CHAPTER 1

Buddhist Medical History

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Buddhism arose in the sixth century BCE in northeastern India, where the indigenous culture and the Indo-Aryan, Brahmanic tradition converged. It was an ascetic movement (*śramaṇa; samaṇa* in Pali), based on the enlightenment experience of its founder, Śākyamuni, or Gautama Buddha. Like the ascetic movements of Jainism and Ājīvikas, Buddhism did not develop out of the Brahmanic-Hindu tradition. Consequently, it was regarded as a rival heterodoxy.

From the time of the Buddha, early Buddhism attracted lay followers, for it was patronized by the rising mercantile families in northeastern India. King Aśoka (274–232 BCE) advocated Buddhism not only as the religion of his vast Mauryan empire but also as a missionary movement to other parts of the world. Buddhism was enthusiastically promoted again during the second century CE by King Kaniṣka, who ruled northern India and Central Asia. Following the route of Hinduization, it expanded into various parts of South and Southeast Asia. It came to Central Asia and China along the so-called Silk Road, and China then became the center of Buddhist expansion into other parts of East Asia. Another route of expansion brought Buddhism into Tibet and eventually to the Mongolian steppe. Since the latter nineteenth century Buddhism has also penetrated various parts of the West.

E. J. Thomas astutely pointed out that the Buddhist movement began "not with a body of doctrine, but with the formation of a society bound by certain rules."[1] The early Buddhist community had four components: monks *(bhikṣu, bhikkhu),* nuns *(bhikṣuṇī, bhikkhunī),* male lay followers *(upāsaka),* and female lay followers *(upāsikā).* The monastic path, however, was acknowledged to be more central.

A century after the demise of the Buddha his community began to develop many informal factions. In the course of time, the community split into three major traditions, each with many subdivisions: (1) Hīnayāna ("small vehicle") or Theravāda ("way of the elders"), a monastic-centered tradition adhering to the Pali canon, became established in South and Southeast Asia; (2) Mahāyāna ("great vehicle"), which follows Sanskrit and/or Chinese scriptures and recognizes both the monastic and the lay paths, became established in East Asia; and (3) the Esoteric or Tantric tradition, the latest form of Buddhism, became established primarily in Tibet and Mongolia but also in Japan. In Tibet this tradition developed a *de facto* theocracy. Unlike Christianity and Islam, Buddhism accommodated many local religious features and thus developed a series of culturally oriented religious forms such as Thai Buddhism, Mongolian Buddhism, and Korean Buddhism.

All Buddhist traditions affirm the centrality and interrelatedness of the *tri-ratana* (or *tri-ratna,* "three jewels")—Buddha, *dharma* (or *dhamma,* law or teaching), and *saṃgha* (or *saṅgha,* Buddhist community)—although each tradition interprets them differently. Buddhist teaching is traced to the Buddha, who, as a supreme physician, diagnosed and presented the remedy for the spiritual health of humankind in Four Noble Truths: (1) the fact of suffering as the basic feature of existence; (2) the cause of suffering; (3) the cessation of the cause; and (4) the eightfold path that leads to cessation—right understanding, right thought, right speech, right action, right livelihood, right effort, right mindfulness, and right concentration. Other notions central to Buddhist beliefs are *anattā* (nonself), "dependent coorigination" (which explains how all physical and psychical phenomena, from ignorance of the true nature of existence to old age and death, are conditionally related to each other), and *karma* (action with inevitable results, the moral law of cause and effect). From the time of King Aśoka, *dharma* came to be understood as the foundation and guide to empirical social and political order as well as to cultural life.

Characteristically, the Mahāyāna tradition stresses the way of the bodhisattva or Buddha-to-be and the mutuality between saving wisdom *(prajñā)* and compassion *(karuṇā).* The Esoteric tradition acknowledges the importance of superhuman knowledge and power *(abhijñā).*

In 1957, Benson Y. Landis estimated the number of Buddhists as roughly 350 million.[2] But since many of those listed by him as adherents

of other religions—Confucianists (300 million), Taoists (50 million), and Shintoists (25 million)—may consider themselves Buddhists at the same time, the total number may be much larger. Buddhism is now one of the most widely diffused religions, scattered over every continent with the probable exception of Africa. There is a sizable Buddhist community in the USSR and in the West as well, where the number of Buddhists has been increasing steadily since World War II.

Wellness and Illness

HEALTH

According to the canonical tradition, the Buddha was concerned with the health of monks and took a keen interest in medicine. Once he and his trusted disciple, Ānanda, found a monk suffering from dysentery and lying fallen in his own excrement. They washed the body of the sick man themselves and then the Buddha told the assembled monks: "Monks, you have not a mother, you have not a father who might tend you. If you, monks, do not tend one another, then who is there who will tend you? Whoever, monks, would tend me, he should tend the sick."[3] Then, after giving rules for the care of the sick, he proclaimed:

> Endowed with five qualities, monks, is one who tends the sick fit to tend the sick: he comes to be competent to provide the medicine; he knows what is beneficial and what is not beneficial; he takes away what is not beneficial, he brings forward what is beneficial; he tends the sick (from) amity of mind, not in the hope of gain; he does not become one who loathes to remove excrement or urine or sweat or vomit; he comes to be competent to gladden . . . delight the sick from time to time with *dhamma*-talk. Endowed with these five qualities, monks, is one who tends the sick fit to tend the sick.[4]

As far as we can ascertain, Buddhism did not develop its own medical tradition. The Buddha himself was attended to by Jīvaka Komārabhacca, who had studied surgery and medicine at Taxilā and was in service at the court of King Bimbisāra. According to A. L. Basham, the science of medicine in India became known as Āyurveda, "the science of living (to a ripe) age."

> The term is significant from the semantic point of view, since its first component *(ayur)* implies that the ancient Indian doctor was concerned not only with curing disease but also with promoting positive health and longevity, while the second *(veda)* has religious overtones.[5]

Health was believed to be conditioned by the balance of three primary fluids in the body (wind, gall, and mucus), and five separate breaths or winds were supposed to control bodily functions. The harmonious operation of these factors was thought to maintain good health, while discord was thought to result in disease.

