

**MEANINGS OF DYING AND DEATH AMONG PATIENTS AND
PRACTITIONERS:
A QUALITATIVE STUDY IN A TIBETAN HOSPITAL**

RENDAN

**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS
(HEALTH SOCIAL SCIENCE)
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY
2013**

COPYRIGHT OF MAHIDOL UNIVERSITY

Thesis
entitled
**MEANINGS OF DYING AND DEATH AMONG PATIENTS AND
PRACTITIONERS:
A QUALITATIVE STUDY IN A TIBETