017 for a related analysis of the body and Tibetan medical ontology.

*Shandha*). The five aggregates are: form/matter, sensation/feeling, perception, formation, and consciousness (Githen 1998; Spiro 1970).

This conception of the (psychophysical) body contrasts with how mind is understood in Western medicine as an epiphenomenon of body, specifically, more as a physical neural-activity in the brain (Greenfield 2002). The ontological base—as the Dalai Lama referred to earlier during the symposium panel—that the formation of zygote is dependent upon the support of subtle consciousness not only underscores the importance of mind, but also the mutual collaboration between mind and body that is vital after the birth, through the course of life, at the time of death, and for the next life.

## **MIND AS A BASIS OF SUFFERING**

*Ignorant (mind) that fails to comprehend the absence of self is the singular cause of all illness (suffering).*  
- *rGyud bZhi* (The Four Tantras)

During my time at the MTK Tibetan Medical School as a student, I was intrigued by the explicit notion of the disease etiology – that the (root) cause of all illness is (unclear) mind. Unclear mind in Tibetan Buddhist thought is the idea of a mind that fosters a false belief of an intrinsic (independent) permanent self. This interpretation of the root cause of disease is aptly referred to as the “distant cause” in the For Tantras (*rGyud bzhi*), the fundamental text of Tibetan medicine, because ordinarily it is masked by the immediate causes and conditions. These immediate causes are afflictive emotions—attachment, aggression, close-mindedness—generated by an individual’s ego that is stimulated by a false belief of an intrinsic self. And the conditions are unwholesome diet, improper behavior, seasonal changes, and external factors including evil spirits. With these emotions and conditions so prevalent and overtly noticeable, it is plausible



that the *mind* factor could be often neglected or even invisible. However, this does not seem to be the case in the etiology of Tibetan medicine.<sup>37</sup>

Studying the relationship between patient and healers in the context of culture, Arthur Kleinman proposed a theory of explanatory models (EMs). With an understanding that individuals and groups can have vastly different conceptions of health and disease, Kleinman described EMs as “notions about an episode of sickness and its treatment that are employed by those engaged in the clinical process” (1980: 105).<sup>38</sup> The need of a holistic approach in determining the underlying factors of health and illness is acutely realized, however, it is poorly embraced in biomedical practice (Astin et al. 2008; Engel 1978). Moreover, Tirodkar and colleagues (2011) argue that although there is a push to educate physicians in the biopsychosocial model which acknowledges physical, behavioral, and psychological aspects of illness, physicians explanatory models of illness are still mostly biomedical. In Tibetan medicine, the concept of etiology, diagnosis, and treatment underscores the importance of a patient (personal) agency focused on bio-physiological, psychological, and social wellbeing with holistic approach to treatment (Loizzo et al. 2009; Clifford 1984).

### **Mental Strength: Hope and Purpose**

Hope and purpose, I think, are children from the same mother that mutually inform, animate, and galvanize each other. In a sense, they exhibit or inhabit each other. The mother here is mind, which nurtures and nourishes them. Considering this analogy, it is clear that the mother or mind has to be strong, stable, and reliable. This is what seems to be happening in the case of

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<sup>37</sup> See Tidwell (2017); Ozawa-de Silva & Ozawa-de Silva (2011); Clifford (1984) for related scholarship in the English literature.

<sup>38</sup> Also see Kleinman et al. (1978) seminal paper where Kleinman and associates discuss the importance of the explanatory model in enabling physicians to provide an optimum care to their patients.

the way Tibetan doctors prioritize mind when they care for terminal patients. Dr. Tamdin, in one of his responses to my question pertaining to the importance of mind, said,

In order to help terminal patients to get access to their power of being motivated so that they can aspire to something based on a [good] life they have led or knowledge they have gained, patients need to be mentally calm and clear. Being mentally strong, a patient is not only in a better position to process and understand the cultural philosophical concepts, such as impermanence and reincarnation, but could also respond positively to any other medical intervention.

I must mention here that the hope and the sense of purpose generated among dying patients I observed during my fieldwork was different from the way hope for terminal patients is discussed in biomedical practice (Thompson 2011; Clayton et al. 2007). I observed that Tibetan physicians like Dr. Tamdin and Dr. Rabten work with dying patients and family members by instilling hope in them vis-à-vis a reminder of the enormous difference it could make by achieving a mental state of calmness and clarity. Often, I have witnessed Tibetan doctors telling patients that a peaceful mind could help dying ones to have a virtuous mindset, which helps at the time of dying as well to acquire a “good next life.”

In his ethnographic study of death and dying among Hyolmo (pronounced yhol-mo) community in the Himalayan Hills on the border of Nepal and Tibet, Robert Desjarlais shares a conversation with one of his main interlocutors, Karma: “Such matters [preparations and state of mind] are crucial because a person’s state of mind while dying contributes to what happens to the consciousness after death, and because a prepared and proper consciousness makes for a good death” (2016: 40). On another occasion, Desjarlais accentuates the importance of work that Hyolmo people put into their preparation for a death: “Many learn how to die. They undertake an

apprenticeship on the subject, lest they approach it in an uninformed way and disturb their chances for a good rebirth” (41).

On the contrary, in the biomedical setting, physicians tend to relate hope solely with cure or remission for terminal patients (Nuland 1993). The power of physicians in instilling hope in patients and family members is huge, and more so in the case of terminal patients. In *How We Die: Reflections on Life's Final Chapter*, Sherwin Nuland expounded the way hope is associated with doctors and its impact on a dying patient,

A young doctor learns no more important lesson than the admonition that he must never allow his patients to lose hope, even when they are obviously dying. Implicit in that oft-repeated counsel is the inference that a patient's source of hope is the doctor himself, and the resources he commands; thus, only a doctor has the power to offer hope, to withhold it, or even to take it away. (p. 222).

Similar to what Nuland noted, I witnessed regularly during my fieldwork that terminal patients and families rely strongly on doctors in making sense of traumatic diagnoses, pain and suffering, and most importantly, making critical decisions related to treatments. I once spoke to a family who deeply regretted the way their father died in the ICU after he went through much hardship for more than a week. The elder daughter who was a nurse told me it was hard for her to make a decision despite her background in medicine. “The doctor at the hospital was not clear about my father's treatment and I wasn't sure what to do, so the easiest thing was to get him admitted in the ICU,” she said. Her mother who had escaped into India via Nepal border with her husband in early 1960s told me she could not even see him when he died.

I realized during my fieldwork that the temporality between life and death is so (organically) intertwined that many Tibetans, particularly lay Tibetans and novice Buddhist

practitioners are not aware of it. I said naturally integrated because Tibetans in general, whether tacitly or consciously, use death while alive to develop a sense of purpose; and use life (rebirth) while dying to develop hope.

### **The Power of Being Reaffirmed – Youdon and Her Family**

To animate this conversation, let me share a story of a patient who I observed for almost two weeks as she was dying, surrounded by her family. An 82-year old woman had multiple chronic health issues and was bedridden since she had had a stroke eleven months prior. I met her not long after I arrived in the field in the fall of 2016.

I heard a rattling knock on my door one early morning, around 5:00 a.m. A desperate looking man named Dorjee stood outside as I peeked through the side of the door. Dorjee asked if I could come with him to check on his mother-in-law. In the field, local Tibetans saw me more as a Tibetan doctor than a researcher, so I would often end up making home visit during odd hours when clinics were closed. It worked well for me because besides being able to help them, it gave me a perfect opportunity to gain access to some patients who became my study participants.

While Dorjee was waiting, I quickly changed clothes and followed him down the stairs to the front lawn where he said he has parked his scooter. It was drizzling and was little chilly. I mounted on his scooter and rode into the first light of the crack of the dawn on a deserted road, leading to a narrow unpaved dirt road inside the settlement camp.

Dorjee's wife Pema greeted us by the door. Pema looked exhausted but kept on thanking me for coming. Her mother Youdon had been immobile for almost a year and had gained lot of weight. Her blood glucose level—as she was a chronic diabetic patient—had spiked lately. Youdon was lying on a bed, eyes closed, and very still, holding prayer beads in her right hand.

Pema told me that her mother had not been keeping well the last few days but particularly early that morning, she had thrown up everything she ate the night before. I could see that she was short of breath; she looked pale and somewhat agitated.

I sat by the side of the bed and slowly took her hand to read her pulse.<sup>39</sup> Her hand was warm and supple. Youdon opened her eyes for a moment as if to accept my presence. On a table next to her bed, there was a cup filled with brownish-water which looked like a tincture made up of mixing blessed pills<sup>40</sup> with water and a small box containing a variety of Western pharmaceutical pills. I took time reading her pulse from one hand to another. I glanced at the catheter bag filled with dark yellowish urine hanging by the side of the bed.

From her pulse and urine, there was clear indication that she was having indigestion and an infection in her stomach. I thought it could be minor food poisoning. I called her name and asked, “Youdon, do you feel any cramps or nausea?” Youdon could hardly utter any word but she opened her eyes (again) and moved her head vertically, signaling she does. By that time Pema came by my side and asked how her mother was. I told her she seemed to have food poisoning and inquired, “What did she eat last night?”

“My mother asked for *chang skol*<sup>41</sup> yesterday, so I made some with butter for her. Maybe that might have caused this,” she said.

“It could be, and also maybe she had bit too much.”

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<sup>39</sup> Pulse reading, in Tibetan medical practice, is one of the primary modes of making a diagnosis. The physician, using her fingertips (of index, middle and ring finger) feels the radial artery by the wrist of a patient’s hands. Besides extrapolating a patient’s constitutional nature or any unusual pulse characteristics that corresponds to any illness, each finger is designated with different internal organs. For instance, the physician’s right-hand index fingertip (two sides) is assigned to heart and small intestine; middle fingertip with spleen and stomach, and so on.

<sup>40</sup> Blessed pills are herbal based pill or powder blessed by high Tibetan Buddhist Lamas, like the Dalai Lama or one’s spiritual teacher. Tibetans usually give such pills to someone with unknown illness, terminal condition, or sometimes, as a prophylaxis, too.

<sup>41</sup> *chang skol* is a broth made of *chang* (Tibetan beer prepared from rice, barley or millet) with bit of butter and dry fruits.

I held Youdon's right hand (the affected side of her body due to the stroke), which seemed dedicated to hold her beads, and gently told her she can have *chang skol* but only in small doses. Youdon looked a little more stable now, so I told her daughter to give her boiled water that could help with her indigestion and some light food. I promised I would come again in the evening with a local Tibetan doctor to see how her mother was doing.

Later that day, I contacted Dr. Thupten Gyaltzen, who was a senior Tibetan doctor at one of the MTK clinics in the Tibetan settlement. Dr. Gyaltzen was in his late-sixties and has been practicing in Mundgod for more than thirty years. He is kind, friendly, and humble. Also, he is unusually tall for Tibetans and he walks around with a slightly uneven gait. When I asked if he could come along to have a look at the patient I saw in the morning, he said, "Lately I haven't been going much to patients' home because my knees have been bothering me. So, I only go to see patients who really cannot come or are brought to a clinic." After assuring him that there is no way the patient could come or be transported to his clinic, we agreed to meet at his clinic after his clinic hours.

Dr. Gyaltzen was waiting for me when I reached the clinic. It took a while for us to get to the patient's house, for we were constantly interrupted by people who either had health related matters to ask Dr. Gyaltzen or would interject random conversation. When we finally got to the house, Dorjee was pulling his scooter out to go to a monastery. Dorjee said he was going to see a monk to discuss about Youdon's health. There were a lot more people inside the house this time. Youdon's two other daughters, their spouses and children have come to help. Pema told us her mother had some vegetable soup and she had not vomited since morning. And then, coming closer, Pema almost whispered to us, "My mother is not responding to any of us, which is not normal. I don't know what I can do."

Youdon looked better than this morning but she did not seem to be interested in talking to us. Before Dr. Gyaltzen approached her, I sat by the corner of Youdon's bed and told her that a senior doctor has come to see her. She gave me a quick gaze and managed a smile. Dr. Gyaltzen took her hand, gave a gentle rub on both her hands, and said, "Ama la (mother in Tibetan), let me see how you are doing." He took time to read her pulse, palpated her abdomen and legs. I checked Youdon's blood pressure and saw it was on the higher side despite her regular medication. "It reads: 190/110." I said, "Youdon has developed swelling in her legs, and Pema said the swelling had gotten worse, too."

Dr. Gyaltzen said these developments could be due to her heart condition. He looked at Youdon and gently told her, "Are you worried about something. It feels like your *rlung*<sup>42</sup> (pronounced *loong*) energy has increased, and it is not good for you." Youdon did not say anything but moved her head to acknowledge what the doctor said.

"You have to be careful what you eat, otherwise, you are doing well. Your heart pulse is weak though," said Dr. Gyaltzen. "I am sure it must be difficult for you but is there any particular thing you are worried about, anything that bothers you?"

Youdon raised her left hand with a little struggle, pointing toward the direction where Pema and others were, and for the first time since I saw her, tried to say something. Her voice was not clear but understandable, "I feel bad for my children and their family; and my youngest child, who is a monk, keeps on worrying about me even though he is busy with his work."

"If you keep on worrying about them, and feeling bad for your situation, it will only make things more difficult for them," related Dr. Gyaltzen. "You have a wonderful family and

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<sup>42</sup> *rlung* is one of the three principal energies in the Tibetan medical understanding of psychophysical body. *rlung* is responsible for neurological function at gross level; and is considered indivisible from mind at the subtlest level.

they all love and care about you, so you should not feel bad about anything. And moreover, your son would be less worried if you are happy.”

Youdon did not say much for the rest of the time we were there but she certainly looked a lot less withdrawn and troubled. Dr. Gyaltzen told Pema that it is better not to prescribe any additional medicines; rather continue to be careful with her diet. Youdon smiled, this time more naturally, and seemed calm when we left her.

I visited Youdon almost every day. She warmed up to me as I saw her more often. One morning, I caught her clenching her jaw. I asked her if she was having any pain or discomfort. She gave me a sign, saying no, and then, as if to distract herself from whatever she must have been experiencing, she began saying her Tibetan ‘*mani*’ mantra while counting beads. Her breathing had become more laborious; she started to grasp for breath even by moving on the bed. Despite rapid physical deterioration, Youdon was responsive to everyone and she seemed more resilient.



Figure 8: Dr. Gyaltzen seeing patient in his clinic in Mundgod.



During my visits, I often saw a monk, sitting on a chair right next to Youdon, reciting prayers from a text. There were times when we would discuss Youdon's condition as he took breaks from reciting. The monk told me Youdon had started to do much better and was calmer since the senior Tibetan doctor came to see her. I later learned that the monk is a rinpoche<sup>43</sup> and is a good friend of her son.

Two days before Youdon died, her pulse was weak, and she started to hallucinate. Pema told me that earlier her mother was acting like her son was present and talking to him. I suggested she called her brother who lives in another city. That evening Youdon died, I saw rinpoche reciting prayers, and in between, gently telling her to stay focused and not to worry about anything. They had put up the Dalai Lama portrait on the wall opposite to Youdon's bed. She died that evening, seemingly calm and attentive, listening to the prayers.

I interviewed Pema and Dorjee months after Youdon died. Both of them said Youdon's death had a huge impact on their lives in terms of the way they look at life and think about death. Pema said they are devoting more time to spiritual practice. Dorjee, scratching his head (which many Tibetans do when they are a little shy to say something) said, "I feel like I have done lots of sinful things, so I am doing lots of sin purification (*sdig bshags*) practices these days." Talking about her late mother, Pema said, "I felt a deep sense of compassion (*snying rje*) for my mother when she was dying. But I was so happy during the last few days of her life because there is nothing more special than seeing your loved one die with a smile."

Youdon's case illustrates how Dr. Gyaltsen navigated his way in reaching out to Youdon and her family members by taking care of Youdon's immediate problem of indigestion while helping Youdon to be positive about whatever time she has. Dr. Gyaltsen employed the

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<sup>43</sup> Rinpoche (which in Tibetan literally means 'precious one') is an honorific term used in Tibetan Buddhist tradition for a reincarnate lama or highly respected religious teacher.

(symbiotic) mind-body conceptual model in caring for Youdon's physical and mental state, which helped to infuse a sense of hope and purpose.

## **CONCLUSION**

Although there is consensus among scholars about the intimate relationship between Tibetan medicine and Buddhism (mainly philosophy and psychology), it is in the care for dying where this intersection is acutely observed. From the epistemology and ontology of the human body to explanatory models of disease ideology to maintenance of health to eventual disintegration of body and transmigration to the next life, it provides Tibetan doctors a unique cultural lens in both conceptual and practical paradigms of end-of-life care in Tibetan medical practice.

I started this work seeking to answer two key questions relating to the role of Tibetan doctors in caring for dying patients: how does end-of-life care in Tibetan medical practice necessitate the integration of medicine and Buddhist philosophy and psychology? And, how does the indivisible integration of medicine and religion stimulate a paradigm shift in caring for dying patients and their family members? It is clear that it is not only Tibetan medical practice that necessitates the integration of medicine and spirituality. Recent work (Warraich 2017; Neumann 2016; Bishop 2014; Gawande 2014; Butler 2013; Smith & Himmel 2013; Cadge 2012; Kaufman 2005; Lavi 2005) demonstrates evidence that end-of-life care in other cultures requires the spiritual component. Mainstream care lacking such integration not only needs remodeling, but a full paradigm shift.

We need a paradigm shift that helps us to rethink and redesign how we take care of dying people. It is important to be aware that how we die is something we can affect. In the current

healthcare setting across North America and Europe where most dying patients hope within those bright-lit room, ongoing beeping machine, and strong iodoform smell room is numbness despite getting their senses assaulted, a shift in perspective about end-of-life care is long overdue.

## CHAPTER 4

### PERSONALIZED CARE FOR DYING PATIENTS

*I am in a profession that has succeeded because of its ability to fix. If your problem is fixable, we know just what to do. But if it's not? The fact that we have no adequate answers to this question is troubling, and has caused callousness, inhumanity, and extraordinary suffering.*

– Atul Gawande, 2014: 8-9.

#### INTRODUCTION

One of the things physicians are concerned about while caring for terminal patients is how to initiate a “hard talk” in order to build a trusting relationship with patients and family members. For instance, the work of Glaser and Strauss (1965) and Gawande (2014) focused on care for dying patients in American hospitals indicates that the interaction between healthcare professionals and terminal patients has changed little during the last five decades. In a cultural practice where doctors are both trained and are expected to cure patients and to help them lead long and healthy lives, it becomes complicated, and often difficult, when they have to confess their own helplessness and inability to assist patients in dying well. It is equally hard to begin a conversation with a patient’s family members on the limitations of a treatment and provide them with honest feedback to make informed decisions.

Atul Gawande, a surgeon and public health leader, recounts an experience with one of his terminal cancer patients, and openly shared his own failure in being candid with the poor prognosis to the patient. He describes how it led to a situation where both the patient and her family were unprepared when the time of death a (2014:172). Such quandaries related to lack of open conversation and preparedness at the time of death have led the healthcare sector, especially in the West, to lean toward the philosophy of “prolonging life at any cost” with detrimental impacts to patients as well as families (Neumann 2016:55; Butler 2013:83).

### **My Dying Friend and His Family: Lost and Confused**

In the spring of 2015, a year before I went to India to conduct my field research, a close Tibetan friend of mine developed severe lung complications due to chronic emphysema. It was a sunny spring morning in San Francisco, and many were out engaged in various outdoor activities enjoying the beautiful weather. My friend, along with his wife and aunt, were in a small room on the fourteenth floor of a huge semi-nursing, semi-hospice facility. My friend was on a ventilator that inserted through an opening to his throat, a procedure called a tracheostomy. He looked utterly pale and wasted; and his half-closed eyes were listless. Every now and then, he would gasp for breath so hard that the side railing of his bed would vibrate.

During the two weeks prior, he had been shuttled between a nursing home and a hospital three times as a result of various complications. Each time he came back from the hospital, he grew weaker, his breathing more laborious, and the number of times they had to perform a suction of his lungs in order to drain mucus and secretions became only more frequent. When I asked my friend's wife if she had thought of changing her husband's treatment, she seemed a little lost and said, "We are not sure what to do. The attending physician told us that, if we want, we can bring him to the hospital in case of any emergency. We are trying to support him by doing whatever we can."

I encouraged her to discuss her husband's treatment with the physician and to be more active in deciding what was best for her husband. It was a difficult situation because I could see that it was hard for any of the family members to question the medical authorities as to whether what the physicians were doing was helpful for the patient. Before I left, I told both my friend's wife and aunt to take time to reevaluate his situation and see what is best for him. Later that

night, the aunt called me and said they had decided to take off the ventilator. “I cannot see him suffer any more,” she said.

It is evident that, most of the time, family members have a hard time strategizing care for a dying relative, let alone making a decision to “pull the plug.” The doctor’s ability to be intellectually nimble in identifying a patient’s quality of physical existence, to engage in open and honest conversation with patients and families, and to provide them with all possible options is crucial in avoiding unnecessary suffering for everyone involved. Unfortunately, these key components are lacking as doctors in the United States seem unprepared to assist dying patients (Gawande 2014: 3); and dying patients getting trapped in a “gray zone” where they transit back and forth between nursing homes and intensive care units until they die often with tremendous pain and suffering (Kaufman 2005:1).

### **Trust and Openness**

During my fieldwork, I noticed a pattern, both as observer and caregiver, where the interaction between Tibetan doctors and terminal patients and their families involved significant trust and openness. A number of my informants (mostly family members) told me that the advice they received from Tibetan doctors helped them in understanding their relative’s illness and the likelihood of an impending death, enabling them to be better prepared for when the time came. This quality of interaction between doctors and terminal patients and their families is an anomaly in contemporary Western medical practice (cf. Neumann 2016).

Barney Glaser and Anselm Strauss (1965), in their influential work on how Americans die in hospitals, underscores the significance of the interactions between hospital staff and patients with regard to an “awareness of dying.” They theorize four different types of awareness—closed awareness, suspicion awareness, pretense awareness, and open awareness—

that influence the way patients interact with medical staff and relatives, and the way patients die in hospitals. Glaser and Strauss note that while open awareness is advantageous in comparison to other forms of awareness, patients are rarely consulted by medical staff about their preferable “time and mode of death.” As a result, a patient who is aware of the terminality of his condition might still erroneously believe that “death is still some months away” (Glaser & Strauss 1965: 79).

One of the significant questions raised in this chapter is: how Tibetan doctors are able to interact with a terminal patient and family in a manner that facilitates a conversation conducive for the patient and family to make appropriate decisions and prepare for an impending death?

If we go through the literature pertaining to end-of-life care in North America, it is evident that a medical practice solely based on a “good idea,” hospice care, for example, would be hard to implement if a cultural structure does not support it. In their book, *Changing the Way we Die* (2013), Fran Smith and Sheila Himmel contend that the reliance on technology to go “until the final breath” and a “collective resistance to accepting death as inevitable and to seriously planning for it” has been a big challenge to the practice of hospice care in America (xvi).<sup>44</sup> Medical culture in the West is focused on curing and “treatment, however futile, is defaulted” (Neumann 2016:55). Likewise, insurance companies incentivize physicians to provide ineffective treatments instead of developing critical conversations about death with terminal patients and the necessary preparations by the aspects of care their policies cover. Katy Butler shows in her observation of how Americans are dying in the ICU that for a dying person, there is no one there to “offer advice, and they are left to die alone without much support (Butler 2013:85).

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<sup>44</sup> See Barrett (2011) and Fisher et al. (2008) arguments about multiple forces that resist hospice care.

In contrast, my ethnographic work demonstrates how a specific paradigm in Tibetan culture helps those in the community to foster care for dying patients and that facilitates an open and honest dialogue at these critical times. While caring for terminally ill patients, I saw Tibetan doctors explicitly and implicitly integrate key Buddhist philosophical and psychological concepts with their medical understanding of the body. Upon deeper examination, I realized that Tibetan doctors employ a methodology that requires minute observations of patients in order to glean information to make a prognosis, prescribe interventions, and initiate conversations with the patient and family.

I remember one Tibetan doctor telling me that caring for a dying patient is like taking care of an infant: “You need to be acutely careful and observant because their bodies change rapidly, and anything could happen at any given moment. And more importantly, everyone is very different in their physical and mental disposition, so doctors need to be even more attentive in order to provide care that is fitting for each dying patient.”

Tibetan doctors whom I observed and spoke to accentuate the importance of understanding the ‘idiosyncratic’ nature of terminal patients they care for at the time of dying. They would tell me that such an astute and fine-grained analysis is key to identifying the dying person’s physical and mental disposition in order to offer optimum care and support to the patient as well as the family. Consequently, a key question is why personalized care is important to Tibetan doctors: How do they employ such care with dying patients? Likewise, this chapter explores how Tibetan doctors operationalize their emphasis on a patient’s psycho-physical propensities informed by Tibetan medical concepts in line with their understanding of the Tibetan Buddhist cultural worldview.



Using personalized care as a conceptual model, I discuss how the human body is conceived in Tibetan Buddhist culture and how such a conception of the body is integrated in their care for dying patients. Building upon this, I show how the understanding of the body is based on both the teachings of Tibetan tantric Buddhism regarding the coarse and subtle psychophysical body; as well as the Tibetan analysis of the seven constitutional natures (*rang bzhin*). I show that these two accounts of understanding the body render cues that aid Tibetan doctors in interacting with terminal patients as well as prescribing certain interventions for patients and families. To acquire a better sense of these distinctions, I explicate some of the key theories that underpin the nuanced classification of the psychophysical human body. Likewise, I explain what other signs are used by doctors, besides characteristics based on a person's constitutional nature, in making diagnoses and prognoses of terminal patients. Further, I present some of the common Tibetan medicines that are prescribed to terminal patients during the stage leading up to their death transition.

## **KARMIC AND GENETIC PREDISPOSITION**

*The causes of birth and death are the same.* – Geshe Yeshe Lhundup

In the summer of 2017, I made a trip to Dharamsala in north India to shadow and interview Dr. Tamdin, visiting physician to the Dalai Lama. On the way, I made a trip to Dehradun, 257 miles south-east of Dharamsala to meet with Dr. Sonam Lhamo. Dr. Lhamo is the head of the MTK Branch Clinic in the Tibetan refugee settlement of Dekyiling, eight miles from Dehradun. She is one of the most senior female Tibetan doctors who has been practicing Tibetan medicine for more than 40 years at various MTK Branch clinics. She is in her mid-sixties and is

known among her patients as exceptionally kind and caring. Dr. Lhamo was also one of the senior doctors with whom I did my internship when she was a resident doctor at the MTK New Delhi Branch clinic. It was a wonderful feeling to see one of my mentors again after almost two decades.

Dr. Lhamo asked me to come during their afternoon tea break to avoid a morning patient rush but there were still dozens of patients sitting in the waiting room waiting for her when I arrived at the clinic. I waited outside her consultation room until I saw a clinic staff member going around with a thermos to serve tea. Considering our narrow time constraints, I took the opportunity to initiate asking Dr. Lhamo about her experiences in caring for dying patients. She emphasized to me that this was an important topic. She told me that she found it helpful to consider age when assisting dying patients even though most of the patients she assists in dying are elderly patients. “When someone is dying,” she added, “that person’s sensory faculties get sensitive before all their senses gradually shut down. Elderly people dying due to age or chronic health conditions display similar characteristics of *rlung* (pronounced *Loong*) energy.” (I will explain the concept of the three primary energies in greater detail later in this chapter). She further said,

I usually tell family members and others to keep their voices low and have a dimmed ambience so as not to overwhelm the dying person’s heightened *rlung* energy. In the Tibetan medical text, it is said that a person’s psychophysical characteristics related to each energy [*rlung*, *mkhris pa*, and *bad kan*] become more pronounced throughout the life cycle. For instance, children are more *bad kan* in their nature, adult have more *mkhris pa*, and elderly people more *rlung*; and at each stage of life, they would be more susceptible to disorders related to each of the respective prominent energies. This also

makes sense to think about when someone finally dies, the person's *rlung* energy would be the last to leave at the subtlest level, and when the person reincarnates, it [again] begins with a subtle *rlung*. This subtle *rlung* develops into coarser *rlung*, then to *bad kan*, *mkhris pa*, and again to *rlung*.<sup>45</sup>

For the purpose of this chapter, what Dr. Lhamo said was interesting for two reasons. First, it unfolded a step toward the role played by the individual's characteristics in the way Tibetan doctors provide care to dying patients, which I will discuss in length in this chapter. Second, the cyclical role of three primary energies connect well with the ontology of birth and rebirth in Tibetan Buddhist culture. This analysis gives insight to the reason "death" plays an important role in the Tibetan cultural worldview, for it provides a bridge between birth and rebirth, until a person is liberated from the cyclic existence of birth, death, and rebirth itself.

For Tibetan Buddhist monks and doctors alike, birth and rebirth are seen as a fruition of the same cause. Geshe Yeshe Lhundup, who is a well-respected teacher at Drepung Monastic University, responded to my question about reincarnation by saying, "The causes of birth and death are the same, and therefore [also are that of] rebirth." Comprehending the mechanism of causal factors of human life and death, according to Geshe Lhundup, is crucial in the way an individual understands oneself and his or her relationship to others and the environment. "Our body is not simply a product of the sexual intercourse that happens between our parents or the coming together of the ovum and sperm [*khams dkar dmar*]," he related. "There is a variety of factors that have to interact and collaborate in order to conceive a child; specifically, the most important aspect here is the extremely subtle consciousness. This subtle consciousness acts as a marker in infusing life when it enters the womb and the cessation of life when it leaves the

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<sup>45</sup> The stanzas of the *Four Tantras* to which she refers is: ཀླུ་པ་རྒྱུད་མེད་མ་མཁྲིས་པའི་མི། བྱིས་པ་བད་ཀན་མི་ཡིན་ན་མོས་གཉན། (Gonpo 1984, *The Root Tantra*, (*rtsa rgyud*), Ch.3: 24)

disintegrated body.” Geshe Lhundup’s explication about birth and death speaks to the core Buddhist concept of interdependent origination, as well as to my brief dialogue with a biologist about human embryology that I shared in the previous chapter.

