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Buddhism and Healthcare**



Buddhism has a long history of association with medicine and healing extending over two thousand years and embracing developments across the whole of Asia. It is now also beginning to make an impression in the West, although presently lacking a developed infrastructure of the kind established by Western religions like Christianity. However, while the connection between Buddhism and healthcare has long been noted, little research has been undertaken in this field. This article outlines the ethical values which underlie Buddhist concern for the sick and gives an overview of the role of healthcare in Buddhism as it spread throughout Asia. Following from this it explores what many commentators have described as a 'malaise' in contemporary medicine and ask why it is that this noble art today leaves many patients and clinicians unfulfilled. It seems something has been lost, and the article offers some reflections as to whether Buddhism and religion more generally can give an indication as to what that might be. The conclusion provides information about the work of Buddhist chaplaincy organizations and Buddhist medical charities.

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Non-Western religions are beginning to play an increasing role in our globalised world. Buddhism has a long association with the healing arts, but its connection to modern medicine has been very little studied. There are few books on this subject and very little information about it. For this reason we cannot easily know where Buddhism stands on many issues, and it is difficult to speak of a 'Buddhist view' or 'position' in simple terms. Ascertaining authoritative positions is not easy, since

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among the world's 350 million Buddhists there are many sects and schools, so much so that some scholars prefer to speak about 'Buddhisms' in the plural, rather than in the singular. What this article can offer, therefore, is only the limited perspective of a scholar with an interest in medical ethics. No doubt there are others who have a more personal involvement with Buddhism and healthcare, for example as chaplains or medical practitioners, who, in the course of their vocations, confront practical problems at the interface between religion and medicine on a daily basis. I salute the work and dedication of such individuals and give brief details of such activities towards the end of this article.

A further problem in representing the views of Buddhists is that statistically there are very few Buddhists in the West when compared to adherents of other faiths, so we are not likely to come across them in healthcare contexts very frequently. According to the last UK census carried out in 2005, only 150,000 people officially designated their religion as 'Buddhism'. This is around 0.3% of the total population and 5% of the non-Christian population. To put the numbers in concrete terms this is about the size of the crowd at two football matches. As far as Germany is concerned, I have seen unofficial estimates of 1% of the population, giving a total of 820,000, although I suspect this is on the high side. For Europe as a whole I suppose the number would be around 3-4 million, and for the USA around 5-6 million. Taken by themselves, however, I think these numbers seriously underestimate the influence of Buddhism on the West in general. They omit, for instance, many people who are unofficial or 'part time' Buddhists, or who draw on Buddhist spirituality without making an exclusive commitment to it. I think this trend towards a more flexible and less denominational religious practice is increasing, and it is very common nowadays for people to say they are 'spiritual but not religious,' which makes it difficult to categorize them statistically. I am not sure what they write on their medical forms, but more likely than not they describe themselves in terms of conventional religious denominations, even if they rarely attend religious services. The point, however, is that although Buddhism does not yet have a large official presence or an institutional infrastructure it has seeped into our culture in quite significant ways which means we are all likely to encounter it at least indirectly in our daily lives, even if only as part of a pervasive 'new age' spirituality.

My objective in this article is to provide an introduction to basic Buddhist teachings that have a bearing on medicine, and give an overview of how healthcare became an integral part of Buddhist practice as Buddhism spread throughout Asia. I will also say something about the ethical values which underlie Buddhist concern for the sick. Following on from this, I will explore what many commentators have described as a 'malaise' in contemporary medicine and ask why it is that this noble art today leaves many patients and clinicians unfulfilled. Something seems to have

been lost, and I will reflect on whether Buddhism and religion in general can give us an indication as to what that might be. I will conclude with some remarks about Buddhist chaplaincy organizations and the work of Buddhist medical charities.

Although as mentioned it has not been explored in any depth, the connection between Buddhism and healthcare has long been noticed by commentators. The *Dictionary of Medical Ethics*, for instance, tells us under its entry on 'Buddhism' that "The principles governing Buddhism and the practice of medicine have much in common." (Duncan et al. 1981) And R. L. Soni (1976: 137) affirms the same when he tells us that "Medicine ... and Buddhism are both concerned in their own way in the alleviation, control and ultimately the removal of human suffering." The parallels were noted in the earliest Buddhist sources, and are brought out in the classic formulation of the 'Three Jewels', which lists the three foundations on which Buddhism rests, namely the Buddha, the *Dharma*, and the *Sangha*. The Buddha is the historical founder of the religion named after him, the *Dharma* is his teachings, and the *Sangha* is the monastic community he founded which today has spread throughout the world. To explain the relationship between the three, the Buddha often used the analogy of medical treatment in which he compared himself to a doctor, his teachings to medicine, and the monastic community to a nurse. But who, then, is the patient? In the Buddhist view of things, we are all patients because as human beings we all suffer, and often in similar ways.