Buddhism was concerned with physical health as an important condition for striving after spiritual health, as told in *Anguttara-Nikaya* (III, 16): "The monk wisely reflecting partakes of his alms food . . . merely to maintain and support this body, to avoid harm and to assist the holy life."[6] Following this principle the early Theravāda tradition tried to confine the monks' medical activities to the monastic orders, without much success. But Basham reminds us that "with the Mahāyāna, medicine became one of the five secular sciences that the monk might study, and Indian medical knowledge was taken by Buddhist monks wherever they went."[7]

The Buddhist view of health and illness has basic ambiguities. According to the doctrine of *karma*, one's existence is the result of one's past actions; yet one can improve the physical and mental state of his or her future by the right mental attitude and by careful attention to measured food, proper digestion, and a regulated living style. On the whole, the laity were less concerned with doctrinal matters. They simply rejoiced when they were blessed with good health, which to them was an essential condition of happiness, as the *Dhammapada* (The path of virtue) teaches: "We live happily indeed, free from ailments among the ailing! Among men who are ailing let us dwell free from ailments!"[8]

SUFFERING

Because Buddhism is a nontheistic religion, it does not ask why God allows suffering. No outside agent, divine or demonic, causes suffering. Nevertheless, suffering is an all-important issue for Buddhism because suffering *(dukkha)*, impermanency *(anicca)*, and nonself *(anattā)* are considered to be the three basic characteristics of existence. According to the canonical tradition, in his First Sermon the Buddha explicated suffering as the first of the Four Noble *(ariyan)* Truths: "Birth is suffering; decay is suffering; illness is suffering; death is suffering; presence of objects we hate is suffering; separation from objects we love is suffering; not to obtain what we desire is suffering."[9] Walpola Rahula reminds us that the Pali word *dukkha* (*duḥkha* in Sanskrit) carries the idea of suffering, pain, sorrow, or misery, as opposed to the word *sukha* (happiness, comfort, or ease), but that in the First Noble Truth the term referred not only to suffering in ordinary usage but also to deeper philosophical notions such as

imperfection, impermanence, emptiness, and insubstantiality. In short, "whatever is impermanent is *dukkha*."[10]

Understandably, such a radical understanding of the nature of existence results in a uniquely Buddhist approach to the meaning of suffering. Above all else, suffering is edificatory. From the Buddhist perspective, recognizing the fact of suffering means understanding the truth of impermanency *(anicca)*: everything is in a constant state of changing, disappearing, and dissolving from moment to moment. Understanding this leads to understanding the truth of nonego or nonself: there is no abiding ego entity, no ontological substance within these bodily and mental phenomena of existence that are usually mistaken as a self or a person. Indeed, without a realistic understanding of the universal fact of suffering as taught in the First Noble Truth, no one can enter the path of the Buddha, who alone discovered the way of emancipation from the universal predicament of suffering.

SICKNESS OR INJURY

It is well nigh impossible to make generalized statements about Buddhist views of sickness or injury. For brevity's sake we may delineate three different approaches practiced by Buddhists, namely, medical, doctrinal, and magical, provided we remember that in reality these three approaches are often interfused.

For the most part, Buddhist communities in India, as well as those in Southeast Asia, followed the Āyurveda, the pan-Indian science of medicine mentioned above, and its deviations, while Buddhists in China depended heavily on Chinese medical science as exemplified by the *Yellow Emperor's Classic of Internal Medicine* and *Shen Nung's Classic on Herbs*. According to these medical views, the functioning of the human body, thought of as a microcosm, is controlled by natural laws, just as the universe is regulated by the laws of cause and effect. Disease results when the constituent elements of the human body malfunction. Thus, as Obeyesekere points out, Sinhala Buddhists accept on one level the Āyurveda's notion that "disease is caused by the upsetting or excitement of any one or more of the three humors basic to the human organism: *vāta* or *vāyu* (wind), *pitta* (bile), *slēshma* or *kapha* (phlegm). Collectively these are known as the *tri-dōsa*, 'the three troubles'"[11] Chinese medical science interprets the natural cause of disease in similar fashion. Evidently, everywhere in Buddhist communities monks and laity alike have always accepted such naturalistic medical views of disease, at least on one level.

On another level, however, the Buddhist view of disease and/or injury cannot be divorced altogether from the doctrine of *karma (kamma)*,

which refers to "the wholesome and unwholesome volitions and their concomitant mental factors, causing rebirths and shaping the destiny of beings."[12] Thus, whether or not and to what extent disease and injury are caused by one's karmic volitions have remained serious questions in the Buddhist community, questions without clear-cut resolutions. As early as the second century BCE a Greek king in Bactria, Menander (Milinda), asked the Buddhist master Nāgasena concerning the relationship between *karma* and the Buddha's own injury and disease. In his answer Nāgasena insisted that although the Buddha had burnt all evil (all consequences of *karma*), a splinter of rock had pierced his foot at one time and he had suffered from dysentery at another but that his injury and disease were not caused by *karma*. Nāgasena explained that not all suffering has its root in *karma*:

> There are several causes by which sufferings arise, by which many beings suffer pain. And what are they? Superabundance of wind, and of bile, and of phlegm, the union of these humours, variations in temperature, the avoiding of dissimilarities, and Karma. From each of these there are some sufferings that arise, and these are the eight causes by which many beings suffer pain.[13]

Nāgasena admitted, of course, that "there is the act that has Karma as its fruit, and the pain so brought about arising from the act done." He also recognized that the Buddha, who was "above all gods" and in whom there was no evil left, was a very special case and that "no one without a Buddha's insight can fix the extent of the action of Karma" vis à vis diseases and injuries that cause pain.[14] The difficulties involved in the question as to which diseases and injuries are caused by the action of *karma* have haunted generations of Buddhists in many lands.

As stated earlier, Buddhism has always been conciliatory to local cultural and religious traditions and has accommodated many non-Buddhist beliefs and practices such as spirit worship in various parts of Asia. Invariably many forms of magical beliefs concerning disease and injury developed, especially in the folk-religious traditions. Obeyesekere, for example, depicts the popular beliefs concerning diseases presumably caused by external (supernatural) agencies (for example, demons and gods)—beliefs that are held by the Sinhala Buddhists in Sri Lanka. "Ultimately," according to his observation, "all misfortunes caused by external agencies are due to unfavorable planetary movements *(graha dōsa)*: astrology in turn however simply indicates a person's *karma*, in this case bad *karma* or *karma dōsa*." He goes on to describe the interesting manner in which the demonic theory of disease causation is linked to the classical medical theory. Moreover, the Sinhala hold that "the identical disease may be caused by either naturalistic (Ayurvedic) or demonological factors. For example, *lē māle* (menorraghia) can be caused by a natural excitement of heat *(uṣna)*

or bile *(pitta)* in the body, or by the demon *Sanni Yaka,* or *Riri Yaka* (blood demon)."[15] Similar observations may be made about folk Buddhist traditions elsewhere.