### **Conception of the Human Body**

In the Tibetan medical classic, the *Four Tantras (rGyud bzhi)*, the cause of conception is explicated using a metaphor of “producing fire by rubbing two sticks of wood.” According to the text, in order for conception to occur, there has to be a convergence of several conditions: healthy sperm and ovum along with a subtle consciousness propelled by the karmic force of afflictive emotions (specifically, an attachment to the parents), supported by the presence of the five sources or elements (*’byung ba lnga*) (Gonpo 1984: 32). We could apply the above metaphor here by observing that the two pieces of wood alone cannot generate fire. In addition, someone has to have an *intention* to make the fire and thus, wield them in such a way to cause the friction to produce fire.

This epistemology of life and death, based on a paradigm in which a person’s consciousness, propelled by karmic force, plays a critical role in animating or de-animating the biological components of the human body, offers a novel model for viewing death and caring for dying patients.<sup>46</sup> The aforementioned paradigm facilitates Tibetan doctors and Buddhist practitioners to engage with death and dying from a perspective that see death as a phenomenon that forms a medium for rebirth to occur, rather than merely shutting down the physical body. Further, it permits Buddhist monks and Tibetan doctors alike to view the psychophysical body of a dying person on coarse, subtle, and extremely subtle levels, and to employ their understandings

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<sup>46</sup> See Compendium Compilation Committee (2018) for similar work in English literature. This volume is one of a four-volume series on bringing together classical Buddhist scientific and philosophical investigation on the nature of reality that is accessible to the contemporary reader. The series was conceived by the Dalai Lama and developed by group of authoritative scholars in the field of Buddhist philosophy and psychology.

in caring for the patient, especially, when a dying person's psychophysical body changes from coarse to subtle at the time of dying.

To expound on the three different levels of psychophysical body in Tibetan culture as laid out in the highest tantra texts: (1) the coarse psychophysical body is based on the body composed of flesh and bones, and five sensory organs; (2) the subtle psychophysical body refers to the channels, *rlung*/winds, dream-state and the intermediate-state body; and (3) the extremely subtle psychophysical body refers to the extremely subtle *rlung* that becomes a medium of the mind during the last four extremely subtle stages of dying (discussed in Chapter 1), which ultimately leads to the clear light mind (*'chi ba'i 'od gsel*) (Compendium Compilation Committee 2018: 381).

Although it was mostly senior doctors who had an understanding of the three different levels of the psychophysical body, particularly at the subtle level as applied in their practice, they certainly employed the concept of individual constitutional natures in caring for their dying patients. In fact, recognizing an individual's constitutional nature is considered critical in designing preventive as well as curative interventions in Tibetan medicine, and could even be used productively by an individual as self-care (Cameron et al. 2012). This concept of looking at the "individual constitution" in determining a person's physical and psychological propensities is based on the psychophysical body at the coarse level.

### **ADDRESSING A DYING PATIENT'S CONSTITUTIONAL NATURE**

For Tibetan doctors, identifying a patient's constitutional nature is critical because, as Dr. Rabten stated, doing so equips them to help patients in the optimum manner. For instance, it presents an effective mode to talk to a patient and to design a specific diet, lifestyle, and

treatment regimen.<sup>47</sup> According to Tibetan medicine, each individual is born with a unique combination of psychophysical components that contribute to a distinct individual constitutional nature. There are seven difference constitutional natures based on the three *nyéspa*, which I will translate here as the three primary energies.

The three primary energies are enumerated as: *rlung*, *mkhris pa*, and *bad kan*. Each of these energies assists and maintains the physical and mental functions of the body. *rLung* is responsible for all movement in the body, including all the coordination between the brain and the rest of the body as well as respiration, bowel movements, menstruation, development and delivery of the fetus, and sharpening of the sensory faculties. It acts as a medium between mind and body. *Mkhris pa* (pronounced *tripa*) is mainly responsible for the digestive system, stimulating bodily heat. It provides courage and determination. *Bad kan* provides firmness and stability to body and mind, connects bodily joints, induces sleep, lubricates the body, and facilitates tolerance (Gonpo 1984).

Interestingly, the use of the term *nyes pa*, on the surface, has an element of self-contradiction because *nyéspa* in Tibetan literally means “fault” while these energies are understood to perform and maintain vital functions of the body. However, it makes sense when viewed from the philosophical perspective that the three *nyes pa* or energies are based on the human afflictive emotions of attachment, anger, and delusion; and that at the moment these emotions are stimulated, these energies could potentially mal-function. Likewise, the use of term “energy” as a translation for *nyes pa* warrants an explanation here. Until recently, *nyes pa* was translated as “humor” (Clifford 1984), similar to Greek medicine, but in recent scholarship,

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<sup>47</sup> See the collaborative study (Cameron et al. 2012) that the co-author co-designed and validated, developing two related tools called the Constitutional Self-Assessment Tool and Lifestyle Guidelines Tool based on the Tibetan medical concept of “constitutional nature” (*rang bzhin*) as informative personalized approaches for the prevention of illness and maintenance of health.

terms such as three principle or primary energies (Cameron et al. 2012; Tsona and Dakpa 2009), and three functional energy systems (Tidwell 2017) were used. The word “energy,” I think, is more commonly used because it is derived from Tibetan word “*nus pa*,” which means a capacity, power, or an energy to perform certain functions. In that sense, the word energy has no correlation with the way it has been used lavishly recently in the world of numerous healing modalities.

### **Individual Constitutional Nature and its Role in Health and Illness**

The association between illness and (individual) personality in contemporary science has only recently been explored (Capitano 2008). It was only the development of the field of psychosomatic medicine that expounded the notion that personality is significant in causing physical disease (Fava 2016; Chaturvedi & Parameshwaran 2015; Taylor et al. 1991; Lipowski 1986). Researchers like John Capitanio suggested that the link between personality and disease is far more complex than we think, and hence has to be studied with a sense of creativity and imagination. More recently, clinicians and researchers have highlighted the significance of tailoring medical intervention that fits an individual’s genetic make-up.

For example, Eran Segal and Eran Elinav at the Weizmann Institute of Science, in their much-celebrated large-scale study to answer the unresolved relationship of humans with their diet explored its mystery (2017). They specifically ask why, despite overwhelming research evidence that diet and lifestyle are major drivers of chronic illnesses, we are not able to find a “best diet” for humans. They proposed that maybe we are asking the wrong question because such a question places too much focus on the food, and not on the person who is eating it. In their book, *The Personalized diet: The Pioneering Program to Lose Weight and Prevent Disease* (2017), they further ask what if differences in our genetics, lifestyle, and our gut bacteria causes

us to respond differently to food; what if these differences explain why some diets work for some people, but not for others? And what if our nutrition needs to be personally tailored to our unique make-up. They further contended, “It is possible that many of the foods you thought were healthy aren’t good for you—not the general “you,” but you *personally*” (3).

The Tibetan medical concept of an individual’s (inherent) constitutional nature and its role in playing with either strengths or weaknesses of a person speaks to current discourse in refining patient care.<sup>48</sup>

### **Seven Constitutional Natures**

The seven constitutional natures, according to Tibetan medicine, are three-solitary natures of each energy, viz., *rlung*, *mkhris pa*, and *bad kan*; three-dual-combined natures, viz., *rlung-mkhris pa*, *mkhris pa-bad kan*, and *bad kan-rlung*; and one with equal proportion of all three energies, viz., *rlung-mkhris pa-bad kan* (Gonpo 1984).

Individuals with one of the seven constitutional natures inherits idiosyncratic characteristics that propel them to exhibit specific physical and mental behaviors. For example, a *rlung*-natured person would be intuitive, imaginative, and mentally sharp yet would have a propensity to be restless, nervous, and susceptible to neurological issues. A *mkhris pa*-natured person would be ambitious, interactive, determined, and a go-getter yet impatient, aggressive, and anxious. And a *bad kan*-natured individual would be calm, patient, resilient yet depressive, introverted, and withdrawn. Recognizing these features in terminal patients provides an additional tool for Tibetan doctors in the form of strategizing treatment and dietary advice when they care for the dying. Moreover, in addition to employing constitutional natures in strategizing

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<sup>48</sup> See di Sarsina et al. (2011) paper on the exploration of Tibetan medicine’s potential contribution in the field of personalized and preventive medicine.



specific medical interventions, Tibetan doctors integrate this perspective into making diagnoses and interacting with patients.

### **Identifying Physical and Mental States of a Dying Person**

When I asked Tibetan doctors how they care for dying patients, one common theme is the importance of determining a dying patient's constitutional nature or personality. They would say that being able to recognize a dying patient's characteristics and his or her propensity for certain behaviors makes things lot easier for everyone – the patient, family members, and for doctors themselves. Dr. Tamdin, for example, elucidated the importance of “personalized care” when I asked him to elaborate by saying,

As I mentioned earlier, a person would have a lot of worries and fears when dying, so it is very important to help a patient support their mental state. We do this generally by helping a dying person to develop or increase their mental courage, to think beyond the present moment of fear, worry, or pain, and encourage them to cultivate hope and a sense of purpose for the sake of everyone, including themselves. Now it is important to know that a person's nature encompasses both physical and mental aspects of the individual; and when the [physical] body is degenerating, it is the mind [consciousness] that becomes very pronounced. So, keeping a close attention on the individual's nature is beneficial in getting a sense of how best to help the patient in stabilizing the [vulnerable] mind as well as addressing any physical discomfort. For example, a person with a *mkhris pa* nature, due to their underlying heat, mentally tend to be a little more aggressive, impatient, easily frustrated; and physically more prone to infection, intense pain, itchiness, and so forth. Some time ago, when I attended an advanced prostate cancer patient, I realized he had

excess *mkhris pa*, so it helped me to assist him accordingly in advising him to follow diet and take medicines that could help calm his *mkhris pa*.

Dr. Rabten has a similar view about how physician can become conscientious about a patient's nature. However, he pointed out that the relationship between an individual's constitutional nature and illness could be effectively employed by patients too. He said, "Besides Tibetan doctors and other caregivers who assist terminal patients, patients themselves can apply their understanding of their natures in dealing with their physical and mental difficulties, as well as to prepare for their death."

Studies have reported that self-introspection can help individuals to lead a healthier and happier life, as well as be better prepared at the time of dying (Bauer-Wu 2011, 2007; Ozawa-de Silva 2006; Kubler-Ross 1969). Based on the phenomenological analysis of our study validating the content of *Constitutional Self-Assessment Tool* to identify one's nature, the study participants reported positive experiences, such as: "It made me really think about myself and how I am, and how I think, and how I behave;" "Knowledge of my constitution can help me live a more balanced life, from eating, to sleeping to moving, to states of mind" (Cameron et al. 2012: 162).

Dr. Rabten stressed the benefit of applying individuals' nature in care for dying by stating,

For example, a patient with *mkhris pa* nature and illness associated with organs like liver, small intestine, could present physical symptoms such as fever, rashes, itchiness, irritation in eyes, and mentally could be irritable, angry, agitated. If we can help [dying] patients with interventions, such as dietary advice, herbal medicines or therapy, based on a deeper understanding of a patient's nature and its related characteristics, she would experience less mental as well as physical suffering and anxiety, and could die with ease, peacefully.

## Understanding Karma Beyond Illness

Let me present a case that exemplifies the need and benefit of the holistic approach that Tibetan doctors employ while caring for dying patients. Karma was diagnosed with advanced liver cancer, but this was not his first bout with health complications. Though apparently young at age 40 for such health challenges, he was diagnosed with liver cirrhosis in 2014.

“Alcohol has consumed him,” Karma’s mother told me when I went to see him at his home. I had seen Karma’s mother a couple times before to help her with her lower back and knee pain. She came to see me at the monastery hospital where I volunteered. She is a lively and cheerful woman, in her early-seventies. But I had never met her son, Karma.

It was around noon in early February when I got a call from the head of the settlement camp asking if I could come see a patient who had been quite ill for several days. I leaped on my motorbike and rode through the heart of Drepung monastery, my base in the field. February is one of the hottest months in that region, and that day was exceptionally hot. As I rode in the scorching sun, the street was deserted except for a few street vendors selling fresh coconut water and several stray dogs sprawled out laying in the shade. An elderly man, who happened to be Karma’s uncle, was waiting for me by the side of the road. After a quick greeting, he ushered me into the house.

The room was noisy with loud sounds coming from a television set. Karma was lying in bed on his back and was engrossed, channel surfing on the television. It was a small room and his bed was right next to the television. There was a table under the television with half-eaten food and a big Coke bottle filled with water. I sat down on a chair next to his bed. Karma gave me a quick glance and then returned his attention back to the remote. His uncle came in to make a more formal introduction, “He is a doctor and he is here to help you.”

“When did you eat lunch?” I asked before moving on to any questions about his health. His uncle shouted from the corner saying he has not eaten much lately. Karma reluctantly managed a smile, perhaps feeling a little uncomfortable with my presence, I suspected. Trying to ease him, I asked him about his mother’s health. Karma showed comfort in talking about his mother, “She has been sitting in her room all the time even though I tell her she should take a walk to the nearby temple,” he said.

His nephew who had been taking care of him had just entered the room a few minutes prior, so he joined our conversation and reminded Karma that his mother had started to go for a short walk now that she started to take Tibetan medicine. Sensing the change in the environment, I requested that we turn down the volume of the television. This time, Karma smiled and said, “I can turn it off.” Now that we all seemed to get more comfortable to some extent, I quickly surveyed his physical condition before verbally checking in on his health issues. Karma looked severely jaundiced and weak — his eyes were sunken and yellowish; he looked pale and lethargic; and his lips were dried with cuts around the corners of his mouth. Karma’s past medical record showed that despite being diagnosed with pre-cirrhosis in 2014, he had not been regular with his treatment. And to make it worse, he had ongoing issues with chronic alcoholic abuse.

In the process of touching and feeling his abdomen for any sense of tenderness and swelling, I noticed a big darkish-red bruise that stretched from the right lower side of his ribcage towards his inner armpit. When I asked about the bruise, Karma’s nephew told me it just showed up two to three days prior without any cause. I instantly told myself this is not a good sign — it looks like internal bleeding and, with his history of cirrhosis and habitual alcohol consumption, I thought there is no way we can keep him here like this. I quickly called a friend of mine who is

biomedical practitioner at a local monastery hospital and asked if he could check on him since they have the necessary facilities at the hospital. Later that afternoon, my doctor friend called and told me they had to transfer him to a bigger hospital in order to control the internal bleeding and support the failing organs.

Two days after Karma was taken to a hospital in the nearby city, I received a call from his uncle asking if I could accompany them to see Karma and assess his situation. Karma's sister, who had come into town since his condition deteriorated, was at the hospital with other family members, but it was hard for them to interact with the hospital doctors. I immediately agreed to go. I had been wondering how Karma was doing. The Indian hospital is close to a two-hour drive from the settlement, and on our way to the hospital, I realized they wanted to know whether having Karma in the intensive care unit was a good decision.

I got a better sense of what was going on at the hospital when we arrived and met Karma's sister, younger brother, and another relative. I learned that they could see Karma only twice a day for 30-minutes each, and that each visit was restricted to a single member of the family. As I heard more from the sister, it was apparent that Karma's time in the ICU was tormenting for himself as well as his family members – Karma had not felt any better in terms of his physical symptoms; and mentally, he seemed terribly distressed and repeatedly told his brother to take him back home.

I asked for the doctor in charge of Karma's case in order to get a better sense of their treatment plan. The doctors and the hospital staff were cooperative and took time to talk to me. When I asked to see him even though it was not regular visitation time, the doctor made an exception and even came along to talk to Karma. The door to the ICU was flocked with people who were waiting to see their relatives. Inside the ICU, there was a nurse station in the middle,

surrounded by 10 to 12 small sections of open rooms with patients hooked up to multiple tubes and ventilators. The deep simulated breathing of patients forced by ventilators in the ICU formed a coordinated noise that sounded like a band of laborers working hard in synchrony.

Karma looked much weaker than the last time I had seen him. He was breathing hard; his eyes were closed as if in pain or trying to avoid the bright fluorescent lights. At times, he looked like he was drifting in and out of consciousness. The attending doctor called Karma's name and when he did not respond, the doctor forcefully rubbed his forehead and sternum, and all of a sudden, Karma woke up, a bit startled. The doctor yelled at him, saying, "Karma, see, your Tibetan doctor is here; do you want to talk to him?"

I moved close to his ear, and said, "Karma, it's me. I came to see you two days ago at your home. It might be difficult but try to keep calm, and don't let your mind drift around." He looked at me and murmured something which I could not understand. I tried again, and said, "Your doctors and nurses are taking good care of you here but let me know if you want to go home. You can move your head if you cannot talk." He moved his head to let me know he wanted to leave.

The attending physicians and his colleagues understood Karma's situation and cooperated with Karma's discharge. It was getting dark when we reached the settlement camp. Karma's mother, uncle, and some of his friends were waiting outside the house. Karma came back to life when he got home: he was much more animated, trying to talk to his mother and brother even though he could hardly breathe. But every now and then, he would get agitated, and when he had pain, he shouted and threw his legs around. I called the local Tibetan doctor, Dr. Gyaltsen, and he agreed to come along next morning.

It was around 7:00 am when Dr. Gyaltzen and I went straight into the room where Karma's bed was set up. Other than the oxygen mask and intravenous drip needle, there was no beeping sound or bright light. Karma seemed more at home. His nephew told us Karma did not sleep much the night before and was talking to himself. Dr. Gyaltzen read Karma's pulse and he said something that stuck with me. He said, "It is fine if you are anxious or scared right now but do not be angry with yourself or the people around you. Do your best to be loving and compassionate to them." Karma did not say anything; he laid there, still, and listened to him. Dr. Gyaltzen sat there for few minutes without saying anything. Before Dr. Gyaltzen and I left, I held Karma's hand and told him I would come back later in the evening.

The scene had changed quite drastically when I got back in the evening. Karma's mother was sitting in the front yard. Her eyes were puffy and red. Before I could ask anything, she said Karma was not doing well. There were more people outside Karma's room – some of them were his camp friends, I was told. A stocky young man with a Tibetan mantra tattoo was standing right by the door with his hand stretched to the other end of the door, like a bouncer. He said *chocho* (brother in Tibetan) was breathing fast and we were scared he might die. Karma's breathing had become shallow, but he seemed to have calmed down a bit.

I sat in the room for a while. It was interesting to see people coming in and out. One of his friends came in and told me that Karma had asked for a cigarette earlier; and when he said he did not have any, Karma laughed and said he must be lying. Karma also told his young niece that he had a joke to tell her. As I sat there, I could not help pondering things Karma and his family went through during the last four days. It is in this situation where I felt *effective* communication between health professionals and family is critical to reach out to a dying patient.

Karma died early the next morning at 3:50 am and his nephew kept a note for me thinking it would be helpful information for me:

12:05 am: ...still he continues to talk [slurring]. He sleeps in side-lying position.

12:07 am: He stops talking, breathing heavily.

12:20 am: He talks again with his eyes closed and opens his eyes for a few seconds.

12:48 am: He wakes up and starts [getting] irritated but doesn't last long, only for 5 minutes.

1:24 am: He opens his eyes for 10 minutes during which he told me a story, which I didn't understand much but I think it was a funny one as he was smiling and laughing. I laughed a little bit with him.

1:30 – 1:48 am: He keeps his eyes open, talks to me and asks for a cigarette.

2:07 am: He is still awake, but he is breathing fast.



Figure 9: During Karma's cremation. Monks reciting a Buddhist text for the deceased

Karma's cremation was performed two days after his death. I saw his mother sitting by the side steps of the house, burning some incense in a big round-shaped earthy pot. Tibetans perform this



as a ritual for forty-nine days after someone's death. Nevertheless, when I approached Karma's mother to see how she was doing, she told me she felt good about her son. "He got a chance to come home and be with family. It is sad that he died young, but he died well. And now, with all the rituals performed, I hope he gets a good rebirth."

## **DIAGNOSIS AND MAKING PROGNOSIS**

In addition to incorporating patients' constitutional nature of patients, Tibetan doctors engage in various means to elicit information in assisting terminal patients. Pulse reading and urine analysis are two of the main modes of gleaning potential cues when Tibetan doctors see patients.

In Tibetan medical practice, pulse reading depicts a perfect example of integrated science and art for it requires a comprehensive understanding of the biophysiological aspects of the body, its relationship to mind, and the acute perceptual technique to infer the state of the body via the physician's fingers. There is a general consensus among Tibetan doctors that one cannot become a good Tibetan doctor without being a good pulse-reader. Tibetan doctors devote a great deal of time memorizing the root medical texts and years of rigorous clinical training to understand and embody numerous pulse characteristics and rhythms and their associations with different parts of the body and its psychophysiological functions (Tidwell 2017).

The significance of the craft of the pulse reading is reflected in the way it is introduced to Tibetan medical students. Pulse is considered a "messenger" between the physician and the "illness." Pulse reading is expounded under thirteen general categories: 1) preliminary guidelines on diet and behavior for physician and patient; 2) appropriate time for pulse reading; 3) accurate placement of the physician's fingers; 4) pressure to be applied on the patient's radial artery; 5)

methods of pulse reading; 6) three natures of the pulse in healthy persons; 7) different pulses in relation to the four seasonal changes and the five elements; 8) seven-wonderous pulses in a healthy person; 9) determining healthy and unhealthy persons based on the frequency of the pulse beat; 10) identifying illness via general and specific pulse rhythms; 11) prognosticating the survival of a patient based on the three death pulses; 12) identifying a non-human harmful external influence pulse and pacifying it with related rituals; and 13) examining the lifespan of a person via the *bla* pulse (Gonpo 2015: 7).

Tibetan doctors use six fingers—index, middle, and ring finger of each hand—to read the pulse from the patient’s radial artery at the wrist. Each finger is divided into two parts forming a total of twelve sections, corresponding to twelve vital and vessel organs (heart, lungs, liver, spleen, kidneys; and large intestine, small intestine, gall bladder, stomach, urinary bladder, and reproductive organ, respectively) in the body. Tibetan doctors apply different pressures through different fingers while reading the pulse. For instance, they make sure the index finger is barely touching the skin, the middle finger a little more emphasis to feel the flesh, and the ring finger with enough pressure to almost feel the bone.<sup>49</sup>

Urine analysis, which falls under the mode of observation (*lta*) (two other modes of diagnosis in Tibetan medicine are touching (*reg*) and questioning (*dri*)), is viewed as a mirror that clearly reflects the state of a person’s health. Tibetan doctors use a urine sample to observe certain characteristics, such as color, steam, sediments, bubbles, scum, and transformation of urine in order to make a diagnosis. In order to make the most of urine analysis, Tibetan doctors are expected to gain theoretical and practical knowledge of the following eight components: 1)

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<sup>49</sup> See Tidwell (2017) where she shares her first Tibetan medical consultation with a Tibetan physician in great detail. The Tibetan physician, who later became one of her primary Tibetan medicine teachers and interlocutors during her doctoral research in northern India (109-111).

preliminary requirement for a patient to follow certain diet and behavior the night before the consultation; 2) proper time for examining urine; 3) specific container for urine sample; 4) assess urine formation; 5) healthy person urine; 6) unhealthy person urine; 7) urine signaling an impending death; and 8) urine influenced by a non-human harmful external influence (Gonpo 2015: 33).

I remember the late Dr. Pema Dorjee, a brilliant clinician, sharing his thought about pulse reading during one of the many medical camps we did together when I was working at MTK in India:

In all my years of practice, I had a special relationship with the unique technique of pulse reading. During my first few years of practice, I really felt like I was being tested every time I would try to read someone's pulse. And then, I started to feel a little better after few years, say 5 to 6 years. I would approach pulse reading as a form of meditation where I used the *feel* of the pulse as a point of concentration and its numerous rhythms as a mode of analysis. In my later years of practice, the focus and scrutiny were still there but I no longer felt like I was being tested. I felt like I had embodied what is explained in the text and what I had experienced and learned through the years of reading patients' pulses. It was a wonderful feeling. So, as it is interpreted in the *Four Tantras*, pulse analysis is very much like a messenger between a doctor and an illness where the doctor receives detailed information.

Most of the Tibetan doctors I spoke to told me that pulse reading becomes more important when checking on terminal patients because it is more reliable. I remember one of our late teachers at the MTK Tibetan Medical College, Dr. Lobsang Chophel, who would always warn us to be single-pointedly focused when we read a patient's pulse. He says, "Always be careful to feel

every detail of your patient's pulse from the beginning of your career, rather than thinking about the symptoms your patient is sharing and what medicines to prescribe. If you keep on thinking about symptoms, you will miss a lot of other information, and this might become your habit in the rest of your practicing career."

During my conversation with Dr. Tamdin, he told me that pulse reading is most helpful in determining a patient's condition at the time of death. On the other hand, urine analysis is good in seeing if the patient has any kind of infection. The centrality of pulse reading is documented in other traditional medical systems, such as traditional Chinese and Greek medicine. In Shigehisa Kuriyama's compelling work presenting a comparative analysis of anatomical aesthetics in Chinese and Greek medicine, he presents a dialogue between the second century B.C.E. Chinese physician, Chunyu Yi and Jia Rong, the patient's husband. Chunyu Yi was said to be summoned to feel the pulse of the patient. This interaction, said Kuriyama, was revealed two millennia later in 1763 by the novelist Cao Xueqin.

"Is this the lady?" asked the doctor.

"Yes, this is my wife," Jia Rong replied. "Do sit down! I expect you would like me to describe her symptoms first, before you feel her pulse?"

"If you permit me, no," said the doctor. "I think it would be better if I felt the pulse first and asked you about the development of the illness afterwards. This is the first time I have been to your house, and as I am not a skilled practitioner and have only come here at our friend Mr. Feng's insistence, I think I should feel the pulse and give you my diagnosis first. We can go on to talk about her symptoms and discuss a course of treatment if you are satisfied with the diagnosis. And of course, it will still be up to you to decide whether or not the treatment I prescribe is to be followed."

“You speak with real authority, doctor,” said Jia Rong. “I only wish we had got to hear of you earlier. Feel her pulse, then, and let us know whether she can be cured, so that my parent may be spared further anxiety.” (1999: 19).

## **PULSE AND URINE ANALYSIS IN TERMINAL PATIENTS**

### **A Senior Monk and his Students**

One night, around 11pm in mid-January, just after I returned from a trip away from the monastery, a young monk knocked on my door and asked for help. He told me his teacher was not feeling well. When we arrived at their place, his teacher was sitting on a chair outside his room, holding his stomach tightly. Before I could ask anything, he told me he was experiencing severe pain in his upper abdominal region. After spending time checking his pulse and looking at his health record, I realized he had been diagnosed with stomach cancer four months earlier. He was in his late eighties and had expressed disinterest in going to the hospital in the city. After checking his pulse, I gave him Tibetan medicine with boiled water for his epigastric pain. Fifteen to twenty minutes later, he started to feel better, but still looked weak. Since it was late, I did not inquire much about his health. I promised to come back early the next morning after his student and I got him to his bed. Before I left, I reminded him to keep a sample of his first urine in the morning. I called a local Tibetan doctor when I got back to my place and arranged for us to meet early the next day to see the senior monk.

I met Dr. Kunsang Dorjee the next morning at 7:30 at the monastery and we walked together to the senior monk’s place. Dr. Dorjee is one of the younger Tibetan doctors in the settlement. He has been in Mundgod only for two years but had already made a name for himself as a kind, soft-spoken, extremely sensitive young doctor. Dr. Dorjee and I took turns checking

the patient's urine and reading his pulse. Neither of us were sure if the monk knew about his earlier diagnosis, so we did not say anything about it in the beginning. After checking his pulse, Dr. Dorjee asked the monk if he had been to any hospital to see a biomedical doctor.

“No, I don't feel like going,” replied the senior monk.

“Why, is it too tiring for you to go to a hospital?” asked Dr. Dorjee.

“I did go to see a doctor at the hospital a month before and they made me do so many tests and gave me many medicines. And when I was in Bodhgaya [1,987 km north east of Mundgod] for the Kalachakra teaching from His Holiness [the Dalai Lama], I had so much pain and weakness that I had to come back in the middle of the teaching. Now, I don't want to go to the hospital again,” he added with a light chuckle.

“How is your sleep?”

“My sleep hasn't been good for some time now.”

“It seems like you have a chronic stomach problem; and on top of that, you have a weak heart.”

“I have been experiencing a lot of problems with my breathing even when I climb a few steps lately, and I feel a bit of contraction in my chest all the time. Is that due to my heart?” As they were talking, I saw in his earlier hospital record that he had been diagnosed with congestive heart failure too.

“Yes, it is. It is fine if you don't want to go to a hospital but make sure to spend time to engage in your spiritual practice. You know your stomach problem is chronic enough that any treatment would not have much effect.”

“I say this to him all the time,” he said, looking at his student, “but he does not listen to me. Tell them there is no use for me to go to that big hospital.”