Tradition tells us that the nature of human suffering impressed itself upon the Buddha when he was a young prince. Although his palace life was comfortable it was unfulfilling, and the Buddha yearned for a deeper and more spiritually satisfying existence. The later legends represent this disaffection in a story in which the Buddha makes four visits outside the palace in a chariot. His overprotective father – constantly fearful that his son would leave home to fulfil the destiny of religious teacher that had been prophesied in a dream – arranged for the streets to be filled with healthy smiling people so that his son would not be troubled by the sight of any unpleasantness. All aged and infirm people were removed from the route, but by chance the Buddha encountered an old man. He was thunderstruck by the discovery of old age and ordered his charioteer to return immediately to the palace where he reflected upon what it meant to grow old. In the second journey he encountered a sick man and in the third a corpse being carried to the cremation ground. These experiences impressed upon him the transient nature of human existence and he realized that not even the palace walls could keep suffering and death at bay. On the fourth trip outside the Buddha encountered a religious mendicant and was inspired to seek a spiritual solution to the problems of the human condition. That very night he decided to leave the palace, and, taking a last look at his sleeping wife and child, departed to become a homeless mendicant.

This simple, poignant story is unlikely to be true in the literal sense. It is hard to believe that the Buddha was as naïve as the story portrays him, or that his disenchantment with palace life was nearly as sudden. It might be more useful to read the story as a parable in which palace life represents complacency and self-delusion, and the vision of the four signs the dawning of a realization about the nature of human existence. If the Buddha were alive today he would see the four signs all around: every elderly person, every hospital, and every funeral would bespeak the brevity and fragility of life, while every church and religious minister would be testimony to the belief that a religious solution to these problems can be found. The parable seems to suggest that although the signs are all around, most people – like the young Buddha – construct mental barriers (the palace walls) to keep unpleasant realities at bay. Even then, there are times when the unwelcome facts of life thrust themselves upon us in a manner it is impossible to ignore, such as in sickness or bereavement, just as they did when the Buddha went forth in his chariot.

The first three of the four ‘signs’ the Buddha encountered revealed a particular dimension of human suffering of a kind encountered in medical practice on a daily basis, namely old age, sickness, and death. Inspired by the fourth, the Buddha renounced the world to find a solution to these problems. His spiritual breakthrough came when he realized that the way to liberation lay through a balanced lifestyle in which moderation was the key element. His early life of ease and comfort had been unfulfilling, and the experiments with austerity and harsh self-denial he had tried subsequently had not worked either. Once he adopted the practice of what he called the ‘middle way,’ however, he achieved his life’s goal. This is advice we often hear in a medical context, in particular with respect to diet, exercise, alcohol, and the avoidance of stress. Reflecting on his experience, the Buddha formulated his teachings in the form of four basic principles which he called the ‘Four Noble Truths’.

The Four Noble Truths state that 1) life involves suffering; 2) suffering has a definite cause; 3) an end to suffering can be found; 3) there is a path leading to the end of suffering. To illustrate the relationship between the four truths, the Buddha explicitly made use of a medical analogy, drawing on his knowledge of contemporary Indian medical practice in which 1) a diagnosis is made; 2) the aetiology of the disease is established; 3) a prognosis is arrived at; 4) a plan of treatment is devised. I will comment directly only on the First Noble Truth, since this may help us later in arriving at an understanding of where modern medicine has gone astray. The textual formulation that has come down to us may be translated as follows:

What, O Monks, is the Noble Truth of Suffering? Birth is suffering, sickness is suffering, old age is suffering, death is suffering. Pain, grief, sorrow, lamentation, and despair are suffering. Association with what is unpleasant is suffering, disassociation

from what is pleasant is suffering. Not to get what one wants is suffering. In short, the five factors of individuality are suffering. (*Sutta Nipāta* 56.11)