MENTAL ILLNESS

Among other characteristics, early Buddhism was known for its tendency toward absolute idealism as exemplified by the opening sentence of the *Dhammapada:* "All that we are is the result of what we have thought: it is founded on our thoughts, it is made up of our thoughts."[16] Related to this idealism were psychological and mental analyses of the human condition so sophisticated that Heinrich Zimmer calls the Four Noble Truths "psycho-dietics."[17] In fact, these characteristics run through all aspects of Buddhist doctrine, ethics, and soteriology. The canonical tradition stresses the importance of equilibrium, harmony, and balance in relation to mental faculties (faith, energy, mindfulness, concentration, and wisdom). Yet the canonical tradition rarely deals with what we now call mental illness as such, because trance and vision experience, divine hearing, and stupefaction, psychogenesis, obsessional neurosis, and paranoia are difficult to evaluate.

The popular or folk Buddhist tradition, on the other hand, has inclined to the view that a variety of nonhuman agents, spirits, or demons cause mental illness. As a consequence, it has practiced many forms of healing cults, exorcism, pacification of spirits, and divination, side by side or in collaboration with established Buddhist institutions. Fortunately, we now have a large number of books and articles by scholars on these eclectic beliefs and practices concerning what we regard as mental illness. Evidently, the religious universe of many lay Buddhists is inhabited by many spirits and demons of non-Buddhist origins, and lay Buddhists today, as in the past, depend on a variety of cultic specialists in addition to Buddhist clergy and physicians in dealing with irregular mental conditions caused by these nonhuman agents.

ALCOHOL AND DRUG ABUSE

One of the five moral rules in the canonical tradition forbids the use of intoxicants and drugs such as wine and liquor because they lead to moral carelessness. This precept was observed more or less faithfully within monastic orders, but it often broke down in village temples where monks served as *de facto* parish priests. Moreover, many lay Buddhists indulged in intoxicants and drugs for medicinal purposes, among others. In the modern period, Buddhist reform movements have advocated strict prohibition of alcoholic beverages, but they have not met with significant success.

Caring and Curing

IMPULSE TO CARE

There are many facets and meanings to caring in Buddhism. At the risk of oversimplification, we might discuss the Pali canonical tradition (the tradition inherited by Theravāda Buddhism in South and Southeast Asia), including both its monastic and its lay orientations, and the Mahāyāna orientation.

Although in principle Buddhism affirms that its truth *(dharma)* can be known and actualized only within the corporate life of the Buddhist community *(saṃgha)*, the monastic-centered canonical tradition quickly developed according to an elitist model. It encouraged monks to strive spiritually toward the states of the Stream Winner (the lowest stage of the path of the noble disciples), the Once-Returner (the state of the noble individual who, after returning to this world once, can overcome suffering), the Never-Returner (the state of being born in a higher world from which one may reach *nirvāṇa* without having to return to this world), and the Holy One (*arahat*, the state of the saint who has been freed from all craving and rebirth and has attained enlightenment). For the sake of this spiritual striving, monks are urged to cultivate four kinds of emotions: loving-kindness *(mettā)* that eliminates the boundary between oneself and others, compassion *(karuṇā)* that enables one to share the suffering of others, sympathetic or altruistic joy *(muditā)* that enables one to rejoice over others' happiness, and equanimity or evenmindedness *(upekkhā)*, the feeling of total identification of oneself with others. Thus we read:

> Therefore, O Brothers, the monk with a mind full of loving-kindness pervading first one direction, then a second one, then a third one, then the fourth one, just so above, below and all around; and everywhere identifying himself with all, he is pervading the whole world with mind full of loving-kindness, with mind wide, developed, unbounded, free from hate and ill-will.[18]

As Winston King reminds us, however, such ethically good emotions and deeds as loving-kindness, compassion, and equanimity do not bring a man to sainthood or enlightenment *(nirvāṇa)*. The perfect deed, according to the canonical tradition, "is the detached thought, word, or deed which has no kammic [karmic] consequence. Hence the highest life seems to be a complete escape from, or transcendence of, the ethical sphere."[19] Thus, caring, as an expression of loving-kindness and compassion, is not an unquestionable virtue. Unless compassion is guarded by a perfected state of equanimity rarely attained, it tends to push the path-seeker to enter again and again the sensuous sphere of this world.[20] The following verses of the *Dhammapada* may be read in this light:

> By oneself the evil is done, by oneself one suffers; by oneself evil is left undone, by oneself one is purified. The pure and the impure (stand and fall) by themselves, no one can purify another.
>
> Let no one forget his own duty for the sake of another's, . . . let a man, after he has discerned his duty, be always attentive to his duty.[21]

It is clear that in the canonical tradition caring involves ambiguities. Monks are urged to strive toward their own enlightenment, an enlightenment that transcends all ethical and human considerations. Although we may be a bit surprised, we can certainly understand why a sick monk was left unattended in the famous incident when the Buddha and Ānanda were touring the monks' quarter. "Lord," said the other monks, "this monk is of no use to the monks, therefore the monks do not attend that monk."[22] Helping the sick monk would not really help other monks in their spiritual striving. It would only interfere with their main religious task. Confronted by this difficult situation, the Buddha advocates a sort of middle way: "He becomes one who does what is beneficial; he knows moderation in what is beneficial; he becomes one who takes medicine; he makes clear the disease just as it comes to be to one who tends the sick and who wishes him well."[23] But it is easier to say what the Buddha advocates than to do it. The history of the canonical tradition reveals that monks were inclined either to strive for their spiritual growth at the expense of compassion (caring for others) or to give themselves to the work of caring for others at the expense of their own spiritual vocation.

Lay Buddhists in the Pali canonical tradition do not aspire to attain *nirvāṇa*, for it is the prerogative of the monks. Their life is based on (1) piety toward the Buddha, his image and pagoda, and toward the monastic order; (2) ethical conduct following the Five Precepts against killing (human or animal), stealing, lying, sexual aggression, and intoxication; and (3) charity (almsgiving) and generosity toward the monks, other human beings, and animals. Following all of these precepts enables them to accumulate good *karma* and thereby to gain rebirth among the gods in heaven. Consequently, the lay Buddhist's impulse for caring is motivated and conditioned by the notion of merit, which governs all aspects of his or her life. Acquiring merit for the next world is so important that, according to Rahula, some laymen in Sri Lanka (Ceylon) had a so-called "Merit-book" in which they recorded their meritorious deeds: "This was usually intended to be read at the death-bed, so that the dying man might gladden his heart and purify his last thoughts to ensure a good birth [in heaven]."[24] S. J. Tambiah found that lay Buddhists in northeast Thailand ranked meritorious deeds according to their importance, as follows: (1) financing the building of a *wat* (monastery), (2) becoming a monk oneself or having a son become a monk, and (3) giving food daily to the monks.[25] Curiously, this ranking does not include any act of charity or service

toward fellow human beings or animals, even though such deeds have been considered meritorious in the history of Buddhism.