Dr. Dorjee told the senior monk that his *rlung* energy has elevated slightly and that he has written a prescription for some Tibetan medicines that would be good for *rlung* and help him sleep. Dr. Dorjee advised the senior monk to take care of his diet and told him to call him whenever he needs any help.

I met the senior monk once after that morning. Around ten days later, the senior monk's student called me to say his teacher passed away early in the morning. He said his teacher asked him and others not to come in his room, saying he needed to do some prayers earlier that day:

After an hour or so, he called me in and said he wanted to sit outside. Gen la [teacher] was so tired and out of breath while getting out of his bed, so he told me he would just sit on the chair next to the bed. So, he sat there for a few minutes, took a deep breath, and died right there. I am happy for Gen la. I and all others learned so much from our Gen la even at the time of his dying.



Figure 10: a) Dr. Dorjee reading pulse of the dying senior monk; b) Dr. Dorjee examining urine sample; c) one of the deceased monk's main students praying during the cremation.

## DEATH PULSE: SIGNS OF IMMINENT DEATH

Death pulse is a pulse signature that Tibetan doctors associate with signs of impending death. Tibetan doctors classify it under three types: (1) changes in the pulse characteristics, (2) absence of the pulse and (3) a pause in the pulse. Changes in characteristics of the pulse in persons facing imminent death is metaphorically explained using the imagery of a flag flapping in the wind, the tip of a hawk tail, a hungry fish or a jumping frog. Changes or anomalies indicating the imminence of death may include the presentation of a weak pulse in a physically healthy person suffering an acute illness, or a strong overflowing pulse shown by a frail person with chronic debilitating illness. An impending death may be indicated where a person with a cold disorder presents hot pulse characteristics and vice versa; as well as by normal pulse characteristics in a person with a pulmonary infection, meat poisoning and/or chronic indigestion.

### **Relationship between External Sensory and Internal Organs**

If a Tibetan doctor finds the absence of any pulse related to a particular organ missing, they will look at that respective sensory organ. In Tibetan medicine, each (internal) vital organ is related with an (external) sensory organ and doctors often use this relationship in their practice. For example, heart is associated with tongue, lungs with nostril, liver with eyes, spleen with lips, and kidney with ears. Therefore, in the case of the disappearance of a heart pulse, doctors will look at the tongue and if it has turned black and the person's eyes are fixed, it indicates imminent death within a day. Imminent death within two days is indicated if the nostrils are drawn inward with nasal hairs standing up in the absence of a lung pulse; in three days if the eyes are rolled up and eyebrows parted apart in the absence of a liver pulse; in five days if the lips dangle and the xiphoid is curved inward in the absence of a spleen pulse; eight days if the earlobes turn



backward with no humming sound in the ears in the absence of a kidney pulse (Gonpo 1984: 585-586).

And finally, a breakage or halt in the pulse rhythm can be due to illness, impending death and external non-human harmful influences. Absence of a pulse and a halt in the pulse due to illness or these harmful influences can be treated with medical intervention or religious practice, respectively, and are not necessarily signs of imminent death.

## **DEATH URINE**

In line with what Dr. Tamdin said about the utility of urine analysis in critically ill patients, Tibetan doctors usually tend to use a disorder related to hot or cold dimensions and its progression as a fundamental structure in making a prognosis. A hot and cold disorder generally is associated with specific major organs in the body. For instance, the organs related to a hot disorder are liver, gall bladder, small intestine, and pancreas; and those related to a cold disorder are the kidneys, lungs, reproductive organs, and urinary bladder. They discern the distinction between hot and cold disorders by analyzing urine in terms of its smell, steam, color, sediments, and bubble formation.

Tibetan doctors describe death urine as possessing certain characteristics of urine which they associate with indications of impending death. If a urine is blood-stained in color, smells like rotten leather and does not change after due treatment with diet, medicine, and therapies, then it is considered indicative of imminent death due to hot disorder. In addition, in the event of imminent death, the features of urine do not change even after the disappearance of *ku ya* (sediments). On the other hand, bluish color urine without any smell and steam, which fails to

respond to any form of treatment is considered an indication of impending death due to cold disorder.

More specifically, a urine sample resembling putrefied vegetable soup with a distinctive arrangement of the refined and residual portions indicate imminent death due to *rlung* disorder; urine similar to a rotten decoction of *chu rtsa* (Himalayan rhubarb) with distinctive arrangement of refined and residual specifies imminent death due to *mkhris pa* disorder. Urine similar to the separate arrangement of *mtshal* (cinnabar-derived red pigment) mixed in water indicates imminent death due to blood disorders. Urine similar to spoiled milk with a separated pattern specifies imminent death due to *bad kan* disorder; urine similar to ink with a separated pattern indicates imminent death due to poisoning. Excretion of putrid urine, known in Tibetan medicine as *'du ba khong rul* (putrid of internal energy), without any kidney disorder is taken as a clear sign of impending death (Gonpo 1984: 590-591).

## **SIGNS OF DEATH AND DYING**

Signs related to death, as explained in Tibetan medicine, are not only used by Tibetan doctors but also by religious figures, family members of the patient and lay people alike. The consideration of these signs is considered important for they are understood as precursors to death that will assist both the physician and dying person to prepare for death as death draws closer and in determining death when a person dies.

Tibetan doctors generally explain death signs under four sections: distant signs, imminent signs, uncertain signs and certain signs. The *Four Tantras* expounds these signs in great detail. To understand the distant sign, Tibetan doctors are instructed to be observant of the messenger, dream, and sudden changes in the behavior of a patient.

Messenger here refers to a person, who calls on the doctor for a home visit or the contact person between the patient and the doctor. A messenger who has a pleasant nature or a spiritual person such as a monk is a favorable sign for the patient's eventual recovery. On the other hand, a messenger with an unpleasant character or an object (like carrying inauspicious items) indicates a bad prognosis. However, messengers with a pleasant nature may also indicate a bad prognosis if they arrive with great fear, out of breath, carrying a stone or a stick in their hand, calling from a distance, engaging in non-virtuous behaviors on their way, wearing inauspicious ornaments or uttering inauspicious words. It is also considered a bad sign if the messenger happens to arrive at the doctor's place when the doctor is mentally disturbed, uttering inauspicious words or when he is chopping and dismantling something or engaging in the ritual practice of burning the belongings of a deceased person. On the way to a patient's house, it is considered inauspicious or a negative sign if a doctor encounters something being cut into pieces, burnt or broken; or sees someone crying, grieving someone being killed; or if a cat, monkey, otter, or snake crosses their path; or sees anything unpleasant.

In contrast, it is taken as a positive sign of patient's recovery if the doctor sees a container full of grains, curd or any other auspicious items, ritual bells, lighting of butter lamps, blossoming flowers, roasted rice flakes or pastries, someone in a white dress or such ornaments, people engaging in spiritual practice, a blazing fire, horses, sheep or cows with their young ones, or if one comes across pleasant sounds, food, drink and ornaments.

### **Dreams: Interpreting the Third Eye**

Dreams play a pivotal role in Tibetan medicine as well and they are perceived as manifestations from imprints in the inner mind. They are classified into six types, based on what is seen, heard, experienced, articulated in prayer, contemplated and as an indicator of one's

physical and mental disorder. Dreams from the early part of sleep, which tend to be forgotten, have no effect, whereas dreams that appear in the morning and may be clearly recollected are considered to bear result.

Dreaming of riding a cat, monkey, tiger, fox or a corpse indicate that patient is gripped by *Yama*, the Lord of Death. In the same vein, dreaming of riding a buffalo, horse, pig, donkey or camel without any clothes and traveling in the southward direction signifies death. Similar indications that the patient is at the mercy of Yama is if the patient dreams of a willow tree with a bird's nest growing from the crown of his or her head or a thorny tree growing out of one's heart, removing a lotus from one's heart, falling off a cliff, sleeping in a cemetery, being surrounded by crows, going back into the mother's womb, drowning or falling into quicksand, having *chang* (Tibetan beer) with a deceased relative or being dragged by them, wearing a red colored dress or ornaments and dancing with a deceased relative. According to Tibetan medicine, these ominous prognostic dreams are due to the obstruction of the consciousness channel caused by an imbalanced condition of one's physical and mental states, based on the three principle energies of *rlung*, *mkhris pa* and *bad kan*. Recurring experiences in dreams of a sick person is an unfavorable sign but not for someone who is healthy.

On the other hand, dreams of gods, leaders, holy or famous people, an intense fire, a sea, seeing one's body covered in blood and filth, wearing white clothes, raising a religious flag or shelter with auspicious signs, and obtaining fruits may be indicative of longevity, health and prosperity. Positive outcomes are expected in dreams where one climbs a mountain or ascends to the top of a beautiful building or a fruit laden tree; mounts a lion, an elephant, a cow or ox; crosses a wide river or sea and travels toward the north and east; overcomes difficult conditions, defeats one's enemies and is praised and venerated by one's parents and deities.

### **Sudden Behavioral Changes**

In Tibetan medicine, abrupt changes in a person's behavior is taken as a precursor to death in both healthy and sick persons. In the case of a sick person, if a patient starts to dislike the physician, the medicine, a spiritual master, friends or relatives, or unexpectedly becomes more cultured, attractive, joyful, or vice versa, it is considered a distant sign of death. When I asked Tibetan doctors if they have seen such changes and reasons behind such changes, four of them told me they have seen such changes. Dr. Gyaltzen, with whom I spent the most amount of time among Tibetan doctors in the field, told me, "I always let family members know first if I notice any changes, especially if a patient is behaving differently from his usual self without any specific reason. This happens because of sudden changes in their *rang bzhin* (constitutional nature) due to an illness. I talk to a patient depending upon how he or she is feeling."

It is also considered that death becomes inevitable when one continues to lose his or her physical radiance and is depressed all the time, or when the religious offering (*gtor ma*) dedicated to a person is declined when offered to crows. Further, a person might not live too long if the water dries out instantly around the heart region or water does not stay on the chest while taking a bath or shower, or if the finger joints do not produce any cracking sound when pulled. Death becomes certain if there is a continuous deterioration of health despite a good diet, if there are changes in body odor, or there is a sudden appearance or disappearance of lice and nits; sudden changes in a person's perception about virtuous and non-virtuous qualities; and if the person fails to see one's body shadow in the morning sun or image in a mirror, or in still water, or if that body appears without head or limbs.

### **Imminent Signs of Death**

The imminent signs of death are explained under two divisions: imminent and extremely imminent. Imminent signs of death comprise bleeding from the body's nine orifices without any external effects, such as poisoning or weapons; the inability to remember what was just said, retraction of the penis with a dangling of scrotum or vice versa; hearing unusual sounds while coughing or sneezing; losing one's sense of smell; a greasy feeling at the crown of the head; developing a new parting of the hair and eyebrows; the appearance of a curved vein like the shape of the new moon on the forehead or lower abdomen; abrupt instabilities in the five sense organs resulting in false perceptions of their respective objects; retraction of the eyes into their sockets and the loss of pupil luster. Similarly, deformity in sensory organs as we discussed during the death pulse manifestation are perceived as a precursor to imminent death.

In the extremely imminent signs of death, the successive dissolution of the five elements or sources (*'byung ba lnga*)—earth, water, fire, air, space—one after the other, and cessation of the five sensory organs' function can be observed in a dying person. According to Tibetan medicine, when one approaches death either due to aging or disease, the five elements, from which one's body is a formed aggregate, start to break down and gradually decay one after another as the following element becomes more pronounced. The dissolution of the five elements discussed here is the psychophysical body at a coarse level in the Tibetan medical texts. The disintegration of the body at a subtle and an extremely subtle level is explicated in chapter 2.

In the Tibetan medical texts, for the body at a coarse level, there is a successive dissolution of each of our five elements in the following order – earth, water, fire, air, space. As the earth element dissolves and the water element becomes more pronounced, one loses muscle tissue and the sight organs degenerate, resulting in loss of vision which diffuses into sound. When the water element dissolves and the fire element become more pronounced, one

experiences dehydration and loss of hearing as auditory organs diffuse into the sense of smell. When the fire element dissolves and the air element becomes more distinct, one loses body temperature and the sense of smell fades away as it diffuses into the sense of taste; and when the air element dissolves, the space element gets more pronounced, and one starts experiencing difficulty in breathing and gradually ceases to breathe. The sense of taste decreases, and diffuses into the sense of touch, and subsequently, one ceases to experience the sense of touch. We lose consciousness when consciousness leaves the body.

It is interesting to consider if or to what extent the dissolution of elements and the sensory faculties at the coarse level expounded in Tibetan medicine relate to the Western medicine biological death described in Western biomedicine based on the brain and the cardiopulmonary function. During my interaction with Western biomedical doctors and nurses from hospice and palliative care at conferences, I had the pleasure of finding a common ground because they were eager to know more about biomarkers Tibetan doctors would look for in actively dying patients. Such interaction could enable interdisciplinary dialogue among Western doctors and Tibetan doctors to talk about the different stages of dying and how biomedical technology and Tibetan medicine understanding of death could complement each other.

According to Tibetan doctors, one can make a distinction between certain and uncertain signs of death. If any of the signs of death that we discussed earlier disappear once the disorder is treated and pacified, it is regarded as uncertain signs of death. And if the signs of the death do not fade away and person continues to experience them, such signs are then considered as certain. In Tibetan medicine, it is necessary for the physician to have a nuanced understanding of the signs of death.

### **Treatment: Herbs, Precious Pills, Blessed Pills, Talking, Listening, or Nothing**

Shadowing, interacting, and hanging out with Tibetan doctors and Buddhist monks day in and day out during my fieldwork made me realize that treatment for dying patients gets tricky considering the mind as the locus of their interactions with dying patients. Sometimes, paying too much focus on the mind can lead to ignoring the physical aspects of a patient, analogous to biomedicine's conversely singular focus on the physiological vitals. That is where, I think, Tibetan doctors' application of the constitutional nature in prescribing herbal medicines or any other remedy based on the need of a patient compensates for any potential deficiency that might arise in the care of dying patients. However, the remedy is eclectic—ranging from Tibetan medicine made from herbs, minerals, gems, metals, and natural substances to blessed pills or simply talking, listening or even nothing, just sitting with the person, giving company.

Dr. Rabten always gets excited when he talks about the way Tibetan doctors can contribute to assisting dying patients. He displays a sense of healthy competition when we discuss about the role of different collaborators, particularly between doctors and monks, in helping patients.

“Of course, it is key to take care of a dying patient's mental state, but it is equally important for caregivers to know the cause of any kind of mental disturbance the patient is having. Sometimes, medicines or good spiritual advice might not have any effect. So, if we are able to discern whether the patient is [mentally] disturbed either due to anger, fear, or a conflict within their family, we can provide a much more effective intervention. For example, a patient of mine who was almost dying with advanced ovarian cancer was mentally very disturbed. After checking her pulse and talking to her, she confessed to ongoing conflict with her family members even though I realized it was more a grudge



from her side. I told her that the primary treatment should be sorting out the family issues. She did not agree with me initially but after a couple days, she warmed up to the idea and was able to solve the family conflict. She died after two months but her relatives told me she responded better to everything, and her quality of life changed dramatically up till when she died.

There are a few Tibetan doctors who subscribe to prescribing precious pills to dying patients even though it is considered effective for non-terminal cancer or chronic illnesses. Only 34 percent of Tibetan doctors (14 out of 42 doctors I interviewed) showed preference in giving precious pills for dying patients. Some of my interlocuters told me that precious pills have lots of ingredients (50 to 100 different ingredients) and it could be hard for a dying patient whose digestive system is weak. However, some doctors told me they prescribe it because many people see it as Tibetan medicine that has both medicinal and spiritual potency. People believe that besides gems and precious stones, precious pills are consecrated by high lamas, sometimes even by the Dalai Lama.

A large number of Tibetan doctors (and most of my monk informants) told me they regularly offer blessed pills to dying patients. They said it helps patients to be connected with a spiritual teacher like the Dalai Lama or any other teacher they have in their minds. So, in a way, the blessed pills work both as a point of reference for the dying patient's effort to steer their focus away from disturbing thoughts and a corporeal reality to their spiritual anchor as they feel the pill in their mouths.

## **CONCLUSION**

Given that Tibetan doctors see ‘mind’ as the focus of their care while caring for dying patients, any form of remedy, even if non-curative, could have some level of effect. With an overarching focus of providing compassionate care based on culturally infused ‘meaning’ revolving around Buddhist concepts of ‘interdependent nature,’ and ‘emptiness,’ I observed that Tibetan doctors provide a reliable source of support and guidance to dying patients and families.

Compassion in particular, I think, is crucial both for physicians and patients, and plays an important role in the healing process or in helping patients to be calm and resilient. Importantly, I think this brings in a related conversation that the efficacy of the treatment or a patient’s healing is not solely contingent upon pharmacological drugs, but the components, such as belief or a placebo effect play an important role in treatment. We could relay such understanding to the effect of the mind-body connection we see frequently in cultural practice like Tibetan medical practice.<sup>50</sup> The fact that mind and body are always interconnected and interdependent in any situation of health or disease configures the physician/patient relationship along the lines of compassionate care, and mandates that the physician must treat the patient with kindness and empathy (Ozawa-de Silva & Ozawa-de Silva, 2011: 113-114). I propose that a medical practice based on the intimate relationship between mind and body with a strong root in key Buddhist principles and its mechanism of treatment based on recognizing a dying patient’s constitutional nature could be an effective paradigm in caring for dying patients.

At the same time, it is also hard to imagine how often a doctor trained in modern biomedicine would have the professional opportunity to observe someone dying in the natural state. In *The Illness Narratives: Suffering, Healing, and the Human Condition*, while presenting a case study where Doctor Hadley Eliot provides support and observes his patient, Gordon

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<sup>50</sup> See Frank & Frank (1961); Kaptchuk (1998, 2009); and Moerman (2002) for their work on the mechanism of placebo.

Stuart, until he died, Arthur Kleinman expresses his respect but could not hide his concern and said, “I admire Hadley Elliot, who offers a kind of care for the final hours that I know I would wish to receive, but that is, in my experience, rare” (1988: 147).

As I emphasized at the outset, the care for terminally ill patients in the West has not changed for the better since Glasser and Strauss lifted the veil in the early sixties; Kleinman contextualized it in the eighties; and Gawande confronted it in the current, existing healthcare system. Nothing has changed.

## CHAPTER 5

### DEATH RITUALS: FAMILIARIZING CONSCIOUSNESS WITH THE UNFAMILIAR WORLD

*In rituals, the most ordinary of actions and gestures become transformed into symbolic expressions, their meaning reinforced each time they are performed.*

- Arnold van Gennep 1909, Cited in Hobson et al. 2017).

#### INTRODUCTION

It was a muggy mid-September afternoon in Mundgod. Sweating profusely, I slowly uncovered the formalin-laden corpse of an 87-year-old woman who had died a night before. The strong chemical instantly permeated the room causing burning sensations in my eyes and invading my olfactory sense. The woman's lifeless body had not decomposed much but her skin was showing signs of discoloration. I carefully repositioned the body in order to perform the death rites that the deceased woman's daughter, whom I shall call Kalsang, had asked me to perform.

Being eldest among her siblings, Kalsang had taken charge of her mother's funeral rites. However, she seemed confused and unsure of things happening around her. "I am not certain if I should follow everything that is listed in the death horoscope or listen to what monks suggested. My relatives as well as community members expect us to perform everything specified in the horoscope, but monks told me it is better to focus solely on doing a good prayer from relevant Buddhist texts," she confessed. I sensed that it was a tense moment for Kalsang because although everyone involved in the funeral seemed to have embraced the common goal of assisting her mother to have a swift transition to the next life, their means of facilitating the goal were different. Kalsang's effort in navigating herself through the conflict in order to carry her

responsibility of conducting funeral rites was interesting, for it brings to light the uncertainty and unpredictability of cultural practices.

The vignettes I presented in earlier chapters were largely focused on deaths that validated the Tibetan Buddhist notion of an ideal death, but I had also observed and participated in cases that did not align with Buddhist notions of death. These cases were dying persons or family members who did not comply with the general Tibetan Buddhist norms of dying well. Such contradictory cases, I think, help to uncover the “action” behind the scene, and permit us to get a better sense of the constant negotiation happening among the cultural members. In an ethnographic account of rituals in a Sherpa community, Sherry Ortner aptly underscores the importance of examining such situations: “The very uncertainty of the situation, the very unpredictability of the outcome, serve to bring to the foreground cultural “stuff” that is normally so taken for granted as to be almost inarticulable” (1978: 1).

The abovementioned position also relates to one of the hypotheses of this dissertation: *Tibetan medical doctors, monks, and family members each have distinctive ideas about their roles in caring for a dying person; what constitutes an ideal death, and the appropriate roles for the other groups in relation to a dying person.* As discussed in the previous Chapter, there are diverse ways of dying, as well as caring for dying people. However, it is crucial to understand the mechanisms of how they were fulfilled in practice. I observed a constant negotiation between Tibetan doctors, Buddhist practitioners, and family members in the operationalization of these different cultural models pertaining to death and dying. Death rituals provide these collaborators fertile ground to engage and enact fundamental Tibetan Buddhist cultural models despite contradiction and conflict.

This chapter examines how Tibetan doctors and Buddhist practitioners collaborate with family members in caring for a dying person; and how they navigate their conceived roles and negotiate with respective collaborators when conflict arises. Importantly, the chapter probes a pair of questions: (1) Why are death rituals important in caring for dying people? (2) What role do death rituals play? I show this by examining death rituals I observed and participated in during my fieldwork. These death rituals were employed during the process of dying as well as after the death of a person. I also demonstrate the bi-directional relationship between a Tibetan Buddhist cultural worldview and the cultural members. In so doing, I explicate how death rituals carry a dual purpose of assisting the dying person to die well and to acquire a good rebirth as well as supporting family members in dealing with the aftermath of their loved ones' death.

## **COLLABORATION AMIDST CONFLICT**

### **Kalsang's Mother's Funeral Rites**

I had just begun to pack for a trip to Bylakuppe<sup>51</sup> later in the evening when my cellphone rang. The call was from Nyima, the owner of a local Tibetan restaurant, where I usually went for my lunch, and who became one of my few adopted relatives in the field. Nyima sounded a little jittery over the phone and asked if I could come over to the restaurant as soon as possible.

Sensing urgency, I had no time to think about what was going on, so I left everything and rushed out. He was waiting by the side of the road, across from his restaurant. Without saying anything, he hopped on my scooter and said, "Let's go, amchi la." Nyima told me on the way that an old woman in his village camp had died late last night, and the deceased woman's daughter urgently needed help.

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<sup>51</sup> Bylakuppe is 243 miles (392 km) south of Mundgod and was one of my other field sites in southern India.

When we reached the deceased woman's house, the porch was filled with people who had come to assist the family. People were preparing butter lamps, chopping vegetables, and some were just sitting and talking to each other. I saw monks reading a Buddhist text inside the room through the transparent window curtain. Nyima went inside the kitchen and came out with a young woman, who he introduced to me as Kalsang, a daughter of the deceased woman. Kalsang thanked me for coming and asked if I could follow her to a room adjoining the kitchen.

Once we were inside the room, Kalsang managed a smile despite looking tired and probably sleep-deprived and said they had not been able to perform some of the death rites and wondered if I could help. Kalsang said Dr. Gyaltsen, a local Tibetan doctor, helped to prepare the death horoscope (Tib. *Shi stsis*) earlier but it was hard for them to decipher some parts of the rites prescribed in the horoscope. A death horoscope is typically prepared by a qualified astrologer but at times, is also prepared by Tibetan doctors or lamas since it does not require an in-depth knowledge of Tibetan astrology. I found that the death horoscope is one of the most important components of death rites once a person dies, except in monastic community, which I discuss later in this chapter. The astrologer uses the deceased person's date of birth and time of death to calculate a death horoscope and prepare it either in Tibetan or English language. The horoscope directs specific actions to be performed right after the person's demise, which includes: who could touch the deceased body; which direction the body has to be placed; what specific rites has to be performed; any belongings of the deceased person that has to be discarded in case of attachment; particular prayers to be recited; time of the cremation, and so forth. For family members, the death horoscope not only seem to fulfill their role in assisting the deceased consciousness transitioning to the next life, but it also provides them a cultural framework to follow without having to think what to do or how to do.





talking, her brother, whom I met briefly earlier on the porch, came in to tell us that we did not have much time to complete the remainder of the funeral rites.

While I had previously attended to a number of dying patients, I had never performed any kind of rituals for them. The last time I was engaged in performing death rituals had been during my father's passing. Fulfilling my role as a son, I remember being directed by a monk as to every step of the funeral rites.<sup>52</sup> I was thus slightly nervous, but I said I would do my best. This was an interesting scenario not only because it revealed how the dying person's caretakers, though embracing the common goal of assisting a person to die well, employed diverse, and at times conflicting, means to fulfill this goal. Further, because the dead body had already been cleaned and covered and prepared for the cremation. Completion of the ritual at this time meant we had to uncover the body.

Kalsang's deceased mother's body was kept near the corner of the room where monks were reciting a Buddhist text. The lifeless body was wrapped in a white cloth with *khatak* dangled all over a string tied up around the bed. Kalsang told me that one component of the rites they had not been able to perform was placing various items on different sides of the corpse. They were not able to understand the items mentioned in the horoscope. After I explained to them the objects—head of a sheep, a mouse, and a pig, an owl's feather, a horse eye, and coal—specified to be placed on different sites of the corpse, Kalsang and her brother stared back at me as if they expected me to tell them how we can arrange all the items before the cremation. The cremation was scheduled early for next morning. Kalsang and her family knew that the items such as a sheep or pig's head could be substituted by ones prepared from dough, but they were

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<sup>52</sup> My father's funeral rites were more elaborate as compared to most of the funeral rites I witnessed in south India. I learned later that this was because the monks who conducted my father's funeral were from a Nyingma Monastery in Dehradun. The Nyingma tradition has more elaborate death rituals than the Geluk tradition (Gouin 2010), which is most prevalent at monasteries where I conducted my fieldwork.

worried about other items. One man volunteered to climb a tree where he thought there was an owl's nest and he might find an owl's feather there. Another person said he could go to the nearby Indian store to check.

Fortunately, we were able to solve the problem when one of the monks suggested that we draw images of the items rather than worrying about the real objects. I had Kalsang's brother quickly download the images on his smart phone and I drew the owl-feather, snake, and horse eye on a piece of paper. I cut those images and, as directed in the horoscope, carefully placed them on top of and underneath the corpse in the specified locations. Likewise, I took a small portion of powdered coal using the other end of a spoon and gently smeared it under the eyes. Finally, Nyima gave me two pieces of black threads, which I placed between the index and middle finger of the deceased woman's hands. By the time I finished the last part of the rite and covered the body with a white cloth, the formalin chemical had my eyes burning watering heavily. Meanwhile, some of Kalsang's relatives had joined us in the room while we were completing the rite. Assuming I was overtaken by emotion, an elderly man came over, gave a light pat on my back, and said, "It is fine, we all have to go through this."

Nonetheless, everyone seemed pleased that the funeral rites prescribed in the death horoscope were completed. Nyima looked at Kalsang and her brother and said everything was good now. Three monks seated on a bed at the other side of the room reading a Buddhist text had taken a tea break. As I was leaving, I thanked the monks and asked what they were reading. One of them told me they were reciting a text, *nyes pa kun sel* (Trans. Dispelling all the Wrong Doings) that was listed in the horoscope.

The aforementioned event was one of the many funeral rites that I attended in the field where cultural dynamics were in full manifestation. During the funeral rites I observed, which

were performed before, during, and after death, Tibetan Buddhist values and beliefs were embodied and enacted through constant contradiction, conflict, bargaining, and reconciliation among the various collaborators who collaborate in helping those dying make the transition. Sherry Ortner, in *Sherpas Through Their Rituals* (1978), articulates such cultural “action” by adopting specific approaches in the in the context of death rituals among Sherpas, which take on a form of “the representative anecdote” and specific “cultural performances.” Ortner elucidates that while the representative anecdote reveals chaos and conflicts during cultural practices, cultural performances bring forth culturally formalized events such as rituals wherein societal members see their fundamental values and beliefs embodied (1).

In the context of this chapter where the collaborators—Tibetan doctors, Buddhist monks, and family members—engaged in diverse (ritual) activities related to death amidst conflict and negotiation, it is critical to begin by exploring the way ritual is conceived among Tibetans. Particularly, I discuss how death rituals, though critical component of caring for dying and the deceased in Tibetan culture, becomes a source of conflict among caregivers.

## **RITUALS AS AN ILLOGICAL RELIGIOUS ACT**

Interestingly, I found that rituals were often discouraged by Tibetan Buddhist practitioners, specifically Geluk<sup>53</sup> practitioners who formed most of my monastic interlocutors. Monks at Drepung monastery were not big supporters of rituals because they often saw them as an “empty action” with little to no intellectual engagement and rational motivation.<sup>54</sup> During my fieldwork, I found my monastic interlocutors conceptualized ritual as based on mere faith fueled

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<sup>53</sup> Geluk (*rGe lugs pa*) is the newest of the four schools of Tibetan Buddhism. The other three are, Nyingma, Kagyu, and Sakya (van Schaik 2011). It was founded by Je Tsongkhapa (1357-1419), a philosopher and Tibetan religious leader.