The American psychiatrist M. Scott Peck (2006: 3) begins his bestselling book *The Road Less Travelled* with the statement “Life is difficult.” Making reference to the First Noble Truth he adds, “This is a great truth, one of the greatest truths.” This truth is the cornerstone of the Buddha’s teaching. The Truth of Suffering states that suffering (Sanskrit: *duḥkha*) is an intrinsic part of life, and it diagnoses the human condition as fundamentally one of ‘dis-ease.’ As we can see, it makes reference to suffering of many kinds, beginning with physical or biological experiences such as birth, sickness, old age, and death. While these often involve physical pain, the deeper problem in the context of the Indian belief in reincarnation is the inevitability of repeated birth, sickness, ageing, and death in lifetime after lifetime, both for oneself and loved ones. Individuals are powerless in the face of these realities, and despite advances in medical science remain vulnerable to sickness and accident by virtue of their physical natures. Importantly, in addition to physical pain, the Truth of Suffering makes reference to emotional and psychological forms of distress such as ‘grief, sorrow, lamentation, and despair.’ These can sometimes present more intractable problems than physical suffering: few lives are free of grief and sorrow, and there are many debilitating psychological conditions, such as chronic depression, from which a complete recovery may never be made.

Beyond these obvious examples of suffering the Truth of Suffering refers to a third, more subtle, kind of suffering which might be termed ‘existential.’ This is seen in the statement “Not to get what one wants is suffering.” The kind of suffering envisaged here is the frustration, disappointment, and disillusionment experienced when life fails to live up to our expectations and things do not go as we wish. The Buddha was no morbid pessimist and certainly knew from his own experience as a young prince that life can have its pleasant moments. The problem, however, is that the good times do not last; sooner or later they fade away, or one becomes bored with what once seemed novel and full of promise. In this context the word *duḥkha* has a more abstract and pervasive sense: it suggests that even when life is not painful it can be unsatisfactory and unfulfilling. In this and many other contexts ‘unsatisfactoriness’ captures the meaning of *duḥkha* better than ‘suffering.’ The First Noble Truth, therefore, views not only sick people, but all human beings, as ‘patients’ in need of healing. For Buddhism, we all suffer in the three main ways described which touch upon overlapping dimensions of the patient as person. If we are to be truly healed it follows that we need treatment for our psychological and existential or spiritual maladies as well as our physical ones. Modern medical bodies have recognized this much, and in the view of the World Health Organization “Health is a state of complete physical, mental, and social well-being and not

merely the absence of disease or infirmity.”¹ The WHO ‘Quality of Life Group’ has also affirmed that spirituality is an important dimension of the quality of life. (WHOQOL Group 1995: 1403-9)

Before leaving the Four Noble Truths it is important to say a word about the second, which explains how suffering arises. Here Buddhism introduces the concept of causality to explain how certain causes lead inexorably to certain effects. This dynamic way of viewing things developed into a central aspect of Buddhist philosophy that came to hold that nothing exists independently and that everything that exists does so in dependence on a network of causes and conditions. The implications of this for medicine are that the patient is not seen as a separate entity but as a being-in-relationship. The patient is sustained by a network of intrapersonal and extrapersonal relationships. The intrapersonal relationships are those that exist between the various systems of the body, and the extrapersonal relationships are those that link the patient to the world at large. Illness disrupts both, and the aim of medicine is to restore the normal balance to these relationships. Sometimes, of course, medicine alone is unable to accomplish this, and the intrapersonal disruption caused by illness turns out to be incurable. There may still be an opportunity, however, to heal the damage caused by the extrapersonal disruption by providing the spiritual support for the patient to be reconciled existentially with their situation and to transcend negative emotions such as fear and resentment. In this way we could say that patients can sometimes be ‘healed’ spiritually even when there is no medical ‘cure.’

At this point we move from doctrine to history as we turn our attention from the second of the ‘Three Jewels’ (the *Dharma*) to the third (the *Sangha*). Here I would like to consider briefly the role of the Buddhist monastic community in healthcare. This body was founded by the Buddha several centuries before the time of Christ, and although the details are still sketchy it seems to have played an important part in the development of the traditional system of Indian medicine known as *Āyurveda*. In this, Buddhism was assisted by its rejection of the caste system and the taboos concerned with purity and pollution which governed the lives of orthodox religious practitioners (Brahmins). To come into contact with a person of a lower caste, or a dead body, could be polluting, and such concerns clearly place limitations on medical treatment and research. Unhindered by such concerns, Buddhist monks began to experiment with treatments and to codify medical practice, producing one of the earliest compilations of medical knowledge in the world. They set up

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1. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

infirmaries and hospices attached to monastery buildings, and included medicine as a recognised subject of study in monastic universities. In due course, this knowledge spread from India to Central, South and East Asia as Buddhist monks travelled beyond their Indian homeland and visitors from other parts of Asia came to India to learn more about Buddhism.