The attitude of the Mahāyāna tradition toward caring is conditioned by its "social emotions," as Edward Conze rightly emphasizes.[26] These were inspired by the Mahāyānist ideal of the all-compassionate bodhisattva or Buddha-to-be who postpones his own attainment of Buddhahood because of his vow to save all beings. The complexities of Mahāyāna doctrine are not important here, but we should at least mention its fundamental conviction that all sentient beings are endowed with and share the same Buddha-nature. Also significant is its notion of the field of merit or the field of compassion. The early and/or Theravāda Buddhists regarded the Buddha and the monastic orders as the fields of merit for the laity. The Mahāyāna tradition, however, expects the monks and monasteries to offer gifts to both people and animals, especially to the poor and the needy, the orphaned, the aged—even to the ant. Now these are considered the field of merit or compassion.[27] Furthermore, many Mahāyāna schools regard the paths of the monastics and the laity as two different but equally legitimate options of religious vocation, urging both monks and laity to cultivate a compassionate heart and to participate in the saving enterprise of the bodhisattvas by practicing the perfection *(pāramitā)* of charity.

Buddhist opinion varies as to whether the impulse to care should extend to those outside the Buddhist fold. For early Buddhist monks and those in the Theravāda tradition, the dividing line did not separate Buddhists and non-Buddhists but monastics and nonmonastics. The latter included Buddhists as well as non-Buddhists. There was no question that the canonical tradition expected monks to care for fellow monks. But whether monks extended their caring deeds to nonmonastics—thereby interfering in effect with the *karma* of other beings and diverting energy from their own spiritual striving—is another matter. The evidence points both ways.

The primary field of merit for the laity in early Buddhism and the Theravāda tradition has always been the Buddha and the monastics, while other human beings and animals have taken second place. Here one finds an intricate mixture of altruism and merit-making for one's own spiritual welfare.

For the Mahāyānists—monks and laity alike—compassion *(karuṇā)* is inseparable from saving knowledge *(prajñā)*. Therefore, deeds of caring must be extended, at least in principle, not only to persons outside the Buddhist fold but to all sentient beings.

MEDICAL MISSIONS

Even before the time of the Buddha, Indian medicine had been well established. Consequently, Buddhist medical missions in our sense of the

term did not exist in the early period of Buddhism. There were, to be sure, some monks who had medical knowledge, but they were cautioned against having too many contacts with householders. The first significant public association of medicine and Buddhism took place during the reign of the newly converted Buddhist King Aśoka. In one of his Rock Edicts, dated circa 257 BCE, we read:

> Everywhere in the dominion of the Beloved of the gods [Aśoka himself] . . . (provision) has been made . . . (for) two (kinds of) medical treatment, (viz.) medical treatment for men and medical treatment for animals.
>
> And wherever there are no (medicinal) herbs that are suitable for men and suitable for animals, everywhere (such) have been caused to be brought and caused to be planted.
>
> And wherever there are no (medical) roots and fruits, everywhere (such) have been caused to be brought and caused to be planted.[28]

Aśoka makes it clear that he is doing all this as an expression of his commitment to the cause of *dharma* and for the sake of merit in the next world.[29] It is difficult to ascertain how extensive or how effective the medical service he initiated was. Nevertheless, his example inspired many later Buddhist rulers in other parts of Asia. For example, the famous king of Ceylon, Duṭṭha-gāmaṇī (101–77 BCE), is credited with providing extensive social welfare services, including eighteen centers at which medical treatment and medicines were made available.[30]

With the rise of the Mahāyāna tradition, medical service became an important act of compassion and charity. Hindu physicians had been restrained by ritual purity from cutting the body of the deceased, whereas the less inhibited Buddhist physicians made great contributions to the knowledge of anatomy. Earlier, pious kings and queens or the state had established medical services, but increasingly monasteries came to offer such services. In addition Mahāyāna Buddhism popularized the cult of the Buddha of Healing *(Bhaiṣajya-guru)* and the practice of reciting certain scriptures for the prevention of and recovery from sickness.[31]

CURING: FAITH AND MEDICINE

Buddhism has many contradictory strands, from rationalistic nontheism to a pietistic wing that borders on theism. All recognize the importance of faith *(saddhā)* over against faithlessness—together with energy over against laziness, mindfulness over against forgetfulness, concentration over against distractedness, and wisdom over against ignorance—as essential ingredients for the striving toward purity. But in Buddhism, faith in the sense of religious affirmation is directed toward the Three Jewels, which are the Buddha (the Enlightened One who discovered and taught the law of deliverance), the *dharma* (the law of deliverance), and the

saṃgha (the Buddhist community). Since medicine deals with natural laws governing the physical condition of human beings, it is thought to belong to a different sphere from faith. But inasmuch as the same human beings are involved in both religious and psychological-physiological life, questions have been raised ever since the time of early Buddhism as to how or whether religious faith and ritual aid the process of curing one's illness. For example, a question is raised in *The Questions of King Milinda* regarding the validity of the Pirit service, a ritual used for the sick. The service has been widely used to the present day, and many Buddhists have believed it was created by the Buddha. The canonical texts do not state this, but Milinda believed that the Pirit had the Buddha's authorization.

Milinda's Buddhist mentor, Nāgasena, also accepted the view that the Buddha sanctioned the service, but he gave a classical Buddhist interpretation of the relation between religious ritual and medicine. He states:

> [The Pirit service] is only meant for those who have some portion of their life yet to run, who are of full age, and restrain themselves from the evils of Karma. And there is no ceremony or artificial means for prolonging the life of one whose allotted span of existence has come to an end. . . . no medicine and no Pirit . . . can prolong the life of one whose allotted period has come to an end. All the medicines in the world are useless . . . to such a one, but Pirit is protection and assistance to those who have a period yet to live, who are full of life, and restrain themselves from the evil of Karma. And it is for that use that Pirit was appointed by the Blessed One.[32]

Nāgasena states further that just as a disease can be turned back by medicine, the power of the Pirit is such that diseases are allayed and calamities depart from the sick person. He was careful to add the qualification, however, that Pirit is a protection to some and not to others:

> And there are three reasons for its failure—the obstruction of Karma, and of sin, and of unbelief. That Pirit which is a protection to beings loses its protecting power by acts done by those beings themselves.[33]