<sup>54</sup> See Boyer and Lienard (2006) for ritual in general as lacking rational motivation.

by superstition, and hence was the core reason for their reservations regarding “indulgence” in ritual. Most of the monks shared a view that ideally it should be the dying person who is prepared and confident with regard to dying well and transitioning smoothly to the next life rather than depending upon others. In such a case, monks believe that performing funeral rites would not change anything for better if the dying person is not prepared. Having said that, it is interesting to consider if the practices that monks engage in and advice they give to others in order to prepare for death could itself be considered a form of ritual. If ritual is understood as a behavior that is diligently performed, repeated, and formalized in one’s daily routine, then, a meditation or repeatedly reciting the same prayers could be categorized as ritual.

In recent decades, the study of rituals in order to get a better understanding of cultural practice and social cohesion has attracted scholars with diverse backgrounds (Bell 1992). A cultural anthropologist, Bradd Shore, for example, in his analysis of ritual as a performance, argues that “Rituals are routine with a symbolic load. Routines perform pragmatic activities with practical ends, such as cleaning house, personal grooming, eating a meal, or navigating to regular destination.” (in press: 3). And for monks, their regular morning routines—prayers, meditation, intention setting, and so forth—becomes ritualized in order for them to be good practitioners. Shore further says, “...routines often become meaningful for people or communities, adding onto the practical actions layers of personal or collective significance that transcends their practical functions and move them into the domain of *symbolic action*. They become rituals” (ibid. 3, author’s emphasis).

Likewise, religious scholar Catherine Bell, notes that theoretical explanations of ritual usually see it as “action and thus automatically distinguish it from the conceptual aspects of

religion, such as beliefs, symbols, and myths.” (1992: 19). However, she questions the “usefulness of distinguishing what is thought and what is doing” (1992: 3). She writes:

...beliefs, creeds, symbols, and myths emerge as forms of mental or conceptual blueprints: they direct, inspire, or promote activity, but they themselves are not activities. Ritual, like action, will act out, express, or perform these conceptual orientations. Sometimes the push for typological clarity will drive such differentiations to the extreme. Ritual is then described as particularly *thoughtless* action—routinized, habitual, obsessive, or mimetic—and therefore the purely formal, secondary, and mere physical expression of logically prior ideas.” (1992: 3, author’s emphasis).

Margaret Gouin (2010), in her study of Tibetan death rituals, makes a similar argument that the dichotomy of the ‘great’ tradition related to “highly literate, formalized, and philosophical” stance of Buddhist monks and lamas and the ‘little’ tradition pertaining to “illiterate and superstitious” categorized by scholars and writers is false (136). Gouin affirms that such categorization ignores that the rituals of the supposedly ‘little’ tradition are performed by monks and other Buddhist professionals.

The aforementioned discussion is crucial in analyzing how rituals are conceived among my study population and why engaging in rituals, such as death ritual, is viewed illogical in the monastic community. Two main reasons became clear to me through the course of my field work, and more so while analyzing my data, that might have caused such attitudes about rituals: (1) Drepung monastic university, along with other two major universities—Gaden and Sera—follow Geluk tradition where students education training focus strongly on the inner science and logic and employs dialectical debate as a primary mode of training (Dreyfus 2003); and (2) Geluk tradition, which is a Tibetan state religion, follows Madhyamaka philosophy which is

grounded on investigating one's mind using the theory of karma (cause and effect) as one of the fundamental concepts (Tsong-kha-Pa 2000). Such conceptualization leans strongly on an individual behavioral action and its result, and hence a cultural belief that how one is in this life and how one will be in the next life is completely contingent upon one's action. As I demonstrate in the later part of this chapter, most of my monk interlocutors had a view that how one dies and what kind of rebirth one would have is all depended on how one has lived his or her life.

I also noticed that the lexicon Tibetans use for ritual makes it difficult to get a fuller sense of the concept of "ritual. Understanding that there is the "widest possible disagreement as to how the word ritual should be understood" in the Western scholarship (Leach 1968: 526), the Tibetan term for ritual, *cho ga*, is often and most broadly associated with religious ceremonies or rites deprived of rationality, and sometimes even considered as a superstitious act. I personally faced a similar dilemma when I came to the United States until I did a directed reading with Dr. Shore in my second year of the graduate program. I realized how much my cultural connotation of ritual as superstitious and a practice for a less educated Buddhist practitioners has informed the way I conceive ritual. Nonetheless, the dispute about the interpretation of the word "ritual" how the word ritual

Moreover, my unintended interaction with some monks during my fieldwork affirmed the way ritual is understood differently. During one of my trips to the outskirts of Mundgod for a data collection, I stayed at Gyudmey (*sGyud smad*) Tantric Monastic School where most of the monks were graduates from Drepung monastery. These monks were there to be trained for the tantric practice after completing their highest monastic education, Geshe Lharam. During my two weeks stay at Gyudmey, I saw all the Geshees from Drepung engaged in a day-long "ritual" practice (except for Wednesday) with a quick break for tea and lunch. The ritual began early in

the morning in a huge prayer hall where monks wearing specific robes and hats recite prayers, beat drums, play Tibetan trumpet, and perform different hand gestures. I was surprised. I asked one of the Geshe I knew: “why you all spend so much time engaged in a practice which looks very much like a ritual?”

The Geshe told me this is the most important component of their tantric training. “During this practice, one recites a root text that one has memorized; and using the sounds of drum, horns, Tibetan trumpet, one trains to visualize (Tib. *dmigs pa*) different stages of birth and death; and embody what they have learned.” “How this is different from other rituals,” I asked.

“This practice involves much deeper level of focus based on what one has learned and motivation one has developed,” he responded.

I think my conversation with the Geshe is interesting, particularly in the context of existing conversation with regard to ritual, that ritual, if not understood from holistic perspective, could be easily categorized into a philosophical concept and a plain practice.

## **WHAT DOES RITUALS DO?**

*In ritual, the world as lived, and the world as imagined turn out to be the same world.*  
– Clifford Geertz.

My intention to delve into ritual here is not because it is ubiquitous in human behavior across cultures nor is it to address how rituals, such as funeral rites, reflect social values. Such explorations have been presented by scholars across the disciplines (Hobson et al. 2018; Seligman et al. 2008; Rappaport 1999; Shore 1996; Turner 1969; Humphrey & Laidlaw 1994; Kertzer 1988; Luhrmann 1989; Geertz 1973; Goffman 1967; Van Gennep 1960). My goal rather is to expound upon how ritual forms an important locus for my research participants to engage in

a collaborative project to help dying people transition. As I mentioned earlier, I propose that this locus not only enables collaborators to play their role, but it reveals a dynamic interaction among them.

The interaction, as we saw in the case of the funeral rites for Kalsang's mother, revealed apprehensions among caregivers as they worked together in doing their best for the deceased person. When I asked family members about the importance of performing funeral rites for their loved ones, almost all of them said they were doing it to help the deceased person to obtain a good rebirth. But they would also say that by performing proper funeral rites, the deceased person's consciousness would not get stuck in *bardo* (the intermediate state) and hence, would not return to haunt them. Likewise, ritual also seemed to showcase a family's love and affection for their deceased member as well as reflect concern with their own reputation in the community.

It was fascinating to see three very distinct motives behind the funeral rites where everyone concerned—the deceased, family members, and community members—have equal stake. It was not only the deceased person who was in the intermediate state, but everyone involved was in a “liminal” state; and the funeral rites help them to cross that boundary at both collective and individual levels. A family social scientist, Paul Rosenblatt, in his cross-cultural analysis on death grief, accentuates what American society could learn from other cultures and said, “Societies in which there is a clearly defined etiquette for people to follow in dealing with a bereaved person may have few problems with the feelings of being abandoned that many bereaved Americans report” (1997: 47).

*Bardo*, in Tibetan literally means “in between.” I discussed in length the six key phases of life and death, which are referred to as six bardos in chapter 1. These six bardos are enumerated as: (1) *skye gnas or rang-bshin bardo* (the intermediate state of living); (2) *rmi-lam*



*bardo* (the intermediate state of dream); (3) *bsam-gtan bardo* (the intermediate state of meditative concentration); (4) *'chi-kha'I bardo* (the intermediate state of death); (5) *chos-nyid bardo* (the intermediate state of reality or *dharmata*, which is considered the ultimate nature of mind as pure awareness, also known as clear-light state); (6) *srid-pa'I bardo* (the intermediate state of rebirth). A person is said to experience specific experiential qualities during each of these intermediate states owing to the different state of consciousness where consciousness does from coarse to subtle to very subtle to back to coarse (Padmasambhava 2005: 479; Thompson 2015: 285; Goss and Klass 1997).

### **Ritual as a Response to Emotional Vulnerability**

In that vein, Pierre Lienard and Pascal Boyer present helpful analysis as they attempt to answer their opening question of the paper: “Why do people, the world over, seem compelled to engage in ritual practices? Why invest time and resources in such behaviors?” (2006: 814). Assuming they have developed an answer reaching into the fundamentals of human behavior, they posit:

Rituals are compelling because specific aspects of human cognitive architecture make these behavioral sequences attention-grabbing, intuitively appropriate, and compelling. Specifically, we consider that particular sequences of collective rituals activate a cognitive-emotional system focused on the detection of and reaction to potential danger. (2006: 814).

The cognitive and psychological impact of rituals was evident during Kalsang’s mother’s funeral rites. The handling of the deceased body during the funeral rites brings them in direct contact with any potential harm the deceased consciousness could bring on family members and community and proper ways to respond to it. Furthermore, performing funeral rites also provides family members an opportunity to engage in public activity to show to community members that

any potential danger from the deceased spirit has been ward off. I observed that Kalsang was not only engaged and busy, but also composed as we worked through performing her mother's funeral rites. She was, however, quite different when I met her three weeks later for our interview. Kalsang was sad and sounded vulnerable; and teared up every time she talked about her mother. When I asked her if she was happy with the way her mother died and the way everything went, she said she was happy that her mother died calmly, without much suffering, albeit she wondered whether her mother could had lived longer if she had taken her to a city hospital.

“My mother didn't want to go to a hospital, so we did what she wanted even though I feel she might have stayed longer if taken to a bigger hospital,” Kalsang related. “But I am happy that we were able to do all the necessary rituals.”

Despite missing her mother and being ambivalent about her decision to let her mother die at home, Kalsang seemed emotionally content and happy that she played her role in fulfilling her mother's wishes and did what was expected of her. Kalsang was able to find meaning in the performance of funeral rites, and thereby, console herself for any remorse she was experiencing. Likewise, one of Kalsang's neighbors, an elderly woman, expressed her satisfaction when I finished the last part of the funeral rites for Kalsang's mother. As I was leaving Kalsang's house, the elderly woman made an implicit remark about the potential danger of the deceased person's consciousness to the community if it lingers around: “Now, everything is good. The deceased person won't have any problem in finding its way, nor would cause any problem to others.”

To reiterate, it was intriguing to observe multiple responses that a particular (death) ritual can stimulate. While Kalsang primarily felt she fulfilled her responsibility as a daughter, her relatives seemed to take solace in fulfilling their responsibility toward community members and

thus maintained social cohesion, and community members felt the potential danger had been eliminated. Each of these responses illustrates the way ritual speaks differently to different people despite it being narrowly formalized and rigid in nature. This prompts an examination of the theory around and mechanism of ritual action.

### **Ritual as a Dialectical Tool**

The power of ritual, as Shore would stress, is a “stabilizing effect...when under stress” (in press: 18), attest to how humans react to stressful situations. However, the intriguing part about a ritual is the dialectical tool that it provides for the participants to engage with unknown situation such as death, as well as with themselves and others. This tool offers a multi-layered mode of interpreting a ritual action that speaks to different members of community. As discussed earlier, being able to engage with stressful situation via ritual not only transforms the situation, but it transmutes individuals’—family members in this case—relationship to a deceased person as well as the community members. Moreover, family members strongly believe that the deceased person expects and depends upon them to perform rituals prescribed in his/her death horoscope.

Robert Desjarlais (2016) examines some of the key questions related to death rituals in his extensive ethnographic account of death and dying among a Yolmo Buddhist community in Nepal by asking: what is the utility of funeral rites? And do funeral rites help survivors to recover from trauma of losing their loved ones? Most of his interlocutors’ responses revolve around their goals and feelings, which reflect both the transformative and symbolic potency of rituals. One of Desjarlais’ informants, Karma, responds in a way that showcases the goal and intention of a ritual performer, as well as the expression of a relationship between the deceased and family members when other options are exhausted:

“Yes, in fact that’s what’s comforting,” Karma said. “The funeral rites convince them that this is what they can do now. This is what you can do for the person whom you miss so much. That is it. There’s nothing else you can do. The only thing you can do is dedicate whatever you can in the name of that person, and that’s how you can connect yourself to this person.” (Robert Desjarlais 2016: 152).

The formation of dialectical relationship with ritual also allows the performers to play with the meaning that underpins ritual act, as well as to reaffirm and reinforce the meaning when it is enacted (Bell 1992). Although the importance of meaning is both implied and contested, it is hard not to notice meaning as a quintessential feature of rituals (Seligman et al. 2008; Humphrey and Laidlaw 1994; Bell 1992). Seligman and colleagues relate any human action to ritual as the way term ritual “frames actions in certain, very specific ways. It is the framing of the actions, not the actions themselves, that makes them rituals” (2008: 5).

### **Rituals as a source of Intention and Sincerity**

Besides providing a cultural tool to navigate a stressful situation, I observed that rituals surrounding care for the dying and the deceased among Tibetans have certain features, such as internalization, intention, motivation, sincerity, and so forth. These rituals, therefore, do not fit into existing scholarship on rituals where any of such characteristics are challenged (Seligman et al. 2008; Humphrey and Laidlaw 1994). In fact, these features that I observed during my fieldwork could be viewed as anomalous. Likewise, I observed that these ritual practices necessitate a performer’s conscious action to develop an intentionality and be motivated to facilitate a collaboration with other collaborators in caring for the dying.

For instance, one of the most important rituals performed during the process of dying as well as post-death is reciting a Tibetan Buddhist text known as *Bar-do thos-grol chen-mo*,

(translated as *The Great Liberation upon Hearing in the Intermediate State*, pronounced *Bardo thodrol chenmo*). This practice of reciting the text with rigidity and formality over and over again was common across all the collaborators. I gathered data both during my participant-observation and interviews that it was imperative for those who read the text to develop clear intention and motivation, to internalize the text, and be sincere toward beneficiaries. Such practice of ritual where a performer must be engaged with genuine feeling and intention calls for an additional layer of explanation.

Seligman and colleagues' (2008) argument that a ritual does not concern itself with an act of sincerity and internalization falls short in the case of rituals that I observed in Tibetan culture. Seligman and colleagues emphasize that performing a ritual is simply following convention and has nothing to do with internal states: "It does not matter how you feel about the convention, if you identify with it or not. In doing a ritual the whole issue of our internal states is often irrelevant. What you *are* is what you *are in the doing*, which is of course an external act (2008: 24). Nevertheless, I would argue that sincerity and relevant toward ritual could depend upon its context as well as the relationship of performers with the act. Observing ritual from a business and particularly a consumer perspective, Dennis Rook subscribes to a "mid-range" interpretation of ritual by neither leaning toward religious nor in completely depriving ritual of its agency:

The term ritual refers to a type of expressive, symbolic activity constructed of multiple behaviors that occur in a fixed, episodic sequence, and that tend to be repeated over time. Ritual behavior is dramatically scripted and acted out and is performed with formality, seriousness, and inner intensity. (1985: 252).

Considering the engagement of both physical and mental behaviors in the performance of ritual, Rook calls for intense observational fieldwork that can go beyond scratching the surface of a

ritual practice. Likewise, Paul Powers uses the Arabic term *niyya* to its translated meaning, to make a case of paying close observation to intention in studying Islamic ritual law. Powers stresses the importance of *niyya* in embodied religious practices; and treats *niyya* as a “formal, taxonomic matter, a mental focus that makes a given act into the specific named duty required by religious law” (2004: 425). Powers further writes:

In general, *niyya* is to be formulated at the beginning of an act and maintained for the duration of that act; if the *niyya* is “lost” or “invalidated,” this invalidates the act of worship and necessitates reperformance. *Niyya* is done “with the heart” and may or may not be expressed “with the tongue.” (2004: 427).

Akin to what Powers indicates about the significance of *niyya* in Islamic ritual practice, motivation and intention are prerequisite in performing ritual practices in Tibetan Buddhist culture. Certain rituals pertaining to death and dying, specifically reciting a Buddhist text, performing *Pho wa* (transference of consciousness), or feeding a deceased person’s consciousness through *sur* ritual (Gouin 2010) seem to demand a conscious act grounded in pure motivation and intention. There is also the idea that serious and formalized action will produce a serious and intense internal state. I will illustrate how theoretical concept drives and motivates the act of ritual through an ethnographic case I observed in the field. Damdul, who is one of the lay-Buddhist practitioners in the Mundgod community, recites the *Tibetan Book of the Dead* (Tib. *bar rdo thos grol*) text to dying people and their family members. He told me that it is critical to be constantly be conscious of his motivation and intention when he performs his ritual for others.

## **FAMILARIZING CONSCIOUSNESS TO THE UNFAILAIR WORLD**

### **Damdul's Life as a Guide for Dying People**

Like several of my other interlocutors, I first heard about Damdul at a local Tibetan restaurant in one of the Tibetan camps. An elderly Tibetan woman who ran the restaurant in one of the Tibetan camps was friendly and enjoyed engaging in conversation with her clients. Being aware of my research, she asked if I had heard about a person who goes around helping dying or dead people. It had been a week since Karma, who I attended to during his last few days had died. The woman told me the helper's name is Damdul and that he had been at Karma's house reciting the *Tibetan Book of the Dead* text since Karma died. I said it would be helpful if she would connect me to Damdul, but before I could ask for any more information, a band of monks marched in and she disappeared into her small kitchen.

Serendipitously, I bumped into Damdul early the next day during my morning run. I saw a man pushing his bicycle pedals hard on a narrow uphill road from Camp 6 to Drepung Monastery. He stopped as we got closer, greeted me, and asked how I was doing. He was a little short of breath, sweating, and confessed that bicycling on this road was his only exercise. By that time, I was wondering where I might have met him, and before I could ask anything about him, he said he was going to Karma's house to recite the *Tibetan Book of the Dead*. He said he saw me at Karma's funeral. Once I realized he was the person to whom the woman from the restaurant was referring, I got excited and asked if I might join him when he recites the text. He did not seem to mind at all and said he would be at Karma's house until noon.

I cut my run short and went back to my room to prepare to go to Karma's house. Damdul had already started reciting the text when I arrived. He looked quite different from when I had met him earlier on the road: sitting cross-legged on a bed where Karma spent the last three days of his life a week prior, Damdul looked fresh and composed, and with his reading glasses, he was

serious and engaged. During the course of the next four hours, I sat and quietly listened to him, spoke to him during his tea-break that he took every hour, and spoke to Karma's younger brother when he came with a small thermos filled with tea.

Damdul was reading from a traditional block print text. He read the text slowly, aloud with clear pronunciation. Whenever he had to repeat certain words or sentences, he would get into a melodic rhythm, almost like he was chanting a song. At times when I sat next to him, he would point his finger to a sentence to guide me in the recitation. During one of his tea breaks, I asked Damdul if he thought about anything while reciting the text. He said that while reciting he literally felt like he was explaining things to the deceased person's consciousness (Karma in this case) and guiding the consciousness through the state of *bardo*.

"This is crucial," Damdul said. "The deceased person could move on to the next life only if he understands and accepts what has happened, that he has died and he needs to be calm and focused, devoid of confusion and fear to gain a good rebirth."

Showing me the particular page of the text that he had been reciting repeatedly, Damdul said it is important for the deceased person to know that he is already dead and that he is in the state of *bardo*. I asked him how much he had to be prepared to do what he does to be focused and attentive while communicating with someone who had a minimal sense of communication or who was already dead. Damdul said a dying person might be weak and in pain but their sensory organs, especially auditory perception, become heightened when close to dying and right after death. Further, he told me he could tell me later about the necessary prerequisites one needs to fulfill before taking the role of reciting the text for dying people, and that he always prepares himself to sharpen his focus and be attentive while reciting the text.



Often, a deceased person's consciousness would be confused about his state of being if he is not familiar with what he might be experiencing and is not prepared to make a transition to the next life. So, it is important for me to be attentive and focused. If I make a mistake, I might make things even more confusing for the deceased person's consciousness.



Figure 15: Damdul reciting *The Tibetan Book of the Dead* Text for Karma

Sitting in the room and listening to Damdul's recitation, it gave me a strong impression that he was engaged in a direct conversation with the deceased person. To give a sense of what Damdul was reading, here is a paragraph from one of the recent English translations of *The Tibetan Book of the Dead* (2005), it reads:

O, Child of Buddha Nature (call the deceased by name), listen without distraction. On the seventh day, a five-faceted multicolored light, [which is indicative of] the purity of your habitual tendencies in the expanse [of reality], will arise before you. Simultaneously, the divine assembly of the awareness holders, arising from the pure realm of the sky farers, will come forward to escort you...And, thus [encircled], may I be rescued from the fearsome passageway of the intermediate state, and be escorted to the [sacred] pure realm

of sky-farers. By making this aspirational prayer with fervent devotion, you will dissolve into rainbow light, in the heart of the divine assembly of the awareness holders, and thereafter, undoubtedly, be born into the pure-realm of sky-farers. (Padmasambhava 2005: 251-154).

### **Tibetan Book of the Dead**

Among thousands of Buddhist texts on meditation related to death and dying, rituals for dying, and yogic manuals for the transference of consciousness at the time of death, the *Tibetan Book of the Dead* is the most well-known text in the West (Goss and Klass 1997). W. Y. Evans-Wentz's named the text the *Tibetan Book of the Dead* (1927), perhaps in his attempt to draw an analogy to *The Egyptian Book of the Dead* (Goss and Klass 1997). The title he gave propagated in the West and all other subsequent translations of the original Tibetan text have retained this same title. I have kept the name "*The Tibetan Book of the Dead*" in this chapter for easier reference and continuity.

The *Tibetan Book of the Dead* explicates in detail the different nature of consciousness before and after death, practices related to transforming one's mind, different stages of dying, after-death state, and how to help those who are dying (Padmasambhava 2005). As mentioned earlier, although *bardo* refers to six different transitional or liminal states, the text is most relevant to the time of death and dying and rebirth. The text has two different sets of instructions: (1) for the deceased; and (2) for the reader. The root verses instruct the deceased as to how to understand the *bardo* experiences and visions, reminding the deceased that "these visions are empty emanations of the subtle mind." The instructions that guide the reader describe "how and when to read the directions for the deceased" (Goss and Klass 1997: 380).

In his introductory commentary to the first complete translation of *The Tibetan Book of the Dead* (2005), the Dalai Lama emphasizes the importance of getting familiarized with the difficult situation of dying and death and preparing for it in order to protect oneself when the situation arises. Discussing his own practice, both its positive effect, as well as the apprehension he experiences, he describes:

Normally in our lives, if we know that we are going to be confronted by a difficult or unfamiliar situation, we prepare and train ourselves for such a circumstance in advance, so that when this event actually happens, we are fully prepared. As I have outlined [earlier], the rehearsal of the processes of death, and those of the intermediate state, and the emergence into a future existence, lies at the very heart of the path in Highest Yoga Tantra. These practices are part of my daily practice also and because of this I somehow feel a sense of excitement when I think about the experience of death. At the same time, though, sometimes I do wonder whether or not I will really be able to fully utilize my own preparatory practices when the actual moment of death comes! (xxviii).

### **Universality of Ritual**

The Tibetan Buddhist conception of death and dying and the transition of a deceased person's consciousness might sound esoteric, but it can also be viewed universally and cross culturally, particularly in the context of ritual. For instance, Arnold van Gennep (1960) made a similar interpretation in his argument that different social rites not only work in generating societal consensus, but also structure the transition of individuals from one social role to another. Hence a "rite of passage" (here, a generic term he uses for all rites that cover marriage, adolescence, death, etc.), is comprised of a "pre-liminal phase," in which the person is freed from his/her previous role; a "transitional or a liminal phase" (or the intermediate state) in which the

person inhabits intermediary roles and is temporarily bereft of a social identity; and a “post-liminal phase,” in which the person is incorporated into the new role (cited in Islamro 2008: 8).

Consistent with van Gennep’s argument that the purpose of this ritual framing of transitions is to reestablish equilibrium to the social order in the face of constant changes in the environment and in one’s life, Tibetan rituals provide support to both the dying person and the family in restoring order in their lives. However, Tibetan Buddhist ritual practices, as illustrated by Damdul’s case, require optimum conscious engagement and focus from the one who performs rituals, as well as the beneficiaries. In fact, most of my interlocutors told me that it involves a rigorous prerequisite training and a regular practice to be able to recite *The Tibetan Book of the Dead* for dying and dead people. Damdul once said, “The text not only elucidates what someone would experience after death, but it explains in detail our nature of mind, changes that happens to our body and mind at the time of dying, and signs of impending death. Therefore, it is helpful if we can read the text while a person is dying even though we are most often called when a person is already dead.” Given that explicit purpose of Tibetan Buddhist ritual to prepare one’s mind to support a dying person’s mind, it cannot be considered an empty or mindless action.

### **Receiving Textual Instruction and Empowerment**

I met Damdul a few days later, early in the morning, at his house for an interview. He was busy milking a cow when I opened the colorful metal gate that led to the front yard of his house. Damdul said it was good that we scheduled our meeting early in the morning. He said an elderly man had died a day earlier and he had to go to attend to the deceased person right after finishing at Karma’s house, which meant he had to go to Karma’s house a little earlier that day. After a few minutes, Damdul asked an old Indian man sitting by the side of a cowshed barn to take his place milking the cow.

Damdul's house was attached to the cowshed. It was a modest house plastered with mud and white-washed wall where he lived with his daughter and younger brother. I took off my shoes by the door as Damdul escorted me to the main room. The main room was furnished with three beds placed around the wall in a U-shape, a table, and a small television set. A thick well-worn text placed on a wooden stand occupied a corner of the table. He sat on an edge of the bed right in front of the text. I assumed that was his go-to place when he was not going around reciting the text for dying or dead people or milking his cows. Soon after we sat down, his daughter came with an over-sized mug filled with hot milk. Before I could finish telling her it was way too much for me to drink, Damdul interrupted me saying I would have no problem drinking it since it was fresh milk from their own cow.

Being mindful of his time and a long day ahead of him, I began by asking how he started his practice of reciting *The Tibetan Book of the Dead* to dying people. He said he started reciting the text for those dying or just passed only six years ago, but he had been interested in the text and its teaching since a very young age. He recalled listening to his father read Tibetan Buddhist texts, including *The Tibetan Book of the Dead* in a make-shift tent when they escaped from Tibet to India in 1966. He was thirteen then, and at nineteen, he received the initial teaching and began the preliminary prerequisite trainings. The prerequisite training, he explained, was engaging in a practice called *sngon 'gro 'bum lnga* (Five-hundred thousand Preliminary Practices). These preliminary practices involved: (1) taking refuge (in a spiritual teacher), (2) generating altruistic intention or bodhichitta, (3) performing mandala offering, (4) reciting the hundred-syllable Vajrasattva mantra, and (5) praying to the lineage teacher. These practices have to be repeated 100,000 times as a prerequisite in order to receive teaching instruction from a lineage-based

teacher (see Patrul Rinpoche 1998 English publication describing these practices as fundamental to any Vajrayana path practice).

Once the prerequisite preliminaries were completed and teaching instruction were received, one was required to obtain an empowerment that gives the practitioner authority to practice highest yoga tantra, and in Damdul's case, permission and potency to recite *The Tibetan Book of the Dead* text to others for greater benefit (also see Padmasambhava 2005: 6-22 for details on the preliminary practices as prerequisite training). Damdul, however, told me that what initially motivated him to do all the preliminary practice training, receive the teaching instructions and receive the empowerment was more for his personal spiritual practice. When I asked why, he said he thought of himself as insufficiently learned to perform such an important ritual. It was only in 2011, he said, when he found himself in a situation where he could not refuse a request to recite the text for someone who had died that he performed the ritual for another. He described,

In 2011, an elderly monk had died in our neighborhood and I went to his house to help. They were looking for people who were able read a prayer text, so I joined a few other people to recite the prayers. Then next day, a sister of the deceased monk asked if I could come over to recite *The Tibetan Book of the Dead* for the deceased monk. I refused and told her I am a lay person who does not have the authority to recite a text to a senior monk. She then told me that I read the prayers clearly and loud with good pronunciation yesterday, and moreover, even if I feel I do not have any effect, the sacred [*The Tibetan Book of the Dead*] text has power to help the deceased monk. So, when she said that to me, I could not say no, and I recited the text for 49 days. Once people in the settlement

heard about me reading the text, one after another started inviting me, and since then, I have been reciting the text whenever I could.

Damdul said even though people usually seek his help once someone has already died, reciting the text before death or in the process of dying can be of immense benefit. Damdul emphasized that since the text elucidates the nature of mind while alive, at the time of dying, post-death in *bardo*, and frightening experiences and images one might see due to changes in the mind and body at these different stages, familiarizing dying people with these changes could protect their anxious consciousness, which is most important. The text, in a way, provides a detailed “roadmap” into death with the sole aim of guiding a dying person’s consciousness to a good rebirth.

In the pursuance to guide the consciousness, a *‘pho ba* (pronounced *phowa*) ritual was performed immediately after a person was declared dead. *Pho ba* in Tibetan literally means ‘to go from one place to another;’ and is generally referred to as “transference of consciousness at the moment of death” in the context of funeral rites (Khadro 1998: 3). Similar to prerequisite trainings and practices required for a person to perform a textual recitation, a person performing *‘pho ba* requires similar training, if not more.

## **GUIDING CONSCIOUSNESS TO THE NEXT LIFE**

### **Lama Chophel as a Vehicle in Transference of Consciousness**

Dolkar, a staff member at the Old Age home in the settlement informed me that Jigme died when I was away on a field trip. I had known Jigme for almost a year. He was diagnosed with lung cancer and would come to see me at the Monastery Clinic regularly. He was adamant that he did not want to go to a (Western) hospital because he thought they would make him have

surgery and take strong medications; and he did not want either. Nonetheless, doctors at the hospital also knew there was not much they could do for him. I met Dolkar the next day and asked if everything went well when Jigmey died. She said,

It was not a good scene. I was having lunch and one of our caretakers called on me saying Jigmey was not looking good. I rushed to his room and saw him having lots of trouble breathing. He was anxious and looked like he was in pain, and then, all of a sudden, he started throwing things from the table everywhere and kicked his blanket to the ground. I felt like he had something to say. A Tibetan doctor who I invited checked Jigmey and said it might be better to assist him here rather than taking him to a hospital. I called his relatives, but when they came, they created more problems. The relatives had an argument about whether to take him to a hospital or keep him here. Finally, I invited a monk here and, both the monk and the Tibetan doctor advised them that it was better for the patient to be here in his own place with relatives. Jigmey died later that day. On our request, Lama Chophel came to perform *pho ba*. We all felt happy and satisfied once Lama Chophel performed *pho ba* [albeit things were a little chaotic when he was dying].

It was interesting to observe a pattern where disorganized and chaotic situations were re-organized, and peace redeemed when rituals directed toward safeguarding the consciousness through the transitional death state were successfully performed. Understanding that the deceased person's consciousness was cared for, and perhaps was put in a position to achieve a good rebirth, helped everyone to come together around the same cause. As I was leaving, Dolkar told me she wanted to make sure her teenage son never smokes because she saw first-hand how much Jigmey suffered in the end, which she attributed to his perpetual smoking habit.



In my attempts to meet with Lama Chopel, I became a little impatient when he did not return my multiple phone calls. I heard that he frequently went into retreat, so I wanted to make sure to interview him before he headed out for another retreat. Fortunately, my field supervisor, Gen Dhondup, knew him well, and helped to arrange our first meeting that led to many other meetings I had with him over the course of my fieldwork.

### **Breaking the Boundary via Heart-Mind Connection**

Besides reading *The Tibetan Book of the Dead* in guiding a deceased person's consciousness, I found the practice of *pho ba*, among other funeral rites, a most fertile source of creating 'commonality' among caregivers in Tibetan Buddhist culture. *Pho ba* rituals appeared to fulfill the goals of all three collaborators I was observing: family members perceived this as an important means to direct the deceased person's consciousness to the *right* place; Tibetan doctors not only saw it as a final act of protecting the deceased's consciousness, but aiding in bringing things under control amidst chaos since other collaborators depends on his judgement; and Tibetan Buddhist monks saw it as both leading to a good rebirth and as an act that necessitated deep meditation and visualization rather than simply participating in action (see Khadro 1998 for detail practice of *pho ba*). In fact, my interaction with many of my interlocutors, particularly Lama Chopel, made me realize that *pho ba* practice was much more than engaging in *action* and was grounded in deep meditation and visualization.

"A practitioner who performs *pho ba* should possess a certain level of spiritual realization and compassion," Lama Chopel stressed. "Spiritual realization so that a practitioner can generate a deep level of focus; and using that stable focus as a conduit, one directs his or her compassion to the deceased person's heart [consciousness]."

I never got a chance to accompany Lama Chopel or others when they performed *pho ba* because Lama Chopel told me that the place had to be completely silent without any disturbance. “Any degree of distraction could hinder the completion of *pho ba*,” he said.

As much as for my research, I was personally curious, even a little skeptical, as to how being focused and visualizing transference of a wave of compassion could help someone else’s heart, much less a dead person’s consciousness, get to its destination. “Does such a ritual practice need a performer to have a strong belief in what he is doing; and how do you know it is effective?” I asked.

“Belief,” he paused probably searching for a word, “*nges shes* [certitude] is what one needs to have before believing in what one does.” He further said,

Since the deceased person has only the consciousness to depend upon, the consciousness becomes very sensitive and receptive toward anything that can assist when everything around is so unpredictable and confusing. But as much as the consciousness is sensitive, it is also unstable and runs everywhere. That is why, we say that it is not only that the deceased’s consciousness requires undivided attention, but also someone it can trust. And generating and sending over genuine compassion helps to attract the deceased’s consciousness and direct it to a suitable rebirth. You can determine if the *pho ba* is successful when you could see either a tiny hole or softness at the crown chakra of deceased’s skull or a light discharge of white and red fluids from the nostrils.

Unlike Humphrey and Laidlaw’s (1994) argument that rituals are mere enactments of an *action* or Seligman and colleagues’ (2008) contention that rituals are not concerned with sincerity, these Tibetan death rituals—reciting the text and transferring consciousness—are concomitant with intention and motivation, particularly a sense of a sincere act for whom the rituals are performed.

Chagdud Khadro (1998), in a small handbook on *pho ba* practice, illustrates the entanglement of physical and mental action by presenting the essence of performing *pho ba* for others (which is one of the many visualization practices in Tibetan Buddhist practice):

The first thing to do when someone dies is to forcefully tap the top of the person's head. This directs the consciousness upward. A *p'howa* practitioner who has achieved good signs may transfer the deceased consciousness. This is accomplished by visualizing oneself as Avalokiteshvara and the deceased as Avalokiteshvara seated in vajra posture above the prone corpse. One visualizes a stream of green energy shooting from one's heart to the heart of the deceased, where it strengthens the vibration of his or her energy...Recognizing that Avalokiteshvara embodies the essence of the deceased enables one to accomplish the transference. The corpse is merely an illusion, a temporary dwelling place; Avalokiteshvara is a pure appearance arising from the indestructible nature of the deceased's mind. Experiencing this directly in meditation frees one from the dichotomy of corpse and visualization. (1998: 75-76).

Other lay practitioners I spoke to told me that one who performs *pho ba* must go through intense training (which Lama Chopel did not mention perhaps being modest); and once a practitioner is able to conduct *pho ba*, the practitioner gains confidence in facing his or her own death. "*Pho ba* practice put oneself in direct contact with death, so it changes the way one views life and death," one of them told me.

I gently inquired about the prerequisite trainings when I met Lama Chopel the following week. He hesitated a bit and said he had always dreamt of committing himself to spiritual life, so he became a monk when he was fourteen-year-old. He was twenty-three when he had a chance to escape to India in 1997. That very year, relishing his new-found freedom, he decided to go into a

long meditation retreat of three years and three months at Bokar Rinpoche Monastery in Mirik, Darjeeling. Besides meeting his relatives and informing them of his decision (since he would not see them for more than three years), he had to recite certain mantras and prayers in order to ward off any obstacles that might arise during the retreat. When I asked what such a long meditation retreat entailed, he said it was all about training his mind.

During the retreat, we started our day at 3 am and went to bed at 9 pm with an hour and a half break in between. We had teachings and directions from our instructor, but most of the time, we spent time in solitude to engage in meditation. Along with 500,000 preliminary practices we had to complete, we spent most of the time investigating the nature of mind, developing a sense of concern and affection for others, analyzing the [ultimate] truth, cultivating compassion, and most of all, constantly meditating on impermanence and emptiness.

We can make an argument here that a repeated recitation of mantras and prayers and engaging in particular practice for years could be an attempt to shut down the sensory faculties (lower level of perceptive consciousness) to experience the higher level of consciousness though it might be happening at the tacit level. Moreover, it is interesting to hypothesize that (ritualization of) certain acts could take away the participants' personal engagement and intention by automatizing the action.

Nonetheless, I would argue that despite such plausible assumptions, *pho ba* or a recitation of a text were distinctive rituals from the funeral rites of Kalsang's mother discussed earlier. Such funeral rites performed post-death were mostly based on prescribed rites specified in the death horoscope (which I discussed earlier). I found these funeral rites—placement of different objects on a corpse, restrictions on who can or cannot touch the corpse, the time of disposing the

corpse—based on what was instructed in the death horoscope, often became a cause of conflict among caretakers. The conflict surfaced because the death horoscope was generally not considered required, and often discouraged by the monastic community in the region of my field site. Yet the death horoscope was indispensable among lay Tibetans.

### **Death Horoscope: Instructions for Family Members**

In the middle of my fieldwork, on December 20, 2016, my younger sister messaged me on a phone app, “Mom passed away this morning.” I did not know what to make out of the message since I had spoken to her a couple of days earlier. My mother had gone to Kathmandu to see my sister and her family and to visit Buddhist holy sites. They had wanted me to join them in Kathmandu, but my fieldwork and an on-going conference made traveling difficult at that time. Assuming my sister was trying to coax me into coming, I decided to call her later and went to the conference. She cried over the phone when I called her later in the afternoon and said, “We all have been waiting for your call because we could not get anyone to prepare the death horoscope for mother. The elders here said they could not do anything with her body until we get the horoscope.” After the phone call, I called one of my astrologer friends and asked for a summarized-version of the death horoscope so that they could commence funeral rites for my mother.

I saw a similar pattern in all the deaths among laypeople that I observed or in families that I interviewed. Although family members would constantly tell me that following the directions specified in the death horoscope would help the deceased person, it also became quite obvious after a while that the instructions were more for focusing activities for the family members than for helping the deceased. My sister and her in-laws, for example, sounded helpless without the death horoscope. Likewise, a man whose mother died after lots of suffering due to

stomach cancer told me that commissioning a *tangkha* (scroll painting) of a particular deity and having monks recite prayers prescribed in the death horoscope made him feel good because these acts would help his mother. Tibetan monks at the Drepung monastery nearby, on the other hand, saw the aforementioned acts as illogical and impractical on the grounds that it goes against one of the fundamental principles of Buddhism: karma or cause and effect.

“If how we die and what kind of rebirth one would have are contingent upon how we have led our life and prepared for death and the next life, then relying on someone else changing your fate does not make sense,” a senior monk told me.

Still, I witnessed on numerous occasions that these differences became malleable and caretakers were able to negotiate and find common ground to collaborate on their project in assisting the deceased person. For instance, when I asked Geshe Phende about his view on the practice of the death horoscope, he tactfully responded by saying we need to be flexible. He said, “Serious Buddhist practitioners would not rely on the death horoscope because they are prepared for death. They would not want any funeral rites prescribed in the horoscope to hinder their practices at the time of death, importantly, how and when their body would be disposed of because some practitioners could stay in *thugs dam* [and need the body undisturbed]. However, this could be different for laypeople because it helps them to have some kind of guidelines to follow when they die. And lay Tibetans would expect their loved ones to follow what is in their death horoscope when they die. So, we need to bear in mind the reason for these differences and act accordingly.”

In essence, Geshe Phende implied the difference between the trained and untrained mind. Tibetans have an expression, “If your mind is trained, it would come in handy at the time of death.” Goss and Klass (1997) make an important remark in this light: “An untrained mind, even

when given the *bardo* instruction after death [via reciting a text and performing *pho ba*], has greater difficulty overcoming egocentric tendencies and perceiving the true nature of the mind” (381). Their comment corroborates a common understanding that additional rituals might be needed for laypeople’s (untrained) consciousness. Family members would make sure to perform rituals comprised of reciting texts, lighting butter lamps, feeding deceased’s consciousness, and so forth for 49 days after passing. As much as the untrained deceased’s consciousness failed to let go, these rituals, in some way, demonstrate that the family members were attached to the deceased family members too. It is in such situation that post-death rituals provide an avenue via which family members are able to communicate with the deceased consciousness to express their intimacy as well as to show the deceased is loved. Desjarlais’s (2016) interaction with his interlocutors illuminates how rituals inform such emotion:

Family members can no longer see or touch or talk or share food with the loved one in any reciprocal, tangible way. Yet the rituals mark a way in which they can convert their affections into new kind of relations, more ethereal and removed from those of everyday life, grounded in ritual practices and the dedication of karmic merit to the deceased.

Loved one sustains allegiance and intimacy. Ritual becomes a medium of familiar care and connection—of love. (153).

Furthermore, Geshe Phende’s comment on the treatment of a dead body was critical in Tibetan Buddhist culture considering the practice of *thugs dam* (a post-death meditation discussed in chapter 1). Some monks told me that certain instructions in the death horoscope related to restrictions on touching a deceased body or disposal of a body at certain time could cause problems if someone was in *thugs dam*. The monks would keep the practitioner’s dead body as long as they deemed the practitioner was in *thugs dam*.

## DISPOSAL OF THE BODY

### Funeral Rites

Once immediate post-death rites are performed, the deceased body is prepared for funeral except for someone who is deemed to be in the state of *thugs dam*. As I have shown above, death rituals during the process of dying, though initiated by family members, is a joint project where Tibetan doctors and monks collaborate in assisting the dying person to die well. However, once the person dies and the immediate post-death rites are performed, disposal of the body is exclusively performed by family members, or in monastic community, is taken care of by monk's students and caretakers. Nevertheless, it is important to note that in Nyingma and Kagyu traditions in Tibetan Buddhism, funeral rites are elaborate and are led by religious figures, akin to my personal experience during my father's funeral where death rites were performed by Kagyu monks.<sup>55</sup> There is another form of funeral—mummification to preserve the body— (Tib. *sku dmar gdung*) reserved for accomplished Buddhist practitioners who stays in *thugs dam* like Lobsang rinpoche I discussed earlier in chapter 1.

While different kinds of funeral rites are associated with Tibetan culture, the Tibetan population in which I did my field work primarily cremate the body. Early literature on funeral in Tibetan Buddhist culture are generally classified under four categories, that is, burial, immersion, cremation, and exposure or sky burial (Turner 1971; Ortner 1978; Goss and Klass 1997). In examining existing reports of funeral rituals in Tibetan Buddhism, Margaret Gouin explains that early Western writers have associated above four forms of funerals with four elements of earth, water, fire, and air respectively. Gouin reports that the contemporary Tibetan

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<sup>55</sup> See Gouin (2010: 56-58), for different forms of Tibetan funerals in detail.



*bon*<sup>56</sup> teacher Namkhai Norbu (1995: 249) attributes the categorization of different ways of disposing body based on four elements to tantric practice. Interestingly, Gouin notes that cremation was reserved for monastics, and in some cases for wealthy people, in Tibet.

Likewise, Gouin expresses reservation about the use of the term “sky burial.” She interprets it as “exposure” (disposal in air) and asserts that the etymology of the term “sky burial” is vague. This form of disposal of the body in Tibetan is known by *phung-po bya gtor*, which literally means “scattering the body [to the] birds.”<sup>57</sup> In this practice, the corpse is taken to the charnel site on top of a mountain, cut into pieces and fed to vultures. Sky burial practice, according to Gouin (2010), is performed for lay people, and could be due to lack of resources, such as wood and other ritual materials. This practice likewise has garnered increasing interest among Chinese government as well as Western media due to sensationalized attention in indigenous Tibetan culture or “exotic foreign rite” or “gruesome and terrifying” way of treating the corpse.<sup>58</sup>

Nonetheless, when I asked my interlocutors about their views on aforementioned different ways of disposing the body, their responses related to the common theme of supporting the deceased consciousness to make a swift transition to the next life. Damdul told me that through the benevolent use of the corpse via burial in earth for worms, or in water for fishes, or giving away to vultures, or burning to feed supernatural beings, the deceased earns merits. He added that such acts also function in letting the deceased know that they are no longer attached to their physical body and that they should move on. Similarly, I observed that the practice of

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<sup>56</sup> *bon* is an indigenous pre-Buddhist Tibetan religion, which has incorporated certain elements of Buddhism when Buddhism was introduced from India to Tibet in the eighth century (see van Schaik 2011).

<sup>57</sup> See, for example, Martin (1996) where he explicates on the practice of sky burial (354-355).

<sup>58</sup> See Noel (1989); Chen (1998); Turner 1971). Also see Gouin’s explication on the sky burial practice (2011: 59-72).

mummifying the body of an accomplished Buddhist practitioner who stays in *thugs dam* is not only seen as the way to show reverence to the practitioner, but also for the practitioner's students and others to be inspired and be reaffirmed of the Buddhist teachings and practices that could assist in dying well and to achieve a good rebirth. Having said that, I want to point out that sometimes, funeral rites get disrupted when survivors get attached to the deceased body, especially in the case of practitioners who are assumed to be in *thugs dam* by his or her disciples and caretakers.

### **Attachment in the Pursuance of Detachment**

In Tibetan refugee settlements in south India, cremation was performed for everyone except in special cases where a deceased person was in *thugs dam*. The body of someone in *thugs dam* was either kept for weeks to months or was mummified. For instance, I presented a case in chapter 1 about Lobsang Rinpoche who stayed in *thugs dam* for 18 days and was mummified under the guidance of the Dalai Lama. However, cases of *thugs dam* have become more frequent—both in monastic and lay communities—in recent years. I think it is fair to be curious about such occurrences, for some of my interviewees assumed that practitioners in former times were more rigorous and serious about their practice compared to current practitioners. On the other hand, we can also assume that we hear more about such cases because there is more public discussion about *thugs dam*.

This recent phenomenon of talking openly about *thugs dam* practice, especially among Tibetans and neuroscientists, owing to the Dalai Lama's emphasis that such practice and its benefit should be accessible and understandable to everyone, has its merits and drawbacks. *Thugs dam* is regarded as one of the highest Tantric practices and is usually not shared by practitioners with others (Ray 2001; The Dalai Lama et al. 1977). Several monks told me that

practitioners would not disclose such a practice in order to avoid being pompous or being attached to the outcome of their practices. Opening the floodgates to discuss freely about *thugs dam* has helped people to be aware of this contemplative technique revolving around death and dying and perhaps the aspiration to apply it in one's own practice. However, it has created a sense of attachment among caretakers—family members and monastic students—of the deceased individual, wishing that the deceased stay in *thugs dam*, to reflect their realization. I have observed such events during my fieldwork, not only disrupting the normal disposal of a corpse, but also causing tension among caretakers.

### **Delaying Disposal of the Body**

“He must be in *thugs dam*,” “Is he in *thugs dam*?” “I think he was in *thugs dam*,” were some of the common comments I heard frequently when I spoke to monks about their teachers or family members about their deceased loved ones. Of course, I did not say anything to counter their assumptions, except when things started to get a little out of control. For example, there were incidents where the body was decomposing and rooms were filled with a distinct rotting odor, but caretakers were unwilling to dispose of the body.

One case where I had to be firm with my role as a Tibetan doctor was when I attended a senior monk who died due to aging. One early morning, he died, and I was not around. The senior monk was a good practitioner and well-respected and loved in the monastery. One early morning he died, and I was not around. His attendants kept the body for two days thinking he was in *thugs dam*. On the second day, around midnight, one of the attendants called my phone asking if I could come and take a look. I could smell the decayed body odor before entering the house and the odor became stronger when I got to the entry way of the room where the body was being kept. The monk's body had discolored and decomposed badly. My earlier interactions with

Jampa Rinpoche and Gen Wangchen discussing the prospect and signs of *thugs dam* (which I discussed in Chapter 1) were of great help in explaining to the attendants what was happening to the body. After the discussion that lasted more than an hour, we decided to cremate the body early the next morning. For Tibetans, particularly Buddhist practitioners—both monastic and lay—meditative practice like *thugs dam* not only informs what they study and strive to comprehend, but it becomes a ‘symbolic artifact’ that reinforces their beliefs and practices. Hence, the body, even when it displays clear signs of death, the attendants use the monk’s biography to infuse the corpse with symbolic meaning. In so doing, they attempt to transform the body while disrupting the normal course of ritual – a ritual to dispose of the body when it is nothing more than flesh.

## CONCLUSION

Death is a universal phenomenon fraught with ritual (Metcalf and Huntington 1991); this is particularly so in Tibetan cultural funeral rites. While ritual is sometimes interpreted as free of intention, meaning, sincerity, or goal (Lienard and Boyer 2006; Humphrey and Laidlaw 1994; Stall 1990 among others), I propose that such is not the case in rituals surrounding death and dying in Tibetan Buddhist culture. From a functional standpoint, I concur with the suggestion of Hobson and colleagues (2018) that rituals are enactments of behaviors that “regulate emotions, perform stated goals, and facilitate social connections” (263). Engaging in death rituals, therefore, helps Tibetan doctors and Buddhist monks to collaborate with family members in caring for dying individuals.

The enactment of death rites and the way collaborators negotiate with each other and collaborate in accomplishing their project of caring for the dying supports one of my hypotheses

I mentioned earlier in the chapter. Despite their distinct ideas about their roles and understanding about an ideal death in relation to the care for dying people, they were able to find a common ground by being mindful and flexible during the operationalization of funeral rites. One key feature related to caring for the dying that stood out during my fieldwork was a collective emphasis on the consciousness of a dying person or the deceased. The collective focus on ‘consciousness’ was intimately tied to a cultural belief in rebirth, which underpins their collaborative project.

Although Buddhist practitioners do not see their spiritual engagement as “ritual,” the nature of their practices, structured around repetition, formality, and strict discipline, could qualify as ritual. The Tibetan Buddhist practitioners’ understanding of death and the ways in which they deal with it, reflects a very ritualized experience, specifically the dissolution meditation where they rehearse and enact a phenomenology of death as a ritual performance. In Shore’s analysis of ritual (in press), the monk’s practices, which are private and less expressive, could be viewed as implicit rituals; and highly elaborated or collective rituals such as Catholic mass or funeral rites performed in public could be referred to as explicit rituals (7).

Moreover, if we set our discussion on ritual as a framework, we could propose that ritual is a fundamental act of humankind in creating interpersonal communication and coordination between lower and higher level of consciousness.<sup>59</sup> Likewise, ritual bridges difference and commonality, ambiguity and clarity, uncontrollable and controllable, chaos and order/calm, in a manner that is structured, ordered, and automatized by repeated enactment of the act so as to transform it into unquestionable human behavior, without any external intervention. In doing so,

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<sup>59</sup> Level of Consciousness here could be inferred as lower and higher self-consciousness in the context of religion (Schleiermacher, 1768-1834) or to simple awareness of perception and emotion versus capability to be conscious of being conscious in the context of cognitive science (Edelman, 1984).

the *coordination* of acts blurs the boundaries of one's self and one's inner nature as well as one's boundary with other members of society, and the environment. To that end, we could draw a conclusion that in general both the theoretical and functional facets of ritual inform activities of the collaborators in myriad ways. Tibetan death rituals seemed to be infused with an explicit moral dimension.

I found that the general conception among my interlocutors that rituals are cultural practices enacted by lay people and performed for the deceased of the "untrained mind" was not the case when ritual practices were examined closely. While there was a marked difference between death rites specified in the death horoscope and rites related to guiding and transferring the deceased consciousness, they shared similar qualities of ritual where performers engage in repetitive and formalized behaviors with certain levels of focus, motivation, intention, and sincerity. Death rite such as *Pho ba* appeared to accomplish the goals of all three collaborators I was observing: family members saw this as an important way to direct the deceased person's consciousness to the *right* place; Tibetan doctors not only perceived it as a final act of protecting the deceased's consciousness, but aiding in bringing things under control amidst chaos; and Tibetan Buddhist monks saw it as both leading to a good rebirth and as an act that necessitated deep meditation and visualization rather than simply participating in *action*. Moreover, I realized over the course my fieldwork that rituals, particularly formalized rituals like Tibetan death rituals, are saturated with meanings and goals, contrary to what others (Humphrey and Laidlaw 1994; Stall 1990) have theorized.

## CHAPTER 6

### RETHINKING THE CONCEPT OF A “GOOD DEATH”

*“As we enter the new millennium, we believe it is time to break the final taboo of the 20<sup>th</sup> century, and to enable people to take control of their final days.”*  
(Debate of the Age Health and Care Study Group, 1999:9)

#### INTRODUCTION

In 1999, the Debate of the Age (DOA) committee specified that in order to acquire a “good death,” we needed to reverse the trend where death is medicalized, professionalized, and sanitized to the extent that it has become alien and out of control for most people. The committee, in their final report entitled *The Future of Health and Care of Older People*, identified 12 principles of a good death (reported in Smith 2000: 129). These 12 principles of a good death are enumerated as: (1) To know when death is coming, and to understand what can be expected; (2) To be able to retain control of what happens; (3) To be afforded dignity and privacy; (4) to have control over pain relief and other symptom control; (5) To have choice and control over where death occurs (at home or elsewhere); (6) To have access to information and expertise of whatever kind is necessary; (7) To have access to any spiritual and emotional support required; (8) To have access to hospice care in any location, not only in hospital; (9) To have control over who is present and who shares the end; (10) To be able to issue advance directives which ensure wishes are respected; (11) To have time to say goodbye, and control over other aspects of timing; and (12) To be able to leave when it is time to go, and not to have life prolonged pointlessly.

The report’s overarching themes, in addition to reducing pain, were (1) control, (2) autonomy, and (3) independence of dying patients. These themes reflect core principles shared

by the pioneers of hospice care—such as Cicely Saunders, Florence Wald, and Elizabeth Kubler-Ross—that propelled the birth of a new way of caring for dying patients in the mid-sixties in England and North America (Smith and Himmel 2013). However, despite growing concern and ongoing discourse in academia, medicine, and the general public to resolve the way we are dying, current literature shows that the quest for a “good death” has remained elusive for a variety of reasons (see, for instance, Neumann 2016; Gawande 2014; Scarre 2012; Green 2008; Kaufman 2005; Webb 1997 to name a few).

In their literature review addressing the definition of a good death based on attitudes of patients, family members, and healthcare providers, Meier and colleagues (2016) establish 11 core themes (267), overlapping with the 12 principles of a good death recognized by the DOA. However, Meier and colleagues argue that the respondent groups differ from each other when it comes to their perspectives on a good death. For instance, while families’ perspectives focused on “quality, completion of life, and dignity,” patients’ focus was on “religiosity/spirituality” at the end of life (261). This discrepancy, I propose, highlights one of the core setbacks that resulted from the divorce of medicine and religion in existing medical practice. Although the foundation of hospice care is rooted in the integration of medical care and the religious/spiritual needs of the dying person<sup>60</sup>, the latter requirement is often ignored in the midst of attending to the dying person’s deteriorating body and dignity by healthcare providers and family members respectively (Neumann 2016). Recent scholarship echoes the general understanding that even though good medical care and control of pain may contribute to achieving a good death, it is

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<sup>60</sup> See Coward and Stajduhar (2012), for example, on the philosophy of hospice care.



unlikely to facilitate “meaning and purpose in old age and death” (Schenck and Roscoe 2009: 62).<sup>61</sup>

Geoffrey Scarre, a moral philosopher, questions the very existence of a “good death,” and made an interesting claim about its prospect. Scarre argues that despite the good intentions behind the DOA principles of a good death, it “rather gives an impression that looking after the dying is akin to organizing a conference, assembling flat-pack furniture or baking a cake: something that ought to turn out all right so long as the rules are followed” (2012: 1083). Scarre’s critique is critical when we take into consideration the significance of the role played by the dying person in dying well. A death without any preparation from the dying person could topple any well-strategized plan as related by the Stoic philosopher Seneca: “Learning how to live takes a whole life, and, which may surprise you more, it takes a whole life to learn how to die” (2005: 6).

While exploring the concept of a good death has been a subject of contentious debate in Euro-American culture, it is not necessarily the case in Tibetan Buddhist culture. Building upon this background, this chapter examines the concept of a “good death” in the context of Tibetan Buddhist culture. The chapter investigates how different notions of death and dying in Tibetan medical and Buddhist practice inform the way death and dying is conceived and enacted. I respond to this question via two main approaches derived from my ethnographic data: (1) interlocutor interviews (comprised of Tibetan medical doctors and Buddhist monks) to inform a philosophical stance toward death and dying; and (2) presenting cases of dying people that illustrate their process of dying. Further, I show how the quality of death is understood and

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<sup>61</sup> Also see Katy Butler’s acclaimed book *Knocking on Heaven’s Door: The Path to a Better Way of Death* (2013) where she writes about the dire state of end-of-life care in America.

applied among Tibetans and what the implication of this is on the dying person as well as their caregivers.

### **THE DICHOTOMY OF A “GOOD” AND A “BAD” DEATH**

Whenever we engage in a conversation related to a good death, a ubiquitous sight in our minds is a person dying at home surrounded by loved ones, communicating their last wishes, and thus dying a “natural death” (Gawande 2014; Aries 1974). This view correlates with one of the common themes identified during my fieldwork among Tibetans. However, in the early spring of 2017, a cardiologist Haider Warraich raised many eyebrows when he wrote in the *New York Times* Opinion section that although such a splendid representation of death (natural death) continues to be widespread in both modern literature and pop culture, “they are mostly fiction at best.” Warraich contends that in the current climate of care for the dying—with myriad resuscitative technologies—a “technology-free natural death” has almost become obsolete.

In the same vein, Scarre makes a case against the fantasy of a good death by adding a philosophical dimension, without denying that some deaths are better than others or that excellent care offered by healthcare providers might ameliorate the process. Scarre defends himself by saying, “Rather, the claim is the philosophical one that since the ending of a human life is always the loss of a valuable, irreplaceable thing, the expression “good death” is necessarily an oxymoron” (2012: 1083). Both Warraich and Scarre’s critiques address the ongoing shift in the way Americans perceive death, as well as dying – a common understanding that death has been stripped of its religious/spiritual meaning and is highly medicalized. Shai Lavi, a committed researcher in interdisciplinary studies on end-of-life care referred to this

phenomenon as a gradual shift from “art to technique” in Americans’ quest for achieving a good death (2005: 10).

Shai Lavi, interestingly, sheds light on the other end of the spectrum of end of life – the hastening of death via euthanasia. Considering the medical advances in the United States over the last couple of centuries, its impact on the ways in which Americans die, and in the context of the moral or ethical question of how patients should die, Lavi’s work contributes to the ongoing discussion by providing a thoughtful and concise history of euthanasia in the United States. Lavi effectively uses the practice of euthanasia to demonstrate the ways in which Americans have stripped the social meaning from dying, specifically as related to religion. According to Lavi, for centuries, the deathbed in the Christian world was governed by religion, and euthanasia signified a death blessed by the grace of God. The literal meaning of euthanasia, Lavi emphasizes, is quite different from its present usage. Euthanasia is a compound of two Greek words—eu and thanatos, which together mean a good death or an easy death. But a good death being an easy death was exclusively the matter of divine province or good fortune, and beyond human control. Lavi argues that “euthanasia,” in its original sense, was “a death one could hope for but never be assured of” (2005: 5).

In the early nineteenth century, Americans named this triumphant passage to death—that is, dying in the arms of Jesus without pain—as “euthanasia.” The word signified a pious death blessed by the grace of God” (2005: 1). By the mid-nineteenth-century, euthanasia meant “a painless death accompanied by physician assistance” (ibid: 2); and by the late-nineteenth-century, euthanasia gained its familiar meaning: “the use of anesthetics to guarantee a swift and painless death” (ibid: 3). Attempts were made to legalize euthanasia and the first pro-euthanasia organization in the United states, the Euthanasia Society of America, was founded in 1938.

However, the proposals to legalize euthanasia is still debated in the United States. Similar to Lavi, numerous scholars in this field have posed the question: How did the idea of euthanasia as the medical hastening of death emerge as a characteristically modern way of dying? (Bishop 2011; Lavi 2005). The origins of euthanasia, in Lavi's view, "lie in the movement of dying from the domain of religion through that of medicine and finally into the jurisdiction of positive law and public policy. It is a movement that itself is driven, following Heidegger, by what I refer to as the rise of technique and the decline of art in our world" (2005: 4). Interestingly, this "new" form of euthanasia in the realm of modern medicine is fiercely objected to by religious institutions (Butler 2013).

Analogous to the way death is prolonged under the scrutiny of medical personnel and modern technologies (Green 2008), Lavi stressed that euthanasia quickly transformed into the new art of dying, where the ordering principle of the deathbed had shifted from religion to medicine. The notion of euthanasia changed where it no longer meant a good death but rather it signified the actions taken by physicians to achieve a "hastened death" (Lavi 2005: 6). The proponents of euthanasia have referred to it as a peaceful death devoid of pain while safeguarding the dignity of the dying person. However, the death of Thomas Youk in 1998 through euthanasia stirred renewed controversy. 52-year-old Youk suffered from amyotrophic lateral sclerosis (ALS), a degenerative nerve disorder where nerve cells slowly die and muscles atrophy until the heart stops receiving signals from the brain and ceases to function. Youk, like many other ALS sufferers, feared his condition would get worse as he lost control over his body, and despite his approval and his family's request to implement euthanasia, Dr. Jack Kevorkian, notoriously known as "Dr. Death," was imprisoned on man-slaughter charges for assisting in that death (Green 2008).

While the nature of death itself has not changed, the way it has been conceived, experienced, and treated has changed over the centuries (Barrett 2008; Aries 1974). Similar to the hastening of death, the modern medical practice of prolonging life has altered the way Americans are dying as compared to earlier times, especially considering that the majority of people living longer are dying from chronic diseases rather than acute infections (Green 2008). Moreover, it is evident that a good or a bad death is not susceptible to fixed categories and is inherently ambiguous in nature.<sup>62</sup>

The aforementioned complexity of a “good death” prompts a series of questions: Why are the majority of Americans not dying the way they want to die? Is there any contradiction between the expectation and reality of a good death? Is a peaceful death defined as a death devoid of pain, and is that a good death? More importantly, if acquiring a good death cannot be based solely on a set of to-do-lists by caregivers (as argued by Scarre), how can one prepare to die well? Moreover, we cannot validate any theory of a “good death” by its very nature, for we cannot ask a dead person for feedback. Nevertheless, we can know through the observation of a dying person whether he or she died peacefully and observe its positive implications on family members and others around the dying person.

Haider Warraich (2017), for instance, makes an interesting point in understanding good death by observing the ways in which our cells die. Warraich argues that although apoptosis causes cells to die, its mechanism of controlled self-demolition is better than other forms of cell-dying, such as necrosis or autophagy, where cells die in the “ugliest and least elegant form,” causing problems to other parts of the body. In contrast, apoptosis sets in when a cell becomes old and quietly dissolves without causing harm to other cells, reducing any chance of mutation.

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<sup>62</sup> See van der Geest (2004) and Long (2004) for attitudes toward a good death in Kwahu-Tafo in Ghana and Japanese societies, respectively

Warrach thus asserts that “Apoptosis represents the ultimate paradox – for the organism to survive, the cells must die, and they must die well (2017: 4).

## **PREPARING FOR DEATH**

It is common sense that preparation for any future event requires acquisition of good knowledge and a certain level of familiarity with the event. In that sense, it is fair to conclude that in order to prepare for death, one has to have a sound understanding of death and the process of dying. Unfortunately, death has proved to be one of the most mysterious worldly phenomena, and humans have only exaggerated that mystery by making it more complicated (Laureys 2005). A renowned American anesthesiologist and medical ethicist, Henry Beecher, rightly remarked: “Only a very bold man, I think, would attempt to define death” (1970). The complexity of defining death in the United States increased in 1968 when the *Ad Hoc* Committee of Harvard Medical School, comprised of physicians, a theologian, a lawyer, and a historian of science, published a landmark paper defining death as an irreversible coma in “A Definition of Irreversible Coma.”

This new definition of death focused entirely on the activity of the brain and stems from the need to provide for a legally regulated procedure for the facilitation of organ transplantation (Lock 2002). As a result, the existential human problem of death that has been linked to the very source of human culture and behavior (Becker 1974; Freud 1915) gained an additional layer of complexity. The report took the problem of death to law and ethics, and in so doing, “has made physicians into lawyers, lawyers into physicians, and both into philosophers” (Joynt 1984). Steven Laureys, a leading researcher in the neurology of consciousness, noted that the redefining of death from cardiorespiratory to neurocentric diagnosis forced by modern technology raised

“ethical, moral, and religious concerns” rather than pacifying the existing controversy (2005: 889).

While death in the West has been dehumanized, stripped of its meaning, made murkier, and most of all, has lost its stature of being a moral compass (Butler 2013), the Tibetan Buddhist tradition has maintained a firm grip over the role of death in everyday life (Varela 1997). Given the close connection between caregivers’ conceptions of death and how they care for dying people (Braswell 2014; Varela 1997), I was particularly curious to examine the relationship between these two components in Tibetan Buddhist culture when I ventured into my fieldwork. The question, “*What is your conception of death?*” thus became one of my customary questions for all my interlocutors. In the course of my fieldwork, most of my monk participants at Drepung monastery encouraged me to meet with Gen<sup>63</sup> Palden Dakpa, who happened to be a special teacher to almost everyone to whom I spoke. It was not until three-fourths of my time in the field had elapsed that I had an opportunity to interview Gen Dakpa.

### **SLEEPING IN A MOTHER’S LAP: JOY, LOVE, AND TRUST**

At the age of 18, Gen Palden Dakpa, like thousands of Tibetans, escaped Tibet into India via Bhutan in 1959, following the Communist Chinese invasion of Tibet. At the time of writing this manuscript, he was 86 years old and had spent over 40 years at Drepung monastery serving in different capacities. Gen Dakpa was extremely modest, almost to the extent of making others feel a little uncomfortable; and it actually was one of the reasons it took so long before I was able to interview him. Every time I would ask him for a time to talk, he would smile politely, tell me

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<sup>63</sup> Gen (*rgan*) in Tibetan literally means adult or elder, but it forms a word teacher (*dge rgan*) when it is combined with another syllable *dge*. The term ‘gen’ (the second syllable of a teacher) is commonly used for a teacher as well as among peers in the monastic community. Here, I used the term ‘gen’ to refer to senior teachers.

he knows very little and that I should speak to other teachers at the monastery who are more knowledgeable. I also did not push him much, hoping that the interview would happen at the right time. Finally, after almost a year of being in the field, I managed to set up an appointment to interview him. Gen Dakpa's attendant, who had some questions regarding his teacher's health, called me, and as we were talking, I asked if there was any way I could come to see Gen Dakpa. The attendant promised to call me after asking Gen Dakpa about it. The attendant later called to say Gen Dakpa would be happy to see me the next day in the afternoon.

The next day was a Sunday. I rode my scooter toward Gen Dakpa's place at around 3 pm in the afternoon. The main street that stretched through the middle of the monastery had started to get crowded with monks and vehicles in preparation for Monday. At the monastery, Monday is a weekly holiday, and the only day when monks could go to a nearby local markets to do shopping or eat in restaurants. It was a much cooler day than usual and the surroundings looked fresh and clean after a heavy rain the night before. Gen Dakpa's attendant was waiting outside his room and told me we could go straight to Gen Dakpa's room, which was right above his own place. He escorted me up narrow stairs to the first floor, to the far corner room.

The front door to Gen Dakpa's living space lead to a tiny little kitchen, and then to the main room. It is a small place with huge windows on either side of the room. The wide windows let in bright light and cool air, but it was also loud from the noise of vehicles running on the street below. I was told that his students had offered to build a better place for him on multiple occasions only for him to say, "if others can live like this, why not me?"

Gen Dakpa was sitting cross-legged on a low-raised single bed when I entered. He hurriedly asked me to come straight inside when he realized I was going to prostrate in front of him to show my respect. I offered my *kha btags* (pronounced *khatak*)—a traditional Tibetan



scarf offered to pay respect—to Gen Dakpa and sat on the carpeted floor in front of him. He looked healthy except for his shortness of breath and swollen feet and legs. He made me feel comfortable by enquiring about my fieldwork and said he appreciates the fact that younger Tibetans were coming to a monastery to study Tibetan Buddhism. When I enquired about his health, he told me he had a heart issue and a recurring skin problem, but generally he was doing well. Looking at his swollen legs, I instantly thought about a potential congestive heart problem.

As I got ready to start my interview, taking out my notebook and voice recorder, he laughed and reminded me again that there wasn't much he could tell me. Leaning forward, he held my hand and said, "Perhaps we can just discuss your research work rather than doing this interview thing?" I respectfully explained to him that it would help me to listen to our conversation again if I recorded it, and moreover, there was no way I could write everything down. So, I placed the voice recorder as close as possible to him as every now and then, the outside noise became quite loud.

### **Conception of Death and How to Die**

To start our conversation, I asked Gen Dakpa how he conceived death. He smiled and said, "Death is one of the most natural things and can happen anytime to anyone." He added, "Death is something everyone should be prepared for; and is even more important for Buddhist practitioners."

I followed up by asking how one should prepare for death. He laughed heartily at my question, repositioned his sitting, and said, "Let me explain to you with an analogy." Now, his demeanor was not only friendly but also excited. He said, "Think about taking an exam at a school." Drawing an analogy between dying and exam taking, he said:

Just like we all graduate from school by sitting in an exam, we graduate from the cycle of samsara by dying. See, if you are attentive in classes from the day one, doing your homework regularly and efficiently, you would not feel stressed and would not panic when the exam draws closer. Rather, you would know that you are prepared, and would look forward to it joyfully as you go to take your exam. In the same manner, if you live your life well, are mindful of your behavior [body, speech and mind ], instead of being anxious, you would joyfully look forward to your dying, without any regret and fear, understanding the prospect of graduating or being free from samsara – the cyclic existence of life, death, and rebirth.

I thought no wonder Gen Dakpa is respected and sought after at the monastery. His skill at articulating complex cultural values and beliefs informed by Buddhist conceptual models in a simple yet erudite manner helped me understand and conceptualize my own death with much more enthusiasm. Likewise, his explanation beautifully tackled the existing quandary about the reliability of achieving a good death based solely on caregivers following a set of principles, and whether there is anything one can do to be empowered enough to die well. Katy Butler (2013), in her endeavor to change the healthcare model of assisting the dying in the United States, following the distressing experience of observing her aged father die, stresses that a good death is extremely hard to obtain in the current US health system. However, Butler proposes a way to shield oneself from an intrusive healthcare system at the time of dying:

Things go better if we practice the steps of the dance beforehand. Perhaps if we find ways to make the pathway to natural death sacred and familiar again, we will recover the courage to face our death. If we don't, technological medicine at the end of life will continue to collude with our fear and ignorance and profit from it. Unless we create new

rites of passage to help prepare for death long before it comes, we will remain vulnerable to the commercial exploitation of our fears and to the implied promise that death can forever be postponed. (2013: 271).

Yet it is understandable that most dying people might get nervous when death actually happens or feel that they haven't led a life to be courageously and fully prepared to die well. Similarly, often it is observed that preparation does not always unfold as planned and one might need help. (Scarre 2012). With that in mind, I asked Gen Dakpa how a dying person can perform as well as one has prepared, considering potential fears and surprises. Gen Dakpa seemed genuinely pleased that our conversation was deepening because apart from being nice and excited (which I assume he was to everyone), his attendant peeped through the door curtain and said someone he was to meet had arrived. I glanced at my wristwatch and realized that we had been talking for well over an hour and I thought that I would likely need to come back again later, but he quickly told his attendant to tell the person to come back the next day.

Gen Dakpa turned his attention back to me and said it is helpful to think about one's spiritual teacher at the time of death. For instance, among Tibetans who are Buddhist, one can think about one's lama, such as His Holiness the Dalai Lama. He came up with another analogy to illustrate the importance of thinking about one's teacher or someone you trust. He said:

Let's think about what a parachute jumper should do when he is nervous or a little overwhelmed, falling rapidly to the ground. When you do a parachute jump, there is a chance that you might get a bit scared and a bit nervous too, especially for the beginners. At that time, it is important that you think about your instructor, and remember his instruction, and pull the pin at the right time. And once the parachute opens, you can land safely on a ground. Likewise, it is helpful to think about your teacher, or someone like

the Dalai Lama, and try to meditate on his teaching. Such a mental state can be of great help to die peacefully, without or with less fear and anxiety.

Gen Dakpa paused for a few seconds, and as if he was thinking about something, grabbed a small metal-ball—almost the size of a golf ball—kept under his bed and gently hit it on the floor several times. I wasn't sure what he was up to until his attendant peeped through the door. It was their mode of communicating whenever Gen Dakpa needed to call on him. Gen Dakpa chuckled and asked, "Shall we have some tea? It seems like we are going to talk for some time." I tried telling him that I was good without tea, but his warmth kept me at bay. He turned back to me after his attendant left and said:

The most important way to prepare for death is actually when you are alive and healthy—actually, right now! It is imperative that one should possess a pure intention in life. One should generally avoid focusing his or her life on money and fame. Rather, one should do one's best in keeping an intention to help others and creating a harmonious environment.

It would be good for everyone to have such an attitude.

However, despite the importance of preparing long before one is to die, he added, "The time of dying is critical too." He said, as he had mentioned earlier, that it is crucial to have a calm mind, and to refrain from any kind of mental poisons/afflictions, such as anger, attachment, or delusion, and rather focus on one's lama (spiritual teacher) or a person whom one trusts and in whom one has a deep faith in. Furthermore, he said that since death (in Tibetan Buddhist culture) is defined as a state when one's consciousness leaves the body, one can continue to think, and use one's cognitive power until the very end, provided a dying person's mind is calm and clear.

As Gen Dakpa emphasized a peaceful mind, I felt a little apprehensive, thinking about a question I wanted to ask. But considering his openness and warmth, I decided to go ahead. I

asked if he had prepared for his own death, and if so, how did he wish to die? Interestingly, he looked at me, with a broad smile, folded his hands together, and said that he doesn't do much preparation at all, other than trying to follow what he had told me earlier about how one should lead one's life. Further, he said, "When my death comes, I wish to die like a child falling asleep in a mother's lap – with joy, love, and trust."



The author with Gen Palden Dakpa in his room at Drepung Loseling Monastery

Gen Dhondup, my field supervisor, echoed what Gen Dakpa said when I asked him if he did any preparation for death. Like many other Tibetan Buddhist practitioners, he seemed uncomfortable talking about his practice. I have often heard and observed that it is considered culturally inappropriate among Tibetans to talk about one's own accomplishments, even more so when it comes to a sacred (tantric) practices such as that of "death meditation". It is emphasized amongst Tibetans that talking about one's own achievement can cause one to get attached to the outcome, which can further inhibit progress and cause suffering. Gen Dhondup, with a nervous smile, said that he did not do anything special to prepare for his own death. He added:

There is not much to prepare for death. The most important thing is to be a kind person, help others, and engage in creating a peaceful and harmonious communal environment. It is quite clear that one would have a bad outcome if one is an ill-natured person. On the other hand, if one is good-natured, it would not only create a peaceful and productive environment in this life, but also have a positive effect in the next life. However, one should study and engage in such practice in advance on a regular basis. If one is acquainted with genuine love and compassion on a daily basis, one can [easily] generate love at the time of dying. For example, if one does not study and prepare well in time, it is certain that one will face hardship at the time of an exam.

Most of my interlocutors at the monasteries I visited shared a similar attitude when it came to prepare for one's death – that the best way to prepare for death is to engage in virtuous acts and refrain from non-virtuous behavior (an inclusive notion of behavior that encompasses actions of body, speech, and mind). Such cultural beliefs that lead to a good (virtuous) life in order to have a good death is not exclusive to Tibetan culture. For instance, Kramer (1998) describes the prevalence of such attitudes among Christians, Jews, Hindus, and Muslims, among others. However, the Tibetan cultural approach toward preparing for death is based on a nuanced understanding of death and dying on a philosophical, physical, and psychological level (discussed in Chapter 2) and its intimate relationship to one's own wellbeing and communal harmony at the time of death. This perspective presents a reliable pathway to dying well. Unlike other cultures, and particularly unlike many contemporary societal contexts, the collaborative project of a "good death" is *actively* spearheaded by the dying person in Tibetan culture. Patient-autonomy in this cultural scenario does not paint a picture of a vulnerable dying person, but rather a captain of the ship, who leads his or her team by example.

An elderly Tibetan layman, who regularly engaged in helping a dying person or the deceased person's family by reading Tibetan Buddhist texts to them, made a pertinent analogy by saying, "The role of a dying person is like a chef; and everyone around is a sous chef. In order to prepare a good meal, the chef has to be efficient, directly or indirectly." His observation was intriguing because such an interpretation of the role of a dying person prompts the question: How could a dying person, with severe physical deterioration and possibly overcome by pain and anguish, endeavor to die well? Why is it crucial for the dying person to be the one leading the process?

## **DEALING WITH PAIN AND SUFFERING**

### **Pema's Death**

Pema seemed to be in a lot of pain and suffering when I first saw him. He was lying on the bed in a tiny room with his eyes shut, his bare chest exposed with protruding ribcage and shoulder bones. He was breathing heavily. Pema, at 93, was one of the oldest residents of the Tibetan Old Peoples' Home in Mundgod, which is run by the Tibetan Central Administration (formerly known as the Tibetan Government-in-Exile). There were close to 70 residents and Pema had been at the Old Peoples' Home for the last 40 years. As I sat next to him on a chair, he surprised me with a rather energetic greeting: "Tashi Delek! (best wishes in Tibetan) Are you the Tibetan doctor they said would come to see me?" I greeted him and said, "Yes, it is good to see you."

"I cannot see anything, but I do almost everything myself," he added.

"I did not know that you cannot see. That is very impressive," I responded.

“I am feeling fine other than this frequent indigestion and constipation,” he said while putting his right hand over his lower abdomen.

“Let me check your pulse and see what I can do.”

“I am glad that you could come because I realized lately that my appetite has gone down, and my other medicine [biomedicine] is not helping me much with my breathing either.”

As I checked Pema’s pulse, I realized that besides his general weakness it seemed like he was developing pulmonary edema, a condition caused by excess fluid in the lungs. I understood that such a condition is not a good sign for someone of Pema’s age. I told Pema that his lungs were taking in too much water and that they were making him weak and causing his difficulty in breathing.

“Do you have any history of tuberculosis?” I asked.

“Yes, a long time ago, maybe 10, 15 years ago.”

“I will prescribe some Tibetan medicines for you, but it would be good to talk to your [Western] biomedical doctor to see if he wants to change any medication.”

Right around that time, one of the caretakers at the Old Peoples’ Home came in with a big kettle. It was morning teatime. It worked out well for me because I wanted to know more about Pema other than what little I could glean about from his worn-out patient record book. After conveying to Pema that I would join him in few minutes, I followed the caretaker. As I was waiting outside Pema’s room for the caretaker to finish serving tea to the rest of the residents, Pema’s monk friend joined me. Pema’s friend, who was from a nearby monastery, told me he came once a week to see him, but that he had been coming more often since Pema’s condition had started to deteriorate during the last few days. I learned from Pema’s friend that he and Pema



were from the same region in Tibet. “Pema is a strong person,” his friend said. “He is kind to everyone despite all the hardship he went through.”

Pema has had a hard life since he escaped from Tibet into India in 1961. I have, however, never seen him complaining or feeling bad about his situation. He lost his eyesight in an accident when sharp small [rock] chips from explosives hit his eyes while working in road construction by the foothills of Himalaya [a newly formed international border between India and China] along with thousands of other Tibetan refugees. When Pema finally found his home at the Tibetan settlement in south India in the late seventies, the tropical humid climate did not suit him. He developed nasty flu-like symptoms for months and was eventually diagnosed with tuberculosis. He recovered from TB after a long course of treatment, but he never really regained his full health.

As we were talking, the caretaker, after serving tea to all the residents, came over with two huge mugs of tea for us. Before I could ask for a smaller portion of tea, she handed me the mug and said, “Have some tea. It is not that good but will help to freshen you up and be more efficient in helping patients.” She was wearing a pair of over-sized rain boots that made her drag her feet as she walked. She looked tired and her eyes gave me the impression that she did not get much sleep but that that did not deter her from energetically doing her job and being amusing at the same time.

“I was the one who called you earlier today to come see Pema because he has not been eating much these last few days and seemed tired most of the time,” she said.

“Did you have anyone else, doctors or nurses, to come over to see him?” I asked.

“We do not but one of our staff went to the local hospital nearby to get some [Western] medicine for his breathing problems that have gotten worse lately. He did not feel better with the new medication, so he asked for a Tibetan doctor.”

“I felt from his pulse that he is quite weak and that he has also developed an infection in his lungs.”

Pema was still lying down when we went inside the room, but he had pushed aside the bedsheet that was covering him earlier. It had become quite hot inside the room. He raised his right hand toward us when he heard us. I held his hand and asked if he had had some tea. He ignored my question and asked if I could give him any Tibetan medicine for his constipation. “My digestion gets better when I have good motion, and that helps with my appetite too,” he added.

I promised I would do so, and told him that besides poor digestion, he had a minor chest infection. I said he had to be careful not to expose his chest to the ceiling fan, which was right above his bed. I prescribed some Tibetan herbal medicines and gave the prescription to the caretaker and told her to contact me if Pema had any problems. Before leaving, I told Pema about the Tibetan medicines I had prescribed for him and that I would come over whenever he needed me.

I did not hear from the staff at the Old Peoples’ Home for four days, and then on the fifth day, the caretaker called my phone early in the morning, around 5 am. She said that Pema’s breathing had gotten worse that night and that he did not look good. I contacted the local Tibetan doctor, Kunsang, to accompany me so that I could have his input. Dr. Kunsang came along with a monk, who was one of the interns at the Tibetan medical clinic.

Inside his small room, Pema was lying still and breathing laboriously but he responded to our presence right away. He greeted us and this time, his voice was low, almost to the point of whispering. Pema's monk friend was there with another monk. Pema's friend told us that they had been around over the last two days, taking care of Pema because Pema could not walk around or do anything. After Dr. Kunsang and the intern checked on Pema, they asked if I would like to see how Pema was doing. Pema's hands were cold, his pulse had grown much weaker, and every now and then, he would squeeze the corner of the bedsheet he was wearing with his left hand. Pema's condition did not look good. When Dr. Kunsang asked Pema if he would like to be shifted to a hospital or if he needed any kind of an intervention to relieve him of pain or breathing difficulty, Pema refused right away – he whispered, and as if to reconfirm his wish, he moved his head sideways, indicating his unwillingness.

After Dr. Kunsang and the intern left, I sat by Pema's side for some time. Pema's monk friend took out a small portable blue-colored speaker out of his bag, hooked it up to his smartphone and played the Dalai Lama's teaching. He kept the speaker right by the corner of the bed so that Pema could hear it. Tibetans believe that hearing the words of a spiritual teacher at the time of dying helps a dying person to stay calm and focused and wards off any feeling of fear or anxiety.

Pema seemed calm and composed other than occasional bouts of pain and heavy breathing. He almost looked as if he was meditating. He would respond and acknowledge me whenever I touched his hand by moving his head. For almost an hour, Pema oscillated between a state of calm, a meditative-like mode where he stayed still and relaxed; and a state of unease where there were abrupt changes in his breathing pattern and his face grimaced in pain. But not once did he groan in pain or seem agitated. Around 9 am, Pema's breathing became shallower

and started to develop a rattling sound. After a few minutes, Pema shed a teardrop from his right eye and slowly stopped breathing. I checked his pulse—both at the radial and carotid arteries this time—and could not feel anything. Once we realized Pema had died, one of the monks took out a text from his bag and told me Pema had asked them to read the text when he died. The monk further told me that the text was a special Buddhist text called *Künrik Ngensong Jonggyü Dakjuk* (Tib. *kun rig ngan song sbyong rgyud bdag 'jug*), *Rites for the Deceased: Self-Empowerment for the Purification of All Bad Migrations Tantra*, which is read to support the dying person's consciousness as the consciousness makes a transition to the next life through the *bardo*.

A few minutes after Pema's death, the room was all calm, other than the sound of the monk reciting the text. There was no crying, chaos, nor hurriedness or anxiety amongst the caregivers. Pema's monk friend was helping the caretaker to fill butter lamps. An elderly lady, who considered Pema a family member, stood by the wall working on her prayer beads. I sat there absorbed in the tranquility that Pema generated during the last minutes of his life. It was interesting to witness the way in which Pema conducted his last moments, from the time I had met him five days earlier, until a few hours before he breathed his last breath. It was almost as if he had a dialectical relationship with his mortality and the pain and suffering that preceded his death.

I felt that Pema's relationship with pain and suffering during the process of dying was more than an acceptance with the reality of our mortality; Pema seemed motivated and dedicated to what he was doing. Inflicted with a chest infection and significant pain during the last five days of his life, he sought relief for his indigestion and constipation, yet at the same time, he made sure he was in control of his dying, important in maintaining his mental clarity. He refused to be taken to a hospital or be given any pain medication; and on the last day, when we were all

getting a little worried and started playing the Dalai Lama’s teaching on the speaker (which is usually a cue among Tibetans that the end is near), he lay still and relaxed, responding to our touch or queries, and died the way he wanted. Pema’s death made me think about how one can die with calmness and a sense of conviction in the face of pain and suffering. How did someone like Pema choose to accept death and overcome his anxiety about dying?



Figure 14: a) Tibetan doctor and monk-doctor intern checking on Pema; b) the author with Pema, c) a monk reciting a Buddhist text after Pema passed away.

## CULTURALLY INFUSED ATTITUDES TOWARD PAIN AND DEATH

Mark Zborowski’s (1952) seminal work on the way members of different cultures may have differing attitudes toward pain and respond to pain differently helps to make some sense of Pema’s way of relating to pain and death. Zborowski posits two of these attitudes toward pain as “pain expectancy and pain acceptance.” He describes pain expectancy as “anticipation of pain as being avoidable in a given situation,” such as in childbirth; and pain acceptance as “characterized by a willingness to experience pain,” such as during initiative rites or part of medical treatment

(1). Refraining from resisting an inevitable event such as death or symptoms associated with the disintegration of the body takes away much of the stress and anxiety, but, as I mentioned earlier, Pema's act seemed to transcend the mere acceptance of pain and suffering associated with death. I posed this question to Geshe Phende. I asked him, "How does someone not only accept pain and suffering, but in some way, change the relationship to pain?"

### **Practicing *tonglen* (Tib. *gtong len*): Others Before Self**

Geshe Phende told me that one of the hallmarks of Tibetan Buddhist practice in dealing with suffering and its related emotions is to investigate them and see if there is a way to transform them. There are different techniques to do that, but one of the most effective tools is *gtong len* (*tonglen*) practice. "*Tonglen*," he said, "in Tibetan, literally means 'give and take'" [*tong* as to give and *len* as to take]. "This might sound simple, but it is very, very powerful," he added, meeting my gaze for a few seconds, as if to alert me not to take it lightly. "I used *tonglen* meditation myself when I almost died a few years ago," he said.

*Tonglen* practice could be helpful for someone at the time of death because it helps the meditator to be strong from inside [mentally]. During *tonglen* meditating, one needs to feel [and experience] while visualizing the process of 'giving and taking'. So, the question is how one should experience that process. In order to do that, one needs to develop [mental] closeness to all the other sentient beings, a deep sense of affection for others. And how does one develop that sense of closeness? One should try to see all the good qualities of others and what they have done for you. If one is able to generate that kind of feeling, then, one can use the experience of pain and suffering to understand others' suffering, empathize, and generate a deep sense of concern and willingness to help them. One could do that by *giving out* love and affection and all the merits one has

accumulated to others; and *taking in* their pain and suffering. In that way, one is able to view pain differently, and thereby transform the way one feels and experiences pain and suffering.