The reasons why monks interested themselves in medical matters were probably fivefold. First, to help deal with the ailments arising from the rigours of monastic life. The hardships faced by monks were considerable, and monasteries were often located in remote places where medical treatment would not otherwise be available if the monks themselves did not administer it. At any time in a given community someone will be unwell, and an institutionalised method of coping with sickness would be needed. A second reason would be to treat the laity. Monks and nuns depended for economic support on the laity, and the good will of the local village community was indispensable. A third, related, reason was that being able to cure illness would be very useful from the point of view of demonstrating the truth and efficacy of Buddhist teachings and their superiority over the beliefs of rival sects. This would be particularly important when Buddhism was seeking to establish itself in new regions and found itself in competition with indigenous systems. A fourth reason would be simple scientific curiosity and the desire to better understand the human body and its functioning. The fifth and final reason is that the Buddha himself had provided a warrant for medical practice through his own word and example, not least in the following words:

You, O monks, have neither a father or a mother who could nurse you. If, O monks, you do not nurse one another, who, then, will nurse you? Whoever, O monks, would nurse me, he should nurse the sick.²

The use and possession of medicines was officially sanctioned for monks as the last of the four 'requisites' (*nissāya*) or items they were permitted to possess. These other three were robes, food, and lodgings. Of course, Buddhist medicine was not like the scientific medicine we are familiar with today, and would often involve a combination of empirical methods and magical cures depending on the practitioner. Natural remedies using herbs, roots, homeopathy, moxibustion, incense, acupuncture, massage, mineral baths, emetics, laxatives, diet, and so forth, were very common. Food itself was one of the main medicines used, and different combinations of astringent, sweet and savoury ingredients were recommended for particular ailments. On the magical side, patients also had recourse to rituals, mantras, amulets, gemstones, chants, charms, mandalas, and recourse to spirits, although such practices were discouraged by the Buddha and more orthodox practitioners.

2. Quoted in Zysk (1991: 41) (translation slightly amended).

In the third century B.C.E. Buddhism in India was given a major impetus when it was adopted by the emperor Ashoka. Ashoka, who was crowned in 258 B.C.E., succeeded in unifying most of India and creating the greatest empire seen before the British Raj. Perhaps adopting a practice from the Persian Achaemenid empire, Ashoka ordered inscriptions to be carved on rock throughout his kingdom. To date, a total of thirty-three of these have been found throughout the length and breadth of India, and in these Ashoka discloses his personal beliefs and offers moral advice to his subjects. In the second of his rock edicts, he makes reference to the provision of medical treatment in the following words:

[I have] made provision for two types of medical treatment: medical treatment for humans and medical treatment for animals. Wherever medical herbs suitable for humans or animals are not available, I have had them imported and grown. Wherever medical roots or fruits are not available I have had them imported and grown. (Ashoka, Rock Edict II; transl. by Ven S. Dhammika)

Ashoka repeatedly stresses his belief in non-violence and respect for life, a concept encapsulated in the Sanskrit word *ahiṃsā*, which means 'non-harming,' or 'non-violence.' This is an ancient Indian moral value respected by many religious sects. In modern times it was made famous by Mahatma Gandhi, and influenced Western thinkers such as Albert Schweitzer in his philosophy of 'reverence for life.' We can see here a similarity with the Hippocratic dictum 'First do no harm.' As we might expect, Buddhist medical practice was influenced by more general Buddhist ethical teachings, and in early Buddhism we find repeated reference to what are known as the four 'sublime states,' consisting of benevolence (*mettā*), compassion (*karuṇā*), sympathetic joy (*muditā*), and equanimity (*upekkhā*). In later Buddhism, we find the six 'Perfections' (*pāramitā*) of the bodhisattva occupying a prominent position. These are generosity (*dāna*), self-restraint (*śīla*), patience (*kṣānti*), endurance (*vīrya*), meditation (*samādhi*) and wisdom (*prajñā*). All of these virtues would be appropriate in the context of medical practice.

Coming down to modern times, I would like to comment from a Buddhist perspective on the problems which many people see as afflicting modern medicine. We hear, for instance, that the practice of medicine has become 'despiritualised' such that – unlike in the Buddhist analysis – 'suffering' is identified exclusively with 'pain,' or purely physical symptoms. In other words, the spiritual wellbeing of the patient is ignored, and the link between body and spirit is broken. In this context, in contrast to what has been described earlier, we can say that diseases are cured, but patients are not healed. Another common complaint is the increasing dehumanization of medicine through ever-greater reliance on technology. At times the patient seems to disappear from view behind a screen of technology, such as scanners and other devices, and appears to the physician only as a readout on a dial. The attitude of patients, conversely, has become one of 'medical consumerism,'

in terms of which patients have unrealistic expectations of medical science, and see doctors as service providers who should be able to fix any problem. Failing a successful 'repair,' patients feel aggrieved and entitled to complain about the service they have received. The mentality of such patients is that they have a right to eternal life and perfect health, and that medical science has an obligation to provide it for them.

Another affliction affecting the practice of medicine today is the tendency towards 'Balkanisation' or the fragmentation of medicine into a range of different specialisms. The pace at which medical knowledge is expanding means that physicians can claim expertise only in ever-narrower fields. This can mean that a patient with a complex condition is often shuffled around between a variety of specialists each of whom has only a partial perspective on the patient's overall condition. This is a trend which seems likely to accelerate as medical teams become larger and more specialized and even with the best communication it may appear to a patient that no-one is in overall charge of his case or can give him accurate and timely information about his condition. Finally, there is the problem of the increasing involvement of politicians, managers, and administrators at all levels of healthcare provision. Hospitals and units are given targets, and league tables measure the performance of units nationally. This means there are financial incentives to record only measurable results, when what may matter more to patients are the intangible and unquantifiable aspects of their care experience. For example, on what scale can it be recorded that a patient passed through denial, anger, and resentment to peace and serenity, even if the treatment failed?

Reflections of the above kind lead us to the conclusion that modern medical practice has little time for religious belief, and indeed there are many who feel strongly that religion has no place in medicine. Many positivist-minded scientists and physicians draw a contrast between science and superstition, classifying all intervention as of either one kind or the other. There is concern about the possibility of proselytizing to patients in a psychologically vulnerable position and holding out false hopes of a miracle cure through 'faith healing.' There is no shortage of charlatans practicing all kinds of 'quack' medicine that are frowned on by established medical bodies. On the other hand studies show that religious belief can have a powerful influence on recovery from illness, and that people who actively practice their faith get better faster. There is no clear link to religious denomination in these studies, which suggests that the specific nature of a person's belief is not the key issue, but rather the support and strength they draw from their religious convictions and the meaning it gives to their suffering. When patients are approached in a respectful manner about their beliefs, the great majority respond positively and welcome discussion of the subject. This is true even in the case of atheists, indicating that patients as a group are not averse to dialogue with their carers on spiritual questions. Various mnemonics have been devised to

assist in taking a patient's 'spiritual history.' HOPE, for example, stands for the patient's sources of *hope*, the role of *organized religion* in their life, their *personal spiritual beliefs*, and the *effect* on care and decision-making that their beliefs might have. Again, SPIRIT, denotes the patient's *spiritual* belief system, their *personal* spirituality, *integration* with their spiritual community, *ritualized* practices and restrictions, *implications* for medical care, and *terminal* events planning.³

A useful perspective on these and other questions concerning the relationship between spirituality and healthcare has been provided by American writer Daniel Sulmasy. Sulmasy is a Franciscan friar and also an M.D., and in his widely-read publications has recorded his experience of the role of religious belief in medical practice.⁴ Sulmasy takes the view that healthcare is inherently spiritual, and develops what he calls a 'biopsychosocial-spiritual' model of healthcare which pays attention to four dimensions of the patient's condition: the biological, the psychological, the social, and the transcendent. He emphasises over and over the importance of three questions that are raised by sickness, namely meaning, value and relationship. What he wishes to draw attention to here is that a patient is not concerned solely with the physical basis of their illness, but also in its existential aspects. In other words, the patient wishes to understand the meaning of their condition and be able to make sense of it in terms of their overall view of life. The illness also raises questions about what value their life has now and how their conception of their self-worth has been changed by their condition. The final important aspect is the way in which the sickness affects their relationship with family, friends, and the world at large.