Early Buddhism tried to maintain a balance between religious belief/rite and medicine by giving a qualified approval to both. The Mahāyāna tradition, by contrast, influenced as it was by the Hindu Bhakti movement, gave greater emphasis to faith, while the Esoteric tradition, which appropriated many features of Hindu Tantrism, stressed the magical power of the Buddhist divinities. The folk Buddhist tradition, which allied itself with spirit cults of all sorts in various parts of Asia, developed various cults of faith healing and various forms of magical incantation, some of which have been studied by Tambiah, Obeyesekere, and Yalman.[34] It is important to add that many Buddhists do not depend on faith healing exclusively. They go to medical doctors simultaneously or they resort to

faith healing only when they are not cured by medicine. There are also cases in which Buddhist clergy act as faith healers. To give one example, Joel M. Halpern cites an account given by a French-educated Lao official about a friend who was a supervisor of road crews. One day the man evidently fired a laborer who was idle on the job, not knowing that the laborer was an evil spirit. When the supervisor went home, he developed body pains. His wife did not know that his sickness was caused by an evil spirit, so she took her husband to a Western-educated doctor who found nothing wrong with him. But when the illness persisted the sick man "went to see a wise old bonze who told him that his malady was an evil phi [i.e., an evil spirit] at work. This particular bonze had stronger spiritual power than the evil spirit and was thus able to force it to leave [the sick person's] body. After this he immediately felt better."[35] The account represents the attitude of many folk Buddhists toward faith healing and/or the relations between faith and medicine in general.

MEDICAL TREATMENT

Before the time of King Aśoka in the third century BCE little is known about the nature of Buddhist medical institutions, if there were any. All we know about Aśoka's medical provision is what we read in the Rock Edict previously mentioned: that he was making medical treatments as well as medical herbs, roots, and fruits available for men and animals. His purpose (the welfare of all people) is in keeping with Buddhist principles. He also adds: "Whatever efforts I am making are in order that I may discharge (my) debts to (all) beings, that I may make them happy here (in this life) and that they may attain heaven in the next (life)."[36] Undoubtedly medical institutions established by Duṭṭha-gāmaṇī in Ceylon and Buddhist kings elsewhere had the same purpose.

What medical treatment was given in those institutions is largely a matter of conjecture. The canonical text contains legendary accounts of the physician, Jīvaka Komārabhacca, who once attended the Buddha. An illegitimate son of a courtesan, Jīvaka was brought up by the royal family. When he had completed seven years of medical training, his teacher told him to tour the vicinity of Taxilā and to bring back any plant that was not medicinal. When he returned empty-handed, his teacher told him he was ready to practice medicine on his own. From the legends about Jīvaka we learn how physicians treated patients in the early days of Buddhism. With a handful of ghee mixed with medicine Jīvaka cured a woman of a severe headache. He removed King Bimbisāra's fistula with ointment. He cut open the skin on the head of a merchant who suffered from a head disease and drew out two living creatures. He cut open a man's stomach in order to correct a twisted bowel, and he cured a neighboring king of jaundice.[37]

From the medical text of the physician of Caraka, a contemporary of

another Buddhist king, Kaniṣka, we learn some of the major components of the Indian medical science, Āyurveda, that the Indian Buddhists accepted: pathology, diagnostics, physiology and anatomy, prognosis, therapeutics, and pharmaceutics.[38] In the main, Indian physicians sought to restore the primal state of health *(restitutio in integum)* by means of a "regimen of preliminary purgatives, enemas, and emetics, followed by a light and wholesome, restorative, *sāttvic* diet."[39] With the rise of Mahāyāna, medical study *(chikitsā-vidyā)* became one of the five disciplines basic to understanding Buddhism itself.[40] This encouraged the proliferation of priest-physicians who aspired to follow the path of the compassionate bodhisattvas. Many Mahāyāna monasteries and nunneries in East Asia operated clinics and dispensed medicine for the sick.[41] The Esoteric tradition, too, stressed medical activities as central to Buddhism. Indeed, Buddhist medical institutions, including a Buddhist medical college (in a strict, literal sense), have remained intact in Tibet until our own time.[42] What has happened to them since the departure of the Dalai Lama from Tibet cannot be verified.

Buddhist medical institutions vary greatly in regard to personnel. For the most part, institutions in the Theravāda tradition depend heavily on professional physicians. In institutions of the Mahāyāna tradition, lay physicians, chiropractors, and others assist priest-physicians, while institutions of the Esoteric tradition are generally staffed by priest-physicians. Most Buddhists have no hesitations about seeking medical advice from non-Buddhist physicians.

Ethics and Justice

ETHICAL DECISIONS REGARDING BIOETHICAL CONCERNS

In sharp contrast to many ethical systems in the West, the ethical principles that one may derive from Buddhism, like the ethics of other Indian religious-philosophical traditions, are more biological and cosmic in orientation. The term *dharma* usually refers to the fixed position of duty and right. It also designates religious observance, secular law, and the law of nature. In a more basic sense, *dharma* implies universal justice based on immanent necessity, for "all that has ever come into existence produces its specific reaction or effect—the law of action and reaction as laid down by the principle of Karma [activity]."[43] According to this biologically oriented view, the deed itself, or the psychic disposition to do it, is transmitted by psychical inheritance from one *karma*-bearer to another because of the inviolable and ethically indifferent law of cause and effect. The uniqueness of the Buddhist stance may be clarified by comparing it with the Brahmanic-Hindu tradition's substance-view of reality *(ātma-vāda)*,

which conceives reality "on the pattern of an inner core or soul *(ātman)*, immutable and identical amidst an outer region of impermanence and change."[44] As Murti succinctly points out:

> Buddha came to deny the soul, a permanent substantial entity, precisely because *he took his stand on the reality of moral consciousness* and the efficacy of Karma. An unchanging eternal soul, as impervious to change, would render spiritual life lose [*sic*] all meaning. . . . The ātman is the root-cause of all attachment, desire, aversion and pain.[45]

The Brahmanic-Hindu tradition affirms further that every person is destined to be born into a fixed place *(sva-dharma)*, a place that mediates the eternal *dharma* and the person. Buddhism, however, rejects the notion of personal *dharma* and affirms that the *dharma*, the liberating law discovered by the Buddha, can be fulfilled only in the Buddhist community *(saṃgha)* (cf. the threefold affirmation of Buddha, *dharma*, and *saṃgha*). Consequently, early Buddhism conceived ethics primarily in terms of a personal morality prerequisite for an individual's salvation, that is, the achievement of *nirvāṇa* for the monks and of better rebirth in the next life for the laity.