Geshe Phende further stressed that as long as one is less focused on oneself, one would be less anxious and happier at the time of dying. “Compassion is the key,” he emphasized with a broad smile.

As I spoke to my interlocutors, how much ever I tried, it was not easy to refrain from wondering how clichéd it sounded every time I heard the word “compassion”, even for someone like me, born and raised in Tibetan culture. It was especially difficult in the beginning, when I was trying to elicit something different, novel, some kind of “groundbreaking recipe” than what I had read or heard about. But to be honest, during the course of my fieldwork, I observed that my understanding of whatever I had heard or read about compassion was not only very shallow, but I felt that I had not even properly dipped my toes into the pool of my interlocutors’ conception and enactment of what they referred to as compassion. Perhaps that was the reason Geshe Phende looked at me intently and made sure I got it when he said: “This might sound simple, but it is very, very powerful.” To my excitement, I quickly realized that compassion was not just one of the tools to stay sane and to be a legitimate Buddhist, but it was the very engine that drove the whole enterprise of being alive, or more precisely, “consciously alive”, as one of my monk friends corrected me when I smugly used the phrase during one of our morning walks.

### **Dying with Compassion in my Heart**

A monk who was one of the cooks in the monastery’s restaurant, and with whom I had developed a good friendship, once surprised me when I asked him how he wished to die. He was more into catching up on football (soccer) news, so every time we met, our conversation usually

began and ended with Messi, Barcelona or Manchester United. I asked him the question more to get a sense of how monks in general (beyond teachers and adept practitioners) see themselves as (ideally) dying. My monk friend, without hesitating with “umm” or “uhhh,” just said, “I wish I could die with love and compassion in my heart.” “That is what would help me the most,” he added.

It is possible that a word like “compassion,” if not made relevant to everyday life, could become compartmentalized as a sheer cultural norm, or even as jargon, where people think they know what it is but fail to articulate it, and hence, find it hard to apply in life. However, it is not to say that the term compassion has not been part of moral narratives across cultures. For example, religious historian Karen Armstrong (2010) notes that the word for compassion in Semitic languages—*rahamanut* in Hebrew and *rahman* in Arabic—is etymologically associated with the word for womb, conjuring the mother’s love for her child as a prototypical expression of our compassion. The Latin root of the word compassion literally means “to suffer with” (Jinpa 2015: xxi). Thupten Jinpa, a well-known Tibetan Buddhist scholar and philosopher, asserted that compassion at its core, “is a response to the inevitable reality of our human condition—our experience of pain and sorrow” (2015: xxi). Jinpa, with his strong Buddhist cultural background and practice, defines compassion as a “sense of concern that arises when we are confronted with another’s suffering and feel motivated to see that suffering relieved” (2015: xx).

### **Compassion as a Supreme Tool**

In his thought-provoking book, *A Fearless Heart: How the Courage to Be Compassionate Can Transform Our Lives*, Jinpa narrates a beautiful story of an elderly monk that the Dalai Lama has often shared during his teachings. Jinpa writes:



The Dalai Lama often tells the remarkable story of an ordinary monk who in Tibet was a member of His Holiness's personal monastery. Unable to escape to India in 1959 with the Dalai Lama, Lopon-la remained behind in Lhasa. In the wake of the Cultural Revolution, however, he was sent to a Chinese labor camp and prison in Tibet, where he remained for eighteen years. In the early 1980s during a period of policy relaxation inside Tibet, Lopon-la was able to come to India, where he rejoined the Namgyal Monastery. As a senior member of the monastery, occasionally he would spend time with the Dalai Lama. During one casual conversation, the Dalai Lama says, Lopon-la remarked that he faced grave dangers on one or two occasions during his prison years. Thinking that he was speaking about some kind of threat to his life, the Dalai Lama asked what kind of danger he had faced. To this, the monk replied, "The danger of losing my compassion toward the Chinese." This is resilience par excellence. (2015: 186-87).

Dr. Shriram Shamasunder, an Indian American Assistant Clinical Professor at the University of California San Francisco, during his time as a volunteer doctor at a small rural hospital in a Tibetan refugee settlement in Bylakuppe in south India, shares his eye-opening experience through poetry. Despite being born and raised in a place not too far from the Tibetan colony, he expresses surprise that he had never known much about Tibetan monasteries and the huge Tibetan refugee settlement. He quickly realized that he was in a place with completely different notions of "life purpose and productivity" (2006: 1). He writes: "Soon after I arrived, I pointed out to a monk that a mosquito was sucking his blood. He [the monk] nodded in acknowledgement and said something brief about the accumulation of merit and allowing another being to nourish itself off your own," while Shamasunder himself was feeling relieved that the region had a low prevalence of malaria. The next day, a monk took him to a local Indian

restaurant and a fly fell into his daal (spicy lentil soup). The monk's reaction took Shamasunder by surprise [and] he wrote the following poem:

*For my friend who said the way the world works broke her heart: good news from the subcontinent. Living with a monk study # 1*

There are those who

When a fly drops Plop! into yellow daal

it is not their bowl of food they worry about.

It is the fly and her wings

The ability of fire and spice

To sear wings

And with so much kindness

They place the fly in their palm

Unfold a white creased napkin

Clean the wings and the space

Between the wings

with water rinse away

Any hot yellowness

Place the fly gentle

On the edge of the table

Until

by the end

Of our meal

The fly has flown

made her way

Back into the world. (2006: 1-2).

For Tibetan Buddhist practitioners, whether consciously or tacitly, the compassionate act does not seem to be an alternative choice. As discussed earlier in Chapter 2, Tibetan Buddhist practitioners employ the stages of dying as an ideal opportunity with which to cultivate compassion and generate resilience through culturally informed contemplative techniques, such as *gtong len* and *thugs dam*, that were devised after thorough investigation and understanding of the intricate relationship between humans' existential fear, suffering, and happiness.

### **Pema in *Thugs dam***

I wondered if Pema was practicing *gtong len* (*Tonglen*) because he seemed mentally strong even though he grew physically weak every passing day. Despite his pain and difficulty in breathing, he was concerned about others around him. This might seem like an ambitious project for ordinary people, but I think it was a continuation of how he had lived his life and perhaps, it would continue into his next life. The question here is can Pema's death be perceived as a good death? It could be argued that such a manner of dying might not be viewed as a good death where the priority is given to controlling pain or extending life using every possible means. Even among my Tibetan interlocutors, some of them considered the need to control pain as an important aspect of dying well. In that sense, Pema's death might not be seen as a good death by all, but I think he died appropriately. Appropriately, in the sense that Pema's death shared the Buddhist idealistic values and beliefs that help to engage in a transpersonal relationship between oneself and others. Moreover, his death also speaks to one of the myriad ways of dying that is valued among Tibetans.

A few months after Pema's demise, I met with his monk friend who had recently finished his Geshe *Lharam*<sup>64</sup> exam and was going through a year of intense tantric training. He was excited to see me, and it seemed like he had something to tell me. Earlier, when Pema had died, I did not get a chance to follow up on what had happened afterwards as I had had to go out of town. When I asked if he had anything to tell me, he told me it had been a special experience for him, to be able to be close to Pema when he died. "Pema was more worried about me than his own condition," he related.

Pema kept on telling me to go back to the monastery so that I could prepare for my exam. I have known him since 1995. He was a kind and deeply spiritual person; and he does his morning prayer and meditation every day, early in the morning. A day before his condition became serious, Pema told me that aside from the text he asked us to read, that I did not have to do anything. He said he had prepared everything. After he died, for almost five days, there was no bad smell [due to putrefaction] coming from his body; and his body looked fresh. So, it seemed like he was in *thugs dam* meditation and people came to see his body. But even if he was not in *thugs dam*, I am so happy that he died well. He died as he lived.

It was clear that Pema's death had a deep impact on his monk friend. He later told me that the way Pema was able to die without fear and peacefully with confidence gave him the impetus that he too could strive to die like him.

Likewise, I had a conversation with another monk, who told me that when he was attending to his dying teacher two years ago, his teacher surprised him by asking if he was afraid. "And then, he asked me if I could see changes related to the stages of dying in him as

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<sup>64</sup> Geshe Lharam is the highest Geshe degree of scholarship conferred within the traditional Tibetan monastic system in the Gelug school of Tibetan Buddhism.

explained in the [Buddhist] text,” he said. The monk recalled it was like a practical class for him and others around him.

## **DYING WITH MULTIPLE OPTIONS**

People have a variety of questions when they learn I am doing research on how Tibetans die and Tibetan approaches to care for dying people. One of the most common questions I get, which is quite a practical one, is what I have learned from my research in terms of dying well. As I mentioned previously in the Introduction to this paper, I was asked a similar question when I spoke to a group of Emory University undergraduate students who were at Drepung Loseling Science and Mediation Center. The students were there as a part of the Emory Mind-Body Sciences Summer Abroad Program studying Tibetan Buddhist philosophy and psychology at various Tibetan research and cultural institutes. Trying to sum up what I had observed and learned up to that point, I said, “One thing I have learned is that I feel like I have a lot more options at hand to think about how I want to die when it comes.”

In Tibetan culture—both in Tibetan medical and Buddhist practice—the manner in which someone dies are underscored, and thus different ways of dying are explicated. However, there is an interesting distinction between the way Tibetan doctors and Buddhist practitioners look at these different characteristics of dying. In Tibetan medical practice, these multiple ways of dying are recognized primarily by Tibetan doctors and are employed when they care for dying patients. Tibetan Buddhist practice, on the other hand, views these multiple options as qualities with which to identify a dying person based on their Buddhist practice or how they have led their life. I observed during my fieldwork that these two notions, though approached differently, complement each other. Tibetan doctors apply their understanding to caring for a dying patient

and guiding family members, as well as Buddhist monks; and Buddhist practitioners apply their understanding in crafting the way they assist a dying person and inform family members and Tibetan doctors of the spiritual background of the dying person.

### **Tibetan Medical Perspective: Anxious, Angry, and Depressed**

I intentionally asked Dr. Dorjee Rabten if it was important for Tibetan doctors to care for dying patients, and if so, how they do so, because as I discussed in Chapter 3, Dr. Rabten is known for treating cancer patients. Dr. Rabten jumped right into the heart of the matter and said, “Of course it is important.” “In Tibetan medicine,” he continued, “there is little distinction between active treatment and passive or no treatment because both of them are forms of treatment – both interventions help dying patients in some way.” I thought he made an interesting point because these two interventions would not only be categorized differently in Western biomedicine but might even contradict each other in certain situations (Neumann 2016; Green 2008). For instance, doctors in north America have a clear instruction when referring a patient to hospice care, that a patient should not receive any form of (curative) treatment (Smith and Sheila 2013).

Dr. Rabten told me that for Tibetan doctors, it is important to know more than the patients’ illness or their vital signs, such as blood pressure, fever, and so on, to help them. He said, “It becomes even more important when it comes to assisting dying patients. That is when doctors need to identify patients’ constitutional nature and provide care accordingly.” He further said,

As we discussed earlier, in Tibetan medicine, we focused on recognizing a patient’s [individual] constitutional nature via pulse reading, urine analysis, and observing a person’s physical outlook. We do this because it provides a much more nuanced

understanding of the patient and thus helps to design a specific treatment. This mode of identifying an individual's nature is extremely helpful when we care for dying patients because a patient with a distinctive [constitutional] nature dies differently. For instance, people with a *rlung* dominant nature are generally sensitive, reactive, and nervous in nature, so at the time of dying, these people are a lot more anxious mentally and physically more reactive to pain or discomfort. *Tripa*-natured people are usually aggressive in nature, so they tend to be angrier and more irritable and would be physically sensitive to pain and infection while dying. And then, *beken* being calm and patient in nature, tend to be sad and depressed and are physically less reactive to pain. So, such understanding is helpful for us in determining how best to care for a dying patient, as well as in guiding other caregivers when a patient is close to dying.

I later inquired with Dr. Rabten as to how patients themselves can take charge in identifying their inherent nature and thereby be more cognizant of the manner in which they might die. Working with Miriam Cameron and several of our colleagues at Men-Tsee-Khang and the University of Minnesota, we devised such a tool—a Constitutional Self-Assessment Tool—in helping individuals to recognize their nature in order to proactively take care of their health (Cameron et al. 2012). However, Dr. Rabten felt that although it could be helpful to have knowledge of one's nature, it might be difficult if a person is not calm and focused at the time of dying. He said that except for some good practitioners most of the time patients are a bit too overwhelmed at the time of dying, and that it is therefore up to doctors to identify these distinctive ways of dying and to guide patients. If Dr. Rabten's description of different ways of dying from a Tibetan medical perspective informs an individual's biological factors and its impact on his or her mind, then, I

think, a Tibetan Buddhist approach speaks to how an individual's mental state influences the psychophysical changes of the dying person.

### **Tibetan Buddhist Perspective: Content, Fearless, and Joyful**

During my initial sittings with Gen Phuntsok and other monks, I often heard them saying when I asked how one could assist a dying person to die well, that a practitioner, who had prepared well, could die with love and joy. It was similar to what Gen Palden Dakpa referred to as “dying in a mother's lap with love and joy,” but I never got the chance to inquire in detail about it. Of course, it can be argued that dying a good death is oxymoronic in nature since death destroys whatever we have strived for (as argued by Scarre 2012). In that case, dying joyfully could be conceived as a myth. So, during one of my meetings with Gen Dhondup, I asked him if he could help me understand what he meant when he said some people can die with joy and love.

It was a chilly October evening and we had just had our dinner. Gen Dhondup, had earlier kindly and thoughtfully asked me to see him in the evening for our bi-weekly meeting so that I could have dinner with him. He told me, “That way I can meet with you and also make sure you are well fed.”

That evening, Gen Dhondup seemed to be down with a cold. He tore some paper tissue from a big roll of toilet paper on the table, blew his nose to his satisfaction, and with a little smile, said, “That should be the goal, to die with joy, but it is hard to accomplish such a feat if one has not prepared well.” According to Gen Dhondup, a dying person can work on dying well and also create a condition in which to transition smoothly to the next life while the consciousness is still in the body. Once the consciousness leaves the body, there is nothing much that can be done – not even prayers and rituals. Everything has to be done while we, or the dying



person is still alive, and the earlier one is prepared for death, the better it will be at the time of dying.

For Gen Dhondup, how one dies and what kind of rebirth one might anticipate is all based on how well one has prepared to face death. He said that it was not only about leading a virtuous life, but that it was also how intimately one was familiar with death and dying; and how diligently one had experienced it. He further described that a combination of good theoretical and practical knowledge pertaining to death and dying could not only lead to a good and virtuous life but could also lead to dying the way that one wished to die.

“In that case, will intellectual and practical capacity determine how well a person could die?” I asked. Gen Dhondup replied,

In Buddhism, if one has led a morally ethical life and engaged in committed contemplative practice in understanding the nature of reality [*stong nyid*], one can gain a clear realization of how one could die. That is why there are three distinct manners, based on a practitioner’s level of [spiritual] insight, that determine how one can die. These three ways of dying are enumerated as: (1) a novice practitioner who dies without any remorse but with fear; (2) an intermediate practitioner who dies without any remorse or fear (3) an adept practitioner who dies with love and joy.

Although I witnessed some practitioners—both monks and laypeople—dying joyfully without any sign of fear or remorse, none of my interlocutors told me that they wished to die joyfully when I asked how they wished to die. I have noticed that adept practitioners, whom I refer to as “Olympian level” practitioners present an intriguing relationship with themselves and others at the time of dying that exemplifies Tibetan Buddhist notions of death and dying. Likewise, their example empowers community members to put it into practice so that they too can have better

control over their own death. One such example was the death of Gen Jamyang Chophel, a 94-year-old practitioner, who was loved and revered by everyone at the monastery.

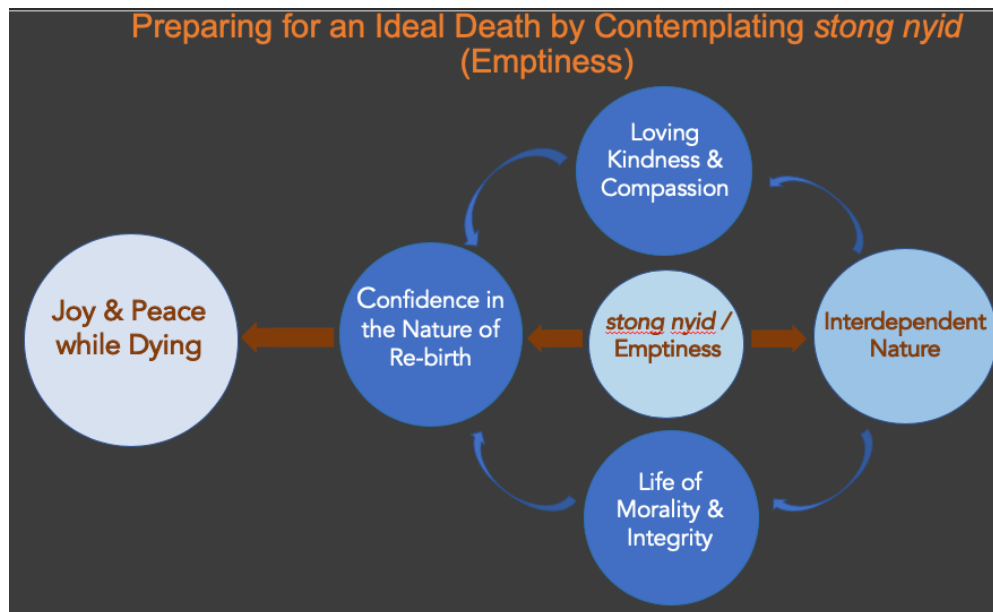


Figure 15: Mechanism of Dying an Ideal Death in Tibetan Buddhist Culture

### Gen Chophel's Death

It was a muggy hot afternoon in mid-September when I went to the Sakya monastery to give a health talk to their monks. The Sakya monastery is a smaller monastery within the Drepung Monastic University campus with close to 800 monks. The Sakya monastery is not affiliated with the Drepung administration but owing to the common space, Sakya monks often join Drepung monastery's academic and prayer gatherings. After the talk, a friend of mine who was one of the senior teachers and who knew of my research, asked me if I would like to meet with a senior monk who had been bedridden for a while. I thanked him for his consideration and gladly accepted his offer.

Gen Chophel had been bedridden since he had had a stroke nine months ago. When my friend and I entered a small room right next to a huge tree, a youngish well-built monk shook my

hand with a broad smile and thanked me for coming. His name was Jamyang, one of Gen Chopel's students. Jamyang had taken full responsibility for caring for his sick teacher. I was actually a little surprised to see his cheerfulness despite being a full-time caregiver for someone who had been bedridden for so long. Jamyang told us Gen Chopel had just fallen asleep but that he could wake him up. I quickly told him to let him sleep and asked if he could tell me about his teacher's health in the meantime.

Jamyang said Gen Chopel had been doing well with his appetite and interacting with him and other people who came to see him, but that he had started to grow weak over the last few weeks. His appetite had diminished lately. "But despite Gen Chopel's recent upended health, his mental state is clear and always calm," he said. Jamyang showed us some of the food supplements and medicines he was giving to his teacher. As we were talking, Gen Chopel woke up and slowly tilted his head toward us. Gen Chopel's first reaction when he saw me was a gentle smile and he slowly raised his right hand and waved to greet us. Jamyang bent and leaned closer to his teacher to introduce me. He asked if I could check his teacher's pulse.

I greeted Gen Chopel and touched his wrists, one at a time, to feel the pulse. His pulse was quite weak with a strong indication of weak digestion and diminished kidney function, but with a strong heartbeat. I looked at his urine bag tied by the corner of the bed – it looked brownish dark with thick sediments. The features of both his pulse and urine did not look good. I leaned forward and asked him if there was anything he needed or food that he fancied. I told him that his pulse was weak and that it was important that he eat whenever he felt like it. He did not say anything back to me but kept on smiling. Just before my friend and I excused ourselves, Gen Chopel looked at his student, which was a signal that he should serve us fruits. We grabbed a

banana each and as we were leaving, Gen Chophel continued to smile and waved at us until we could no longer see him.

Jamyang followed us outside. I told Jamyang (as I had conveyed to Gen Chophel), that his teacher's health was degenerating fast, and that he should not put any restriction on his diet nor try to feed him anything if he refused to eat. Jamyang acknowledged my advice and said he would be in touch. I was amazed at Gen Chophel's joyful nature and told myself that it was no wonder that Jamyang was cheerful.

I was in another field site when Jamyang called my phone to inform me that Gen Chophel had passed away peacefully. It was the first of October, a little more than a week since I had last seen Gen Chophel. When I went to see Jamyang on my return to Mundgod, he was still cheerful. He told me that he and other monks at the monastery were blessed to witness the way Gen Chophel died. "Gen Chophel seemed ready on the morning he died," he said. "He kept looking outside the window, enjoying the cool breeze coming from the multiple layers of trees, and waved at monks who were passing by." Gen Chophel's body was kept for five days because they felt he stayed in *thugs dam* as his body did not decay until the morning of fifth day.



Fig. a) Gen Chophel with Jamyang; b) Gen Chophel's deceased body in *thugs dam*

## CONCLUSION

Learning how to die, according to the Tibetans I interviewed, is an important cultural practice that informs both living and dying people. Tibetans invest great deal of time in studying and familiarizing themselves with death in order to prepare to be able to die well or learn from others who die well. There is a clear indication that the culturally endorsed dialectical relationship between life and death at an individual and collective level possesses both worldly and spiritual utility.<sup>65</sup> All my research stakeholders—Tibetan doctors, monks, and family members—apply a Buddhist worldview in responding to and dealing with death, although in different capacities based on their Buddhist educational background.

Monastic as well as lay communities believe that thinking about death helps to make sense of the Buddhist teaching of the “impermanent” nature of everything, which aids in tackling humans’ insatiable greed and attachment. A monk told me that thinking about death pushed him to stop procrastinating on practicing what he was learning at the monastic school. “I cannot be lazy, thinking I will study and meditate to train my mind tomorrow. I do not know when I might die,” he stressed.

To reiterate, a “good death” in Tibetan Buddhist culture is an appropriation of one’s capacity to die well based on multifaceted causes and conditions. On the one hand, Tibetan doctors use their understanding of an individual’s constitutional nature in assuming a specific death for a patient and on the other hand Tibetan Buddhist practitioners employ a person’s level of Buddhist practice to determine how a person might die. Moreover, factors such as pain and suffering that are commonly thought to cause a bad death are not conceived as leading to a bad

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<sup>65</sup> For an additional ethnographic account, see Desjarlais (2016) for the Yolmo Buddhist relation to death and dying.

death. Tibetans in general, based on their understanding of Buddhist philosophy and their level of practice, aspire to die in a particular manner that validates their culturally idealistic values. Given the complexity and multiple ways in which a person aspires to die, I argue that it would be more fitting to refer to a good death as an “ideal death.” In so doing, any particular way of dying does not have to be labelled as a good or a bad, rather it could be viewed as an appropriate death in its own context.

It is fair to extrapolate from the aforementioned discussion that much of the emphasis is placed on the role of a dying person’s ability to die in a way he or she had aspired. Similarly, the ethnographic vignettes presented illustrate how Tibetan Buddhist practitioners’ study, conceive, contemplate, and eventually, enact an idiosyncratic death that animates Tibetan Buddhist values and beliefs related to death and dying. However, as discussed in previous chapters, there are a myriad of ways in which caregivers—Tibetan doctors, Buddhist monks, and family members—work together in assisting dying patients to die well. These stakeholders collaborate to facilitate the collective goal of protecting the dying person’s consciousness so that the dying person dies peacefully and makes a smooth transition to the next life.

## CHAPTER 7: CONCLUSION

### Reaffirming Tibetan Buddhist Models of Death and Dying

On September 25, 2019, numerous Indian television news channels and newspapers in northern India covered the news of a 94-year-old Tibetan Buddhist teacher, Lama Wangdor Rinpoche's passing, and his spiritual accomplishment of being in *thugs dam* at his residence in Tso Pema, an important region for Buddhist retreatants and practitioners due to the legendary spiritual activities achieved there by Guru Padmasambhava, one of Tibetan Buddhism's most important figures, and the potential conditions the place offers for others to gain great spiritual realization. Regional TV news channels showed live updates of Wangdor Rinpoche in *thugs dam* with the caption in Hindi: "BIG BREAKING NEWS: Lama Wangdor Rinpoche in meditation since past seven days." The news reporter narrated that, despite having been clinically dead for the past seven days, there were no signs of decomposition and that the body looked fresh. The reporter related that the senior monks who are monitoring Rinpoche's body plan to embalm the body once Rinpoche concluded his *thugs dam*. He further reported that locals from the neighboring areas had started to flock to the small town tucked in the foothills of the Himalayas to witness "Rinpoche's miracle." Media response to this event as primetime news has become an interesting development with regard to the practice of *thugs dam* for a variety of reasons.

First, this level of media attention to and coverage of *thugs dam* has never happened before. I remember local newspapers reporting Lobsang Nyima Rinpoche staying in *thugs dam* in 2008 (which I presented in chapter 1), but it did not become breaking news even with the significant number of local Tibetans and Indians traveling to the site for blessings. Perhaps, such increased media attention could stem from recent efforts by the Dalai Lama to revive the ancient

Indo-Buddhist Nalanda center of intellectual learning in India. Owing to his advanced age and a few health scares in the last couple of years, the Dalai Lama has drastically cut down his international trips. However, this has not made his schedule any lighter other than a decrease in time spent on extended flights. Local Indian organizations, universities, schools, hospitals, religious institutions, and various community groups continue to beseech him as their most valued guest speaker. The Dalai Lama himself has actually embraced this new role in the local Indian community, for he is often heard saying that reviving the ancient Indo-Buddhist tradition is one of his main goals and who better than Indians to take that responsibility. This has made the Dalai Lama and Buddhism much more visible in the Indian community, especially in the media. Nevertheless, the coverage of a cultural phenomenon like *thugs dam*, which is a part of Buddhist tantric practice and used to be a secret practice, has become accessible to millions of people in a short period of time via media.

Second, the growing interest among scientists, specifically neuroscientists, has generated a great deal of interest about *thugs dam* practice in Indian media and the general public. Besides the collaborative project between Men-Tsee-Khang and Delek Hospital in India with the Center for Healthy Minds at University at Wisconsin-Madison in the United States, a team of neuroscientists from Lomonosov Moscow State University's Center for Consciousness Studies has recently initiated a collaboration with monastic institutions in south India to scientifically study *thugs dam*. I remember giving an interview during my fieldwork to the Health and Spirituality editorial section of one of the major newspapers in India – *The Times of India*. The first question the journalist asked was, “Death is generally viewed as a morbid subject. Is the *thugs dam* research turning this belief around?” I found the journalist's question interesting because I did in fact find that, during my fieldwork in the Tibetan refugee community, viewing



death through the lens of a cultural phenomenon such as *thugs dam*, helps to reframe one's relationship to death and the way one prepares for his or her death.

Third, and most importantly, is sacredness and relatability of the space. The place where Wangdor Rinpoche stayed in *thugs dam* is a place where Padmasambhava (Tib. *gu ru rin po che*) was believed to have spent time meditating in the cave and engaging in many supranormal activities before going to Tibet in the eighth century on an invitation of the Tibetan king, Trisong Detsen (Tib. *khri strong lbe btsan*). Padmasambhava also composed the *Tibetan Book of the Dead* (Tib. *bar rdo thos grol*), the book discussed in earlier chapters detailing the significance of the mind and its different forms while a person is alive, in the process of dying, after death, and at the time of being reborn (Padmasambhava 2005). Tso Pema (Tib. *mtsho pad ma*), which in Tibetan literally means, "lotus lake," has become a sacred abode for practitioners like Wangdor Rinpoche and a pilgrimage place for Buddhists across the world. Buddhist practitioners such as Wangdor Rinpoche and Lobsang Nyima Rinpoche have given life to the teachings and scholarship of ancient Buddhist scholars such as Padmasambhava and others. These advanced practitioners have dedicated their life to studying and investigating the mind using Buddhist texts and applying instructions from the texts and their teachers into practice while alive and at the time of dying. By so doing, they not only animate the ancient Buddhist texts and emphasize the potency of the teacher-student relationship, but also reaffirm people's faith in cultural beliefs surrounding life and death.



Figure 16: Lama Wangdor Rinpoche's *thugs dam* covered on a local Indian news channel on September 24, 2019

I proposed in this dissertation that the practice of *thugs dam* informs the Tibetan cultural worldview related to the conception of the human body and the ways in which it dissolves at the time of dying. This framework of a nuanced understanding of human existence at the biological and psychological level and the interplay between mind and body via meditative practice in tantric tradition underpins the epistemology and ontology of Tibetan medical practice (cf. Zivkovic 2014: 27-28). Likewise, *thugs dam* reifies the Buddhist concept of reincarnation.