It is by no means clear, however, where answers to such questions are to be sought in the context of modern medical practice. This is true not just in the West but also in the East. Moichiri Hayashi (2009: 2), the Director of Kosei General Hospital,⁵ Tokyo, a Buddhist institution, recently confessed "We hear the term 'healing' a lot, and perhaps the root problem in Japanese medical care is that it is not clear just who should attempt to provide spiritual healing for the patient." I suspect this problem is widespread, and there seems to be no general agreement on how the spiritual needs of patients should be met. Sulmasy (2006: 176 ff) offers three models of how this can be provided, all of which have some problems. The first he calls the 'Doctor-Priest' model. Here, the physician takes on the role of priest and endeavors to treat both the physical and spiritual needs of the patient. Perhaps the prototype for this would be the shaman or medicine-man of primitive societies, who offers healing of both mind and body. In a modern context, however, it is hard to see how a

3. For HOPE see Gowri Anandarajah and Ellen Hight (2001: 81-89); for SPIRIT see Todd A. Maughans (1996: 11-15).

4. See Sulmasy (1997, 2006a and 2006 b).

5. Kōsei Byōin 倭成病院, run by the Risshō Kōseikai Buddhist organization.

single individual could acquire the necessary expertise to be both a medical specialist and a spiritual counselor. There is also an advantage in keeping these roles separate so that an effective division of labour can be made and resources concentrated more effectively.

The second model is that of the 'Parallel Track.' This is the one encountered in most hospitals, and involves the division of labour referred to above in terms of which physicians confine themselves to medical matters and chaplains to spiritual ones. A problem here is that many patients who do not profess clear religious beliefs will tend to fall between the cracks. Humanists and atheists, for example, may have no chaplain assigned to them because they do not belong to any religious denomination. Nevertheless, they may have the same existential concerns about meaning, value and relationship as religious believers. A further problem with this model is that it seems to embed institutionally the false dichotomy between science and spirituality which is at the root of the problems faced by modern medicine. This separation seems to be saying, in effect, that body and spirit *are* separate and should be treated that way, rather than affirming the unity and integrity of 'the patient as person.'

The third and last model is known as 'Collaborative Ministry.' This involves chaplains actively collaborating as part of the healthcare team rather than by visiting the patient only on referral. This practice is more common in hospices, where the care of the terminally ill means that mortality is a topic discussed at every bedside. However, it is not clear how successful this model could be in the normal hospital context and some practical problems present themselves. For example, should chaplains accompany the medical team on their daily rounds, and what issues of confidentiality would be raised by open discussion of religious belief? Would the medical team be expected to participate in joint prayers for the patient's recovery? Clearly, there remain questions as to how to implement the collaborative model in practice, even though it does embody the ideal of the indivisibility of body and spirit to a greater extent than any of the others.

Turning now to the area of Buddhist resources for healthcare, it is very difficult to get an accurate picture of what provision exists. As with other faith-based health systems, Buddhist resources make up a diffuse network of organizations and groups with no central administration or control. The provision resembles a 'galaxy' of more or less separate activities loosely coordinated at various levels by nation, school and sect, and including everything from village herbalists to modern hospitals. In terms of scale, my impression is that the Buddhist provision overall is considerably less than that of Christian-based organizations and charities, which are represented in almost every country and are actively involved in disaster and famine relief. A few of the more well-known groups and activities which spring to mind are the San Francisco Zen Center's hospice volunteer program, the Hartford Zen Center's

Maitri AIDS Hospice, the Upaya Community's 'Being with Dying' program, the UK-based Buddhist Hospice Trust, and more recently the charitable work of Compassion Relief.