As far as we can ascertain, early Buddhism did not attempt to combine ethical and medical concerns in a unified category of bioethics. To be sure, early Buddhists knew a great deal about the constituents of the body—the hair of the head, hair of the body, nail, skin, teeth, flesh, nerves, bones, marrow, kidneys, heart, liver, pleura, spleen, lungs, intestines, bowels, stomach, feces, bile, phlegm, pus, blood, sweat, fat, tears, serum, spittle, mucus, nose mucus, synovial fluid, and urine[47]—and they knew the processes of the formation of the fetus and of the birth and growth of human bodies. They also had access to rather advanced surgical and medical arts. But they considered prevention and treatment of diseases to belong to the sphere of life that had no direct relevance to moral and spiritual striving. They accepted religious life and medical treatment as two separate spheres without articulating a system of ethics that might mediate between them and provide guidance to physicians. As a result, physicians were compelled to make medical judgments in specific cases solely on medical and surgical grounds. Of course, even if early Buddhists had wanted to develop a positive system of bioethics, the fundamental doctrine of no-self *(anātman)* did not encourage the systematic reflection needed. In addition the doctrine of *karma*, the law of cause and effect, would have presented a real dilemma to any would-be Buddhist bioethicist. Consider a physician confronted by a situation in which he could save either a mother or a baby but not both. What principle, according to his best medical judgment, could he invoke to determine how he should act according to Buddhist ethics? How would he know whether it was the

mother's *karma* to die or the child's? If the mother should beg him, should the physician save the child, or should he save the mother at the request of her family on the grounds that the mother could bear another child? Either way, the physician might interfere with the law of karmic justice.

Yet another important factor was not conducive to the development of a system of bioethics: early Buddhism was not inclined to develop any coherent system of social ethics in general, even after King Aśoka affirmed *dharma* as the guiding principle of his vast empire. We have already seen that Aśoka, motivated by his compassion and by his desire to gain merit, provided medical treatment and planted medical herbs for the benefit of people and animals. Suppose a contagious disease had broken out in a crowded community and the families of the sick had begged a physician not to disclose the nature of the disease. What would the physician have done? There were no carefully worked out ethical principles to guide either the physician involved or the Minister of Dharma, whose duty it was to enforce *dharma* according to Aśoka's scheme.

Winston King astutely observed the inherent difficulties Buddhist ethics faces in balancing the issues of intention and result. It is taken for granted that a good intention does not produce an evil deed; conversely, a good intention or a good result cannot compensate for an evil deed. But, King asks, what should one do if one sees a snake ready to attack a child? If one kills the snake, will the act of killing—a sin with evil consequences—be compensated by the act of saving a child? A Buddhist might question our commonsense judgment that the intention and the deed of saving a child might compensate for the sin of killing an animal. The child, one might reason, might not have been killed or might have been saved by other means. Yet King correctly asks whether a person who killed a snake and saved a child would interfere with karmic processes, or would that person simply be the agent of *karma* "and hence guiltless"?[48] It is easy to see that Buddhists would confront similar ethical ambiguities in dealing with many medical cases. Should one take the course of nonaction in order not to interfere with karmic processes? Should one act, assuming that one is just an agent of *karma*? Or does one have a karmic duty to perform a specific act even if one's acting inevitably involves the possibility of other evil consequences?

RESOURCES AND EXPEDIENTS USED IN DEALING WITH BIOETHICAL PROBLEMS

Although Buddhists have as a matter of course faced many bioethical problems, the Buddhist tradition has not acknowledged them as bioethical issues until quite recently. The assembly of the monastic orders was the form closest to a "resource" in the Buddhist tradition. It dealt, however, only with the activities of the monks. To judge from the *Vinaya* texts,

the assembly placed high priority on "intention" in evaluating the monks' deeds. We read, for example:

> Whatever monk should intentionally deprive a human being of life or should look about so as to be his knife-bringer . . . or should incite (anyone) to death: he also is one who is defeated, he is not in communion.[49]

The *Vinaya* texts cite numerous case histories:

> At one time while a certain monk was eating, some meat stuck in his throat. A certain monk gave a blow to that monk's neck; the meat fell out with blood, and that monk died. He was remorseful . . . "There is no offence, monk, as you did not mean to cause his death."[50]

> At one time a certain monk had a headache. The monks gave him medical treatment through the nose. The monk died. . . . "There is no offence involving defeat."[51]

But other acts were condemned, as when one monk was asked by a pregnant woman to give her an abortive preparation, which resulted in her child's death, or when another monk, at the request of a barren woman, gave her fertility medicine that caused her to die.[52] Despite recording individual medical cases, however, the *Vinaya* does not seem to provide positive principles for dealing with the difficult ethical issues involved.

The Buddhist tradition provided no resource or guidance to the laity except general moral principles, such as those found in the eightfold path: "right understanding" regarding the characteristics of existence (impermanence, suffering, and no-self or no-soul) and the nature of moral law regarding "right thought," "right effort," "right mindfulness," and "right action" ("(1) Not to kill, but to practice love and harmlessness to all; (2) Not to take that which is not given, but to practice charity and generosity; (3) Not to commit sexual misconduct, but to practice purity and self-control; (4) Not to indulge in false speech; . . . (5) Not to partake of intoxicating drinks or drugs").[53] Beyond these, the laity usually consulted the clergy and medical experts on a case-by-case basis for help in dealing with medical-ethical problems. The consulting of practitioners of fortune-telling, divination, palmistry, and related magical arts has also been rather widespread.

GUIDING AUTHORITIES

The most significant Buddhist medical institution developed in Tibet, where religion and medicine achieved a high degree of integration. Under the thirteenth Dalai Lama (1895–1933), the College or House of Medicine

and Astronomy was established in Lhasa, equipped with lecture halls, a hospital, living quarters for teachers and students, and laboratories. Until the flight of the current Dalai Lama to India, the college received one student from each provincial monastery in addition to able private students.[54] Outside Tibet, the Buddhist community did not develop anything like a Buddhist medical academy or college. Historically, however, large Buddhist monasteries, especially in Mahāyāna countries, had clinics attached to them, and the people turned to these institutions for authoritative advice. Moreover, physicians of Buddhist persuasion served in such government institutions as the Great Medical Bureau (T'ai-i-shu) in China during the T'ang dynasty.

Since the introduction of modern Western medicine during the past two centuries, many medical colleges, hospitals, and clinics have been established in various parts of Asia. Most operate under secular auspices, but Buddhist groups have founded some. Side by side with westernized modern medicine, herb medicine and other traditional forms of medical practice continue to be in demand. As a result, it is difficult to generalize about authorities to which Buddhist adherents turn for guidance. It is probably safe to assume that the religious universe of contemporary Buddhists is spacious enough to embrace westernized modern medicine, traditional medicine, and a host of diviners, sorcerers, and fortune-tellers. All maintain varying degrees of authority in guiding those faithful who encounter difficult bioethical problems, whether they recognize them as such or not.