During my last month in the field in December 2017, I had a chance to meet with a young incarnate lama, a reincarnation of Lobsang Nyima Rinpoche, who died and stayed in *thugs dam* in 2008. Lobsang Rinpoche's embalmed body has been preserved in an ornate room on the fifth floor of the Drepung Loseling main prayer hall. For Tibetans, particularly in the monastic community, having access to both the previous (in the form of the embalmed body) and the present (as the reincarnate lama) life of Lobsang Rinpoche's *body* provides them a window to connect Rinpoche's past life to the present, and the present to potential future reincarnations. In that light, the concept of reincarnation is not only animated, but it also lays out spiritually-prescribed behaviors one adopts in acquiring an ideal death so as to yield a desirable rebirth.

Importantly, as I noted in chapter 3, I found that the concept of reincarnation in Tibetan Buddhism in the context of death and end-of-life care is not understood as a mere “symbolic” defense mechanism as proposed by Lifton and Olson (1974) in their interpretation of symbolic immortality. For reincarnate lama, reincarnation is “arguably the most lively extension of the lama’s lifecourse” where the continuity of lama across “physical forms challenges perceptions of a singular body and linear lifespan; and a young lama can “follow the lifecourse of a predecessor and the transformative process of rebirth can shape a social reality where intellectual growth is conceived in terms of enduring tendencies from previous lives” (Zivkovic 2014: 25). And for Buddhist practitioners and lay Tibetans, the retrospective lives of reincarnate lamas, their intellectual and spiritual power in current lives, and capacity for conscious rebirths, fuel and reaffirm their conceptions of good rebirth. During my fieldwork, I found that Tibetans irrespective of their educational background in Buddhist philosophy and psychology view reincarnation as inextricably linked to life and death. It is also important to note that the Tibetan Buddhist idea of rebirth is strikingly different from Judo-Christian concept of next life related to “heavenly immortality” (Nytrøe 2013: 35). My interlocutors, though employ the continuation of life to the next life at the time of death as primary element of viewing death, they underscore the fact the ultimate goal of Buddhist practice is to be free from being reborn.

In light of the Tibetan Buddhist understanding of reincarnation, this dissertation attempts to answer the central question: What constitutes an ideal death in Tibetan Buddhist culture? I began my fieldwork by conducting an open-ended interview with Tibetan doctors, Buddhist monks, and lay Tibetans in order to understand their attitudes toward death. I found that Tibetans conceive of death as a necessary part of the life course that aids in motivating morally ethical behavior, and that for adept practitioners, death is a moment of critical spiritual development

rather than something to avoid while prolonging life at any cost. Moreover, Tibetans see death as a means of taming humankind's most deceiving emotions—desire and attachment—by embracing the key Buddhist concept of impermanence, animated by the certainty of death.

Tibetan Buddhist practitioners, taking this recognition a step further, meticulously studying and familiarizing themselves with the process of dying, deemed to be the most potent state for engagement in deep meditation, a meditation aimed at transforming their relationship to death, as well as to themselves and others.<sup>66</sup> However, one interesting finding related to how Tibetans view death which I discussed in Chapter 1 is their fear of death. The majority of Tibetans, including Buddhist practitioners, told me that they were fearful of death. When inquired why, they told me that one cannot be motivated to live an ethical life and hope for a good rebirth if one loses fear for death. This, I think, is important not only for this dissertation in conceptualizing notions of death among Tibetans, but also to respond to recent study by Nichols and colleagues (2018) where they argue that their findings of Tibetan monks being fearful of death is unexpected.

Another important finding related to the practice of *thugs dam* is the question of “who would stay in *thugs dam*” and the spiritual credibility associated with the practice. I found that *thugs dam* is often associated with the practitioner's spiritual advancement (also see Zivkovic 2014), and hence, when a senior practitioner dies, Tibetans, particularly monastics, would start talking about if the deceased was in *thugs dam* or not. I felt that such mentality could cause unnecessary rumors among community, and in some cases, interrupt funeral rites as I discussed

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<sup>66</sup> Religious studies scholar Geoffrey Samuel, in his examination of how Tibetan Buddhism is presented in the West, emphasizes that “Tibetan Buddhism is better seen as what it has, in a way, always presented itself as being: a transformative practice, a technology for remaking the self, and in the process reconceptualizing both self and the world to which the self relates (2005: 338).

in chapter 6. When I asked some senior teachers at the monasteries, they told me that not everyone would find the need of staying in *thugs dam* at the time of death. They further told me that in addition to the rigorous study of the nature of mind and body and their interplay, and the integration and disintegration of body, if one has clear motivation and purpose, one can simulate a dying process while alive and engage in deep meditation; and if needed, one can stay in *thugs dam* at the time of dying.

The popularity and rise in studying Tibetan Buddhist texts such as the *Tibetan Book of the Dead* (2005) and *Words of My Perfect Teacher* (1994) and the practice of simulating the dying process so as to prepare for death among monastics and lay Tibetans, which I described in previous chapters, speaks to how Tibetans respond to death and dying.

Also, the understanding that care for the dying among Tibetans is a culturally orchestrated process involving Tibetan doctors, monks, and family members and my hypothesis that these collaborators have distinct ideas of their roles in caring for a dying person, I found their shared interest in caring for the dying person's consciousness as the key factor in their collaboration. Despite differences, they play their roles and sought each other's help in their collective goal to keep the dying person's mind at ease. I observed that family members see the role of arranging and initiating death rituals, such as reading of *the Tibetan Book of the Dead* and other texts and inviting practitioners to perform *pho ba* and so on, as important means to help keep the dying person's mind calm and to direct the deceased person's consciousness to the *right* place. Tibetan doctors take the role of counseling a dying person as well as family members to create a conducive environment for a peaceful death and helping in bringing things under control amidst chaos since other collaborators depend on his judgement. And Tibetan Buddhist monks engage in reading certain texts, perform *pho ba*, and talks to a dying person to assist the swift

transition of the deceased consciousness for a good rebirth. While performing *pho ba*, monks would stay in deep meditation and visualization in order to connect with the deceased consciousness.

Moreover, I discussed about how differences among collaborators in their endeavor to help the dying person die well could lead to conflict among them and the need for a constant negotiation as they enact their roles. For example, I showed in Chapter 6 that monks do not support certain death rites, such as following the direction of the death horoscope that family members consider critical. However, once the differences are resolved among them by understanding their common interest, I found that the death rituals play a significant role in providing a common ground for the collaborators to negotiate with each other in fulfilling their roles. Although most of the monks I interviewed claimed that they do not believe in and use the death horoscope in carrying out any form of death rites in monastic community, they told me that if it serves the purpose of fulfilling family members' role in assisting the deceased consciousness, they have nothing against it. Interestingly, the enactment of death rites, such as reciting specific prayers, performing *phowa* in assisting the transitioning of the deceased consciousness to the next life, modifying the environment in which the deceased body is kept, or placing different objects on the deceased body creates a frame in which each collaborator takes a turn to lead the other collaborators in assisting the deceased. This also provides the collaborators with equal footing, thereby breaking any form of hierarchy that could potentially cause tension among caregivers. Thus, my work has shown that the culturally orchestrated collaboration in assisting a dying person to die well, though informed by overarching Tibetan Buddhist values and beliefs, is constantly negotiated.

I have argued that although the descriptor “dying well” is often based on the binary of a good and a bad death, the Tibetan cultural concept of a good death is multifarious and aligns more with how each collaborator seeks to fulfill the ideal of a good death. Based on 105 interviews and 22 deaths observed during fieldwork, I found that the interpretation of a good death is more an appropriation of a person’s capacity to die well based on a myriad of causes and conditions. To illustrate, Tibetan doctors use their understanding of the individual constitutional nature (Tib. *rang bzhin*) in assuming a specific death for a patient; Tibetan monks employ a person’s level of Buddhist practice in determining how a person might die; and lay Tibetans focus on the proper completion of prayers and rituals for the deceased person. For example, Tibetan doctors view a dying person who is anxious and has low resistance toward pain or physical discomfort as a *rlung*-natured person and thus is expected to behave that way. In such scenario, Tibetan doctors pay special attention to explaining to both the dying person and relatives of the person’s physical and mental propensity, prescribing Tibetan drugs or serving food and beverage that could help calm *rlung*, and most of all, being patient and kind.

Likewise, Tibetan monks see a dying person who expresses remorse and fear as someone with less familiarity with Buddhist practice and hence not well prepared to die. Importantly, these rationalities are not necessarily contingent upon the physical pain and discomfort that are commonly assumed to cause a bad death in modern biomedicine. I found that Tibetans in general, based on their understanding of Buddhist philosophy and level of practice, aspire to die in a particular manner that validates their culturally idealistic values. Given the complexity and multiplicity of the way in which a good death is constructed and enacted both in preparing for one’s death and caring for the dying, I argue that it would be more fitting to refer to a good death

as an “ideal death.” In so doing, any particular way of dying does not have to be labelled as good or bad, rather it could be viewed as an appropriate death in its own context.

Both in my interviews and surveys, I asked Tibetans two interrelated questions: what is an ideal death for you? And what is the most important thing in caring for a dying person? More than 54 percent of the responders identified dying without remorse and fear and 26 percent with joy as an ideal death; and 90 percent considered caring for mental state and emotion as most important aspects in caring for the dying. I showed in previous chapters, particularly in Chapter 1, that the conception of an ideal death among Buddhist practitioners, both monastic and lay, is laid on the framework of a deep feeling of joy and confidence at the time of dying. I found that for many of these practitioners the overlap between joy and confidence is shaped by the life they have led and the rebirth they could possibly achieve. They would often use the term “*snying stops*,” literally meaning “heart power,” and say that once you are ready for the death and the next life, there is no room for remorse and fear.

Interestingly, I have heard monks as well as Tibetan doctors saying, “We have to do our best to raise *snying stops* of a dying person. That’s what will help in dying well.” Often, Buddhist practitioners would tell me that the key to developing such mindset is to meditate on *stong nyi* (interdependence), which will propel to cultivate compassion toward others and generate resilience in the face of death. I noticed during my fieldwork that such model of dying does not necessarily work all the time. However, among 22 deaths that I observed and participated in, practitioners and older Tibetans died peacefully, and some even stayed in *thugs dam*. Some, when assisted by caretakers, were able to die well. Likewise, I observed that younger people have harder time in dying well. Once when I was attending to a young dying man who was having a difficult time, the Tibetan doctor told me that it could be due to his *tripa*



nature because younger persons generally have more *tripa*, and thus both his mind and body resist against the dissolution of the body.

Finally, this dissertation demonstrated the relationship between biology and culture via the intersection of Tibetan medical and Buddhist practice in caring for dying people. I observed that in caring for terminal patients, it is impossible for Tibetan doctors to decouple Tibetan medicine from Buddhism. For Tibetan doctors, the very notion of the formation of the body, etiologies of disease, diagnostics, modes of interacting with their patients and designing treatments for dying people are informed by Buddhist psycho-philosophical concepts. I illustrated in Chapter 3 how such a medical paradigm structured on the Buddhist cultural model offers family members freedom to seek medical and spiritual care concurrently and to seek guidance from both doctors and monks.

As illustrated in chapter 4, I showed how Tibetan doctors, incorporating philosophical and psychological features of Tibetan Buddhism in their practices, employ personalized care to dying persons based on their “constitutional nature.” This enables Tibetan doctors to provide more holistic care; care which not only address the biophysical, but also the psychological, social, and spiritual aspects of patients. Borrowing Bishop’s term “biopsychosociospiritual” (2011), I argue that the inextricable integration of Tibetan medicine and Buddhism in end-of-life care deals with the overall needs of the patient.

### **Potential Contributions**

This dissertation makes clear what the debates are in studies of death and dying by viewing death and the process of dying through a cultural lens that reflects the intertwined nature of medical and religious practice. Specifically, the relevance of the study is that it deals with the conception of death, which does not end with the physical death of the body. The cultural models

of death, as explained in Tibetan medical and Buddhist practice, encourage Tibetan doctors and Tibetan monks to collaborate in facilitating an ideal death. In her research on the role of religion and spirituality in some of the largest American "secular" hospitals, Wendy Cadge (2012) finds that religious beliefs and the hospital chaplains are most pertinent to end-of-life issues despite their lack of close integration with medical treatment.

This dissertation has therefore added to four sub-disciplines of scholarship within anthropology: death and dying, end-of-life care, Asian medical systems, and Buddhist studies. The first subfield attempts to theorize the potential conflict between using biological versus sociocultural markers of death and dying in framing the care for dying persons. The scientific study of death as well as the study of end-of-life care has exploded in recent decades, yet the definition of death has remained contested and ambiguous. This is particularly important because scholars have emphasized that end-of-life care depends upon how death is defined across these intertwined and interrelated matrices of sociocultural and medico-biological approaches (Lock 2012; Bishop 2011, Braswell 2014). In that pursuance, scholars in recent decades have noted the importance of both biologically and socially constructed notions of death and dying. Lock (2002) argues that developments in medical technology have compelled a rethinking of the accepted boundaries between life and death. Likewise, Kaufman and Morgan (2005) argue that the changes spurred by modern technologies have produced many ethical dilemmas, both in terms of the very notion of death and the process of caring for dying persons.

The rigorous endeavor among scholars and physicians to construct a clearer definition of death is evident from recent scholarship and one reason for the effort to construct a less ambiguous notion of death is its implications on end-of-life care. In ...*And a Time to Die* (2005), Kaufman presents a detailed ethnographic description of how the hospital shapes death by either

prolonging life or hastening death. Similarly, disability and bioethicist theorists have reflected on how relying exclusively on either biological or sociocultural concepts of death in isolation could have a negative impact on end-of-life care. For instance, Braswell, in his seminal work on disability and bioethics at the end-of-life (2014), proposes that we rethink the current bioethical definitions of death as an "isolated biological endpoint," in order to reform the U.S hospice care.

In the same vein, Tanya Zivkovic's (2010) anthropological study of death and rebirth in Tibetan Buddhist culture highlights the challenges of using exclusively biological markers in determining death. Zivkovic's rich ethnographic work explains the social life of a deceased Tibetan Buddhist lama and his relationship with his faithful devotees in Darjeeling, India. She calls for a greater critical attention to culturally-specific understandings of life and death because the acceptance that our life courses are "natural," predetermined by biology, bears little relevance as a universal to all individuals in society, such as observed with the life trajectories of eminent Tibetan Buddhist lamas (172-173). Zivkovic contends that the life histories for these lamas do not cease with biological death; rather the social life of Buddhist lamas continues through the media of reincarnation, bodily transmogrification, and hagiography.

However, there is no ethnographic study yet of how such a cultural model of death and the process of dying is operationalized in the Collaboratory endeavor among Tibetan doctors, monks, and family members in caring for dying persons. By examining the ways in which specific cultural practices shape end-of-life care, this project speaks to the value of Tibetan medical practice that integrates Buddhist philosophy and practice. Further, taking cues from aforementioned work, this ethnographic study aims to contribute toward shifting the narrative from biophysiological to biopsychosociospiritual in the determination of death as well as care for the dying.

The second literature deals with the significant implications of the belief in reincarnation for the end-of-life care experience. It engages the ethnographic investigation of interaction between medical doctors, religious/spiritual figures, and family members while caring for dying patients in a society that accepts reincarnation. Glaser and Strauss (1965), recognizing that death has shifted from home to hospitals in the United States, studied how people die in the hospital. They did this by focusing on interaction between hospital staff and patients. As stated earlier, Cadge (2012) takes a closer look at the interaction between hospital staff—especially religious figures such as chaplains—and patients in contemporary, secular hospitals in America. For Cadge, hospitals are the microcosms for posing questions related to investigating the existence of religious pluralism in the U.S, and more so when it has to deal with life-and-death issues. One of the reasons that I propose to study death and dying in Tibetan medicine is that it presents a fertile ground to explore the synergistic interaction of Tibetan medicine and Buddhist practice. Moreover, the novelty of this project is an ethnographic study of the interaction between Tibetan doctors, Buddhist monks, and family members of a dying patient in facilitating an ideal death in a cultural setting where cultural views distinctly shape the death process.

The third literature focuses on medical anthropology of Asian medical systems, specifically, the Tibetan medical tradition. The last fifty years have seen a dramatic expansion of the work of medical anthropologists on the comparative study of medical systems, especially the study of Asian medical systems (Leslie and Young 1992; Janes 1995, 2002; Adams 2001). Recent anthropological and clinical scholarship on Tibetan medicine focuses on the comparative study of Tibetan medicine in different Asian societies, pharmacology, historical analysis, and on the effects of external forces such as sociopolitical dynamics, transnationalism, and globalization (Gerke 2019; Tawni 2019; Bauer-Wu et al. 2014; Choedon et al. 2014; Cameron et al. 2012;

Garrett 2008). However, scholars have stressed the paucity of work where uniqueness of Tibetan medical practice has been emphasized (Kloos 2013; Pordie 2008; Adam et al. 2011). The need for more in-depth, ethnographic studies, which focus on particular aspects of medical practice has been underscored as well (Lock 2008). In that light, this dissertation contributes to recent ethnographic studies of Tibetan medical practice. Tidwell, for example, did an ethnographic investigation of Tibetan medical diagnostic techniques and treatment approach in Tibetan Medical Colleges in India and Tibet (2017).

Finally, the research speaks to the Buddhist studies pertaining to its multilayered social utility in Tibetan Buddhist culture. Specifically, this dissertation shows the relationship between texts (theory) and praxis and how they inform and reaffirm each other. The findings of the research shed light on the dynamic social life of a well-known Tibetan Buddhist text the *Tibetan Book of the Dead* through ethnographic investigation. Likewise, it illustrates the inextricable link that Tibetan Buddhism shares with Tibetan medical practice, particularly in providing care for terminally ill patients. This dissertation presents a deeper insight into both extant Tibetan Buddhist texts, as well as Buddhist cultural beliefs and values that exist only in the minds of community members. Equally, the research complements recent work on Buddhist studies related to death and dying, reincarnation, and tantric practice (Lindsay 2018; Desjarlais 2016, 2014; Gyatso 2015; Zivkovic 2014; Samuel 2014; Garrett 2008).

### **Consequences and Next Steps**

The dissertation showed that the Tibetan Buddhist epistemology of death and its cultural utility provide a cultural model that assists a person to die, and, as an auxiliary benefit, facilitates care for the dying with resilience and utmost compassion. However, one main concern, as most audiences shared where I presented my work is, how this epistemology might be applied in non-

Buddhist society, or in mainstream biomedical setting. Similar to how thousands of non-Tibetan or non-Buddhist patients benefit from seeing Tibetan doctors across the world,<sup>67</sup> I believe that the findings of this research could make substantial contribution to end-of-life care in the West. Such end-of-life care could be either in biomedical clinical setting, hospice/palliative care, or nursing home. Based on current status, more than two-third of Americans die in hospitals or nursing homes even though more than 75 percent express the desire to die at home (Rubio 2016).

Similarly, although 17 percent of Medicare spending goes to patients' last six months due to overtreatment in the last stages of life, Rubio argues that the very need for most of these patients rarely results in positive outcomes. He states, "Despite the unprecedented amount of resources going to expend life and newer opportunities to end it, a "good death" remains an elusive goal for many" (2016: 194). Gawande (2014) strongly asserts that one of the main limitations in existing end-of-life care is a lack of proper physician-patient communication that happens either in the physician's office or by the patient's bedside.

One of the goals of this dissertation is to contribute to translational research and an ethnographically grounded perspective to communicate skills in facilitating optimum care for terminal patients. Furthermore, this work highlights an approach that has application in the West where varied medical and religious values come into play in facilitating a death process. Finally, the research could extend work on the need of a holistic approach in both conceptualizing death and dying and in designing care for dying persons.

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<sup>67</sup> See, for example, 2019 National Center for Complementary and Integrative Medicine report where 30 percent of adults and close to 12 percent of children in the US seek complementary and alternative therapies (NCCIH 2019).

## Appendices

## Appendix 1: Semi-structured Interview Schedule

### Facilitating an Ideal Death: Tibetan Medical and Religious Approaches to Death and Dying in a Tibetan Refugee Community in South India

Date:

#### Part I: Understanding death and dying: (Doctors, Buddhist Practitioners, Family members)

Open-ended questions:

1. How do you conceive death?
2. Could you tell me what things in your life have shaped your view about death and dying?
3. Do you think your understanding of death affects the way you live your own life? If so, explain.
4. Do you think your understanding of death affects the way you provide care to terminal patients or dying persons? If so, how?
5. What are some of your most memorable experiences of observing death and dying?
6. Do you differentiate between death and dying? If so, how?
7. Have you ever observed *thugs dam*? If so, could you tell me what was your experience? And what you think of it?

#### Part II: Doctors, Buddhist Practitioners:

Open-ended questions:

1. How often do you see terminal patients?
2. How much experience have you had in your caring for dying patients?
3. Could you tell me how you help a terminally ill patient or someone who is dying?
4. Are there any differences between the way you treat a dying person in terms of gender, age or the religious background? If so, how?
5. What is the Buddhist understanding of death?
6. Tell me how you negotiate the Buddhist view of death and the personal experience of your patient/loved one dying?

#### Part III: Life history and education background:

Open-ended questions:

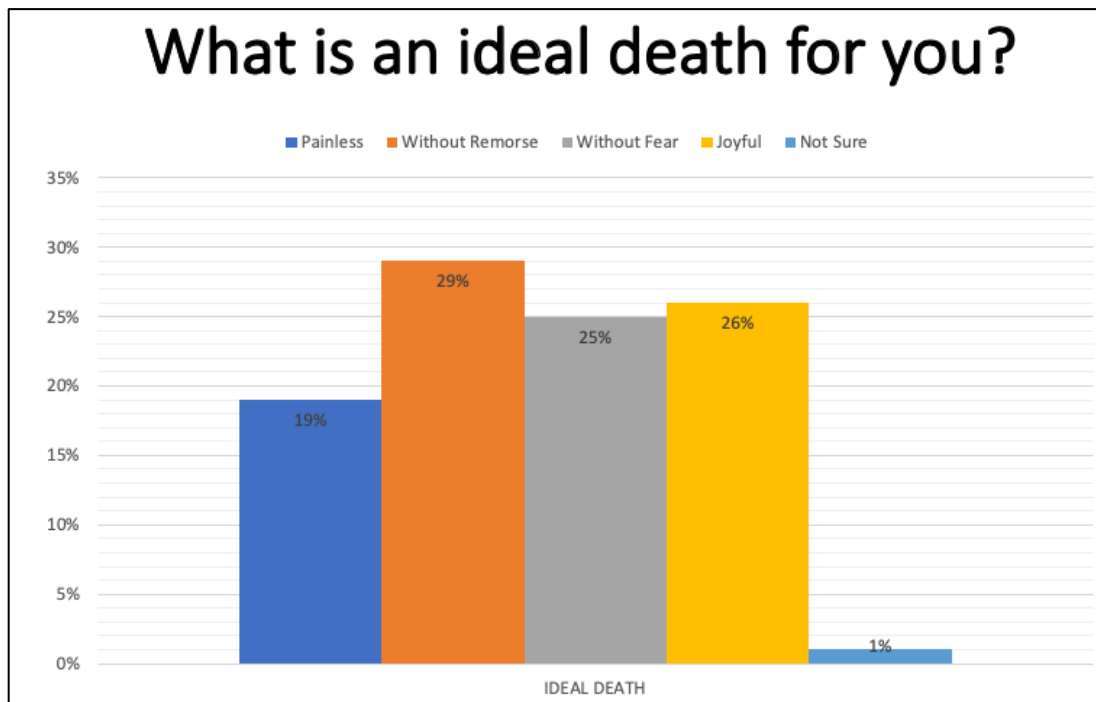
1. Where were you born?
2. Where did you go to school?
3. How long have you been practicing Tibetan medicine/Buddhist practice?
4. Did you have any training in Buddhism? Do you practice any form of meditation?

#### **Close-ended Questions:**

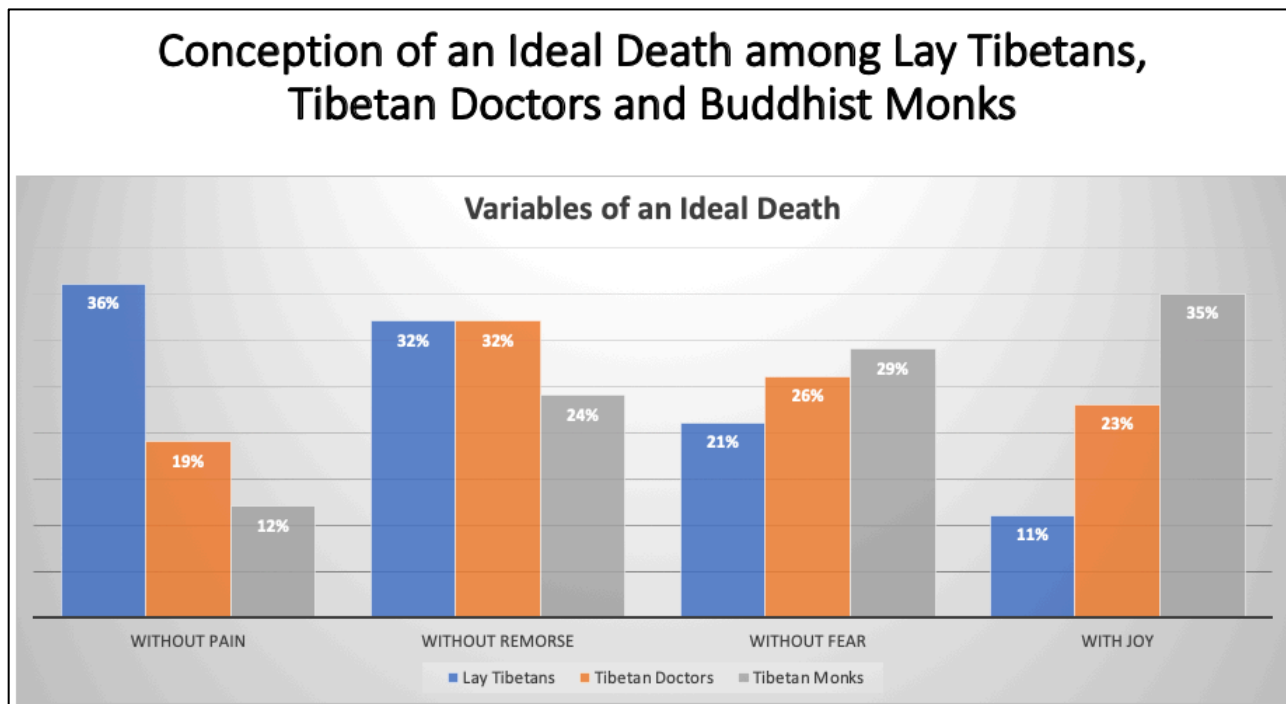
1. Is a “good death” associated with less pain? Yes / No
2. Is a “bad death” dying with lots of pain and anxiety? Yes / No
3. Have you ever heard of *thugdam*? Yes / No
4. Is attending to dying patients an important part of your practice? Yes / No
5. How often do you prescribe “precious pills” to dying persons? Often / sometimes / rarely

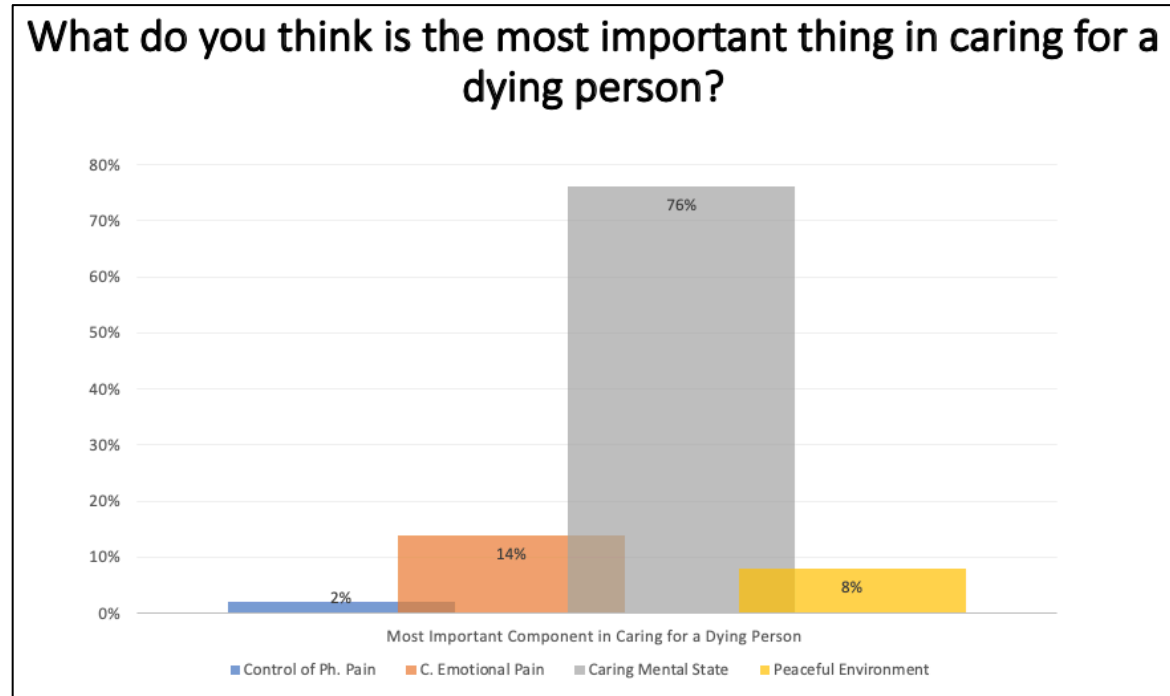


**Appendix 2:** Conception of an ideal death among Tibetans



**Appendix 3:** Variations in the conception of an ideal death among Tibetans



**Appendix 3: Most important component in caring for a dying person among Tibetans**

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