Compassion Relief, an offshoot of the Tzu Chi Foundation in Taiwan, is the largest of the groups mentioned, and operates medical and general healthcare outreach programmes in California, Hawai'i, and New York, in addition to its international bone marrow bank. In November 1993, under the leadership of Ven. Cheng Yen, Compassion Relief U.S.A. established its medical outreach free clinic in Alhambra, California, providing Chinese and Western medicine, in addition to dental care that includes two mobile dental units to the disadvantaged, underprivileged, and uninsured communities of Los Angeles proper. Ven. Cheng Yen's medical mission started in Taiwan, where she realized that the primary cause of people's suffering stems from the lack of adequate healthcare and inability to cultivation and sustain healthy living. In May, 1997, Compassion Relief U.S.A. founded its second free clinic on Honolulu, Hawai'i, serving the economically disenfranchised indigenous populations of the islands, focusing on providing primary healthcare for school aged children, and free vaccinations. From its base in Honolulu, Compassion Relief extends its medical outreach to the outlying Pacific Islands (e.g. Samoa). The newest addition to Compassion Relief's medical outreach was established in September 1997, in New York City. Compassion Relief's New York mobile free clinic, travels around the New York area, delivering and providing basic healthcare to low income families, homeless residents, and the uninsured. By 2000 it had already served over four thousand patients. Compassion Relief's free clinic medical mission outreach also functions in other countries, for example Canada, the Philippines, Brazil, Indonesia, Vietnam, Japan, and mainland China.⁶

With regard to Buddhist chaplaincy organisation, these seem to have appeared largely within the last decade and there are various groupings and accreditation bodies in existence. In the England and Wales the Multi-Faith Group for Healthcare Chaplaincy includes representatives of nine world faiths, and describes its aims as "facilitating a common understanding amongst Faith Groups, chaplaincy bodies and users; providing a means of consultation between Faiths; cooperating with healthcare and chaplaincy organisation, bodies, and authorities," and more.⁷ A Buddhist chaplaincy support group known as 'Kalyana Mitra' ('spiritual friend') offers a forum for sponsoring outreach work and bringing together chaplains from any Buddhist tradition and field of activity, such as hospitals, prisons, and immigration centres. As the organisation's publicity admits, however, "In the United

6. I am indebted for this information on the work of Compassion Relief to Dr Jonathan H.X. Lee's unpublished paper "Bring Strangers Together: Chinese/Chinese American Engaged Buddhism, Race and Inter-Ethnic Relations in America."

7. <http://www.mfghc.com/index.htm>, website visited 5 July 2010.

Kingdom there is little awareness of Buddhist Chaplaincy. Few posts exist, and very few paid posts exist for Buddhist chaplains.⁸ A major UK-based Buddhist group, the Triratna Buddhist Community (formerly known as the Friends of the Western Buddhist Order), has also established a Buddhist Healthcare Chaplaincy Group under the auspices of its 'Buddhist Care Network.' Other initiatives include the Kadampa Buddhist Health Care Chaplaincy established in 2003 which operates on a multi-faith basis. "This inclusive approach," its website states, "enables the work of chaplaincy spiritual-care to bring benefit to all world faiths and to as wide a variety of people as possible, whether of a particular faith or none."⁹

In the USA professional training is available to Buddhist chaplains through organisations validated by the Association of Professional Chaplains. There are at least four places currently offering training for Buddhist chaplains. Naropa University in Boulder, Colorado, offers a Master of Divinity (M.Div) qualification, as does the Institute of Buddhist Studies in Berkeley, California. This is a Buddhist seminary and graduate school run by the Japan-based Jodo Shinshu sect. Students here can join the Buddhist Chaplaincy Training Program as part of a general MA qualification. The University of West at Rosemead, also in California, was founded by a Chinese sect based in Taiwan. This is a small university with a few hundred students, and launched a Chaplaincy Program recently in 2009 offering a three-year residential M.Div programme. Finally, Harvard University's M.Div. program, although not geared explicitly toward Buddhists, allows students to study any tradition in which teaching is available, including Buddhism. Harvard is also in the process of developing a suite of 'Buddhist Ministry' courses.

In conclusion, I think we can sum up the relation between Buddhism and healthcare by saying that Buddhism has an extremely long history of association with medicine and healing extending over two thousand years and embracing developments across the whole of Asia. It is now also beginning to make an impression in the West, although presently lacking a developed infrastructure of the kind established by Christianity. Buddhist teachings explicitly acknowledge this connection in the 'Three Jewels' of the Buddha, *Dharma* and *Saṅgha*, which are frequently compared to the medical triad of doctor, medicine, and nurse. Buddhism's views about medical treatment flow from its moral teachings, of which compassion and non-harming (*ahiṃsā*) are key elements. Importantly, its view of human wellbeing is not limited purely to freedom from disease, and it looks beyond that to the health of the whole person by offering a therapy for mind, body and spirit.

8. <http://www.buddhistchaplains.com/>, website visited 5 July 2010.

9. http://kbhcc.org/kadampa_chaplains.html, website visited 5 July 2010.

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