Passages

A few words may help explain why there is such a bewildering variety of notions and practices concerning passages of life in the Buddhist world. The Buddha had forsaken the world; and mendicant disciples, following his example, left home to lead the religious life. At the same time, he attracted many lay disciples, male and female. It was taken for granted that monastics were the core of the Buddhist community. After the demise of the Buddha, they took upon themselves the role of guardians and transmitters of the founder's teaching. But Caroline A. F. Rhys Davids astutely reminds us that although the Pali canon was "compiled by members of a religious order and largely concerned with the mental experiences and ideas of recluses, and with their outlook on the world," it included a discourse on domestic and social matters based on the Buddha's doctrines of love and goodwill. The discourse was entitled the "Sigala Homily," and it testified to the continued importance of the lay components in the early Buddhist community.[55]

Even so, in contrast to many religious traditions in India and else-

where, early Buddhism said virtually nothing, positive or negative, about the religious and social significance of the various stages of the householder's life. As Eliot points out, "the Buddha prescribed no ceremonies for births, deaths, and marriages, and apparently expected the laity to continue in the observance of such rites as were in use."[56] Thus, unlike the monks, whose stages of life were guided by the code of discipline *(Vinaya)*, early lay Buddhists in India followed the non-Buddhist mores and observances familiar to them in dealing with the major events in their lives. Since the Indian Buddhist community did not develop Buddhist forms to celebrate life-passages, the same pattern was followed later by lay Buddhists in other parts of Asia. Each group appropriated the non-Buddhist customs in its own locality. This practice accounts for the wide variety of interpretations and customs concerning life-passages in the different Buddhist nations of Asia. There are accounts of Buddhist traditions in South and Southeast Asia, the Himalayan border area, Tibet and Mongolia, China, Korea, and Japan. In the limited space available here we cannot cover all local variations; we can discuss only those bare essentials that are shared, more or less, by Buddhists in various parts of Asia.

BEGINNING OF LIFE

At the expense of oversimplification, we might distinguish three layers of meaning in the Buddhist tradition for the "beginning" as well as for the "end" of "life": religious, empirical (physiological), and cultural. In religious terms, the all-important doctrine of *anattā* (nonego, no-self, or no-soul) states that what is known as a person is a temporary combination of bodily and mental elements that lacks any self-reliant substance, such as an ego or a self. What is called life, marked by birth and death, is only an insignificant part of an unbroken chain, the continuous combination, dissolution, and recombination of physical and mental elements known as *saṃsāra* (round of rebirth or transmigration). *Saṃsāra* implies a constant repetition of birth and death in the three worlds and the six realms of existence according to the law of *karma*. Thus a single lifetime and its beginning have no religious significance except as they testify to the doctrine of impermanence of life and the world. It should be stressed that in this cosmic scheme, human beings share equal status with other beings.

On the empirical level, birth or the beginning of life is accepted as a natural consequence of conception, which is instrumental in bringing into existence the temporary combination of corporeality, feeling, perception, mental formation, and consciousness, as well as sensitive organs, with all the identifiable physical and mental marks.[57] Even on the empirical, physiological level, however, there is no unanimity concerning what constitutes the beginning of life. One canonical text leads us to believe that "from the mind's first arising, from (the time of) consciousness becoming

first manifest in a mother's womb until the time of death, here meanwhile he is called a *human being*."[58] But opinions are divided among Buddhist theorists and among physicians as well as to whether life begins at conception, at some time during pregnancy, or at birth.

On the cultural level, there are, for the reasons given earlier, a bewildering variety of meanings attached to the beginning of life or birth, colored by the mores, taboos, customs, and kinship systems of the different parts of the Buddhist world. In Burma, for example, where there is no family name to inherit, less importance is assigned to the birth of a child than in, say, East Asia. However, Burmese Buddhists, like their East Asian counterparts, prefer the birth of a male child but for different reasons. For the Burmese, "only a male child can be initiated in youth into the Buddhist priesthood, and the sponsoring of this ceremony is an important deed of merit on the parents' part."[59] This is just one example of how Buddhist and local cultural features converge in dealing with the phenomenon of the beginning of life.

SEXUALITY

Sexuality, too, has many layers of meaning—religious, cultural, physiological, ethical, and so on—in the Buddhist world. We are told that on his deathbed the Buddha warned his trusted disciple Ānanda against the seductiveness of the female:

> "How should we behave, my lord, in regard to the feminine sex?"
> "Not to see them, O Ānanda."
> "But, Blessed One, if we do see them?"
> "Not to speak to them, O Ānanda."
> "But, my lord, if they speak to us?"
> "Keep wide awake, O Ānanda."[60]

The Buddha warned the monks not only against the female sex but also against masturbation on the grounds that it was not becoming for one who is committed to the goal of stilling passion. Moreover, "it is not for the benefit of unbelievers, nor for increase in the number of believers, but it is . . . to the detriment of unbelievers as well as of believers."[61] "Emission of semen during a dream," however, is not considered an offense.[62] Because monks are to observe perfect chastity, sexual intercourse is, of course, forbidden to them. They are also strictly warned against homosexuality, considered to be a perverted act. Thus we read:

> If there is a man, and thinking it to be a man . . . doubtful . . . thinking it to be an animal . . . thinking it to be a woman . . . thinking it to be an eunuch, if the monk is infatuated and rubs the man's body . . . touches it, there is an offence of wrong-doing.

> If there is an animal, and thinking it to be a woman . . . thinking it to be an eunuch . . . thinking it to be a man, if the monk is infatuated and rubs the animal's body . . . touches it, there is an offence of wrong-doing.[63]

Sexuality has different connotations for householders than for monks and nuns. Here again cultural contexts, sexual mores, and social organizations vary greatly in the various parts of the Buddhist world. In much of traditional Asia, polygamy, male and female prostitution, and the institution of the eunuch were tolerated if not officially recognized. The five moral rules that in principle bind all lay Buddhists include abstention from unlawful sexual acts such as intercourse with girls who are still under the protection of father or mother, brother or sister, or relatives; and intercourse with married women, female convicts, and betrothed girls.[64] Otherwise, the Buddhist tradition itself gave no specific injunctions in such sexual matters as masturbation and homosexuality. Evidently, various means of contraception were known and practiced among householders, especially in poverty-stricken areas.

DIGNITY OF LIFE

Inasmuch as Buddhist views of life are permeated by the doctrine of *karma*, the "dignity of life" has very different implications for the Buddhist tradition than for the Western world. This difference probably accounts for its official silence on matters of euthanasia and the prolongation of life. These were considered primarily medical problems to be handled without invoking religious principles. Buddhism has spoken out clearly against injuring, killing, or destroying life in both human beings and animals. But because of the previously mentioned ambiguity about when life begins, there have never been any clear-cut views on abortion. There are canonical references against it, but they seem to condemn monks' involvement with abortion rather than abortion itself.[65] Equally ambiguous is the Buddhist stance on suicide. Some have condemned it, but others have approved it. The ambiguity was evident most conspicuously during the war in Vietnam, when some monks immolated themselves.

DYING

We have already touched upon an important aspect of the Buddhist understanding of death in the discussion on the beginning of life. To be brief, death marks the end of life, which is nothing but a temporary combination of bodily and mental elements. Still, death is the necessary prerequisite for the process of rebirth, which is destined to continue according to the principle of *karma*. Religiously speaking, death is not an evil

but an integral part of universal suffering which, according to the first of the Four Noble Truths, characterizes the nature of existence.

> In the absolute sense, beings have only a very short moment to live, life lasting as long as a single moment of consciousness lasts. Just as a cart-wheel, whether rolling or whether at a standstill, at all times only rests on a single point of its periphery: even so the life of a living being lasts only for the duration of a single moment of consciousness. As soon as that moment ceases, the being also ceases.[66]

In a real sense, an essential part of the Buddhist vocation is to reflect on this truth, which will lead one toward the path of ultimate enlightenment and liberation, just as it did the Buddha. Thus, according to Buddhism, a deceased person will be missed but should not be mourned!

Notes

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4. Ibid., pp. 433–434.
5. A. L. Basham, "The Practice of Medicine in Ancient and Medieval India," in *Asian Medical Systems: A Comparative Study*, ed. Charles M. Leslie (Berkeley, 1976), p. 20.
6. Cited in Nyanatiloka, *Buddhist Dictionary* (Colombo, Sri Lanka, 1956), p. 30.
7. Basham, p. 24.
8. F. Max Müller, trans., *The Dhammapada: A Collection of Verses*, in *Sacred Books of the East*, vol. 10 (Oxford, 1881), p. 54.
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11. Gananath Obeyesekere, "The Ritual Drama of the *Sanni* Demons: Collective Representations of Disease in Ceylon," *Comparative Studies in Society and History* 11, no. 2 (April 1969):175.
12. Nyanatiloka, p. 71.
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14. Ibid., pp. 192–193.
15. Obeyesekere, p. 175.
16. Müller, p. 3.
17. Heinrich Zimmer, *Philosophies of India*, ed. Joseph Campbell (New York, 1951), p. 469.
18. Cited in Nyanatiloka, p. 33.
19. Winston L. King, *In the Hope of Nibbana* (La Salle, IL, 1946), p. 31.
20. See ibid., p. 173.

21. Müller, p. 46.
22. Horner, p. 432.
23. Ibid., p. 433.
24. Walpola Rahula, *History of Buddhism in Ceylon* (Colombo, Sri Lanka, 1956), p. 254.
25. Stanley J. Tambiah, *Buddhism and Spirit Cults in Northeast Thailand* (Cambridge, England, 1970), pp. 146–147.
26. Edward Conze, *Buddhist Thought in India* (Ann Arbor, MI, 1962), p. 217.
27. See Kenneth Ch'en, *The Chinese Transformation of Buddhism* (Princeton, 1973), p. 295.
28. Amulyachandra Sen, *Asoka's Edicts* (Calcutta, 1956), p. 66.
29. Ibid., p. 90.
30. Trevor Ling, *The Buddha: Buddhist Civilization in India and Ceylon* (London, 1973), p. 186.
31. See Ilza Veith and Atsumi Minami, "A Buddhist Prayer against Sickness," *History of Religions* 5, no. 2 (Winter 1966):239–249.
32. Rhys Davids, p. 214.
33. Ibid., p. 218.
34. See Tambiah; Obeyesekere; also Nur Yalman, "The Structure of Sinhalese Healing Rituals," in *Religion in South Asia*, ed. Edward B. Harper (Seattle, 1964), pp. 115–150.
35. Joel M. Halpern, "Traditional Medicine and the Role of the Phi in Laos," *The Eastern Anthropologist* 16, no. 3 (1963):195.
36. Sen, p. 78.
37. Horner, pp. 380–393.
38. Basham, p. 20.
39. Zimmer, p. 548.
40. Veith and Minami, p. 243.
41. See Ch'en, pp. 294–303.
42. See Rechung Rinpoche and Jampal Kunzang, *Tibetan Medicine* (Berkeley and Los Angeles, 1973); and Ilza Veith, *Medizin in Tibet* (Berlin, n.d.).
43. Betty Heiman, *Indian and Western Philosophy: A Study in Contrast* (London, 1937), p. 70.
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45. Ibid., p. 17; emphasis mine.
46. Yashapal, "Surgery and Medicine in the Days of Gautama," *Indian Historical Quarterly* 25 (1949):102.
47. King, 136. Although he followed the Pali rendering, *kamma*, I have chosen to use the Sanskrit form, *karma*.
48. Isaline B. Horner, trans., *The Book of the Discipline (Vinaya-Pitaka)*, vol. 1, *Suttavibhanga* (London, 1949), pp. 125–126.
49. Ibid., p. 139.
50. Ibid., p. 143.
51. Ibid., pp. 144–145.
52. H. Saddhatissa, *Buddhist Ethics: Essence of Buddhism* (New York, 1970), p. 71.
53. Rinpoche and Kunzang, pp. 22–23.
54. Thomas W. and Caroline A. F. Rhys Davids, trans., *Dialogue of the Buddha*, pt. 3, in *Sacred Books of the Buddhists*, vol. 4 (London, 1957), pp. 170, 173–184.
55. Sir Charles Eliot, *Hinduism and Buddhism*, vol. 2 (New York, 1954), p. 120.

56. See Thomas W. and Caroline A. F. Rhys Davids, trans., *Dialogue of the Buddha*, pt. 2, in Sacred Books of the Buddhists, vol. 3, *Maha Satipatthana Suttanta* 5, p. 330.
57. Horner, *Suttavibhanga*, p. 126.
58. Margaret Mead, ed., *Cultural Patterns and Technical Change* (New York, 1955), p. 38.
59. Taken from *Mahaparinibhana Sutta*, quoted in A. Foucher, *The Life of the Buddha*, abridged translation by S. B. Boas (Middletown, CT, 1963), p. 109.
60. Horner, *Suttavibhanga*, pp. 193–195.
61. Ibid., p. 106.
62. Ibid., pp. 204–205. The Tantric Buddhist notions and practices regarding sex, which are very different from those of other Buddhist traditions, are not included in this article.
63. See Nyanatiloka, p. 69.
64. Horner, *Suttavibhanga*, pp. 144–145.
65. Nyanatiloka, p. 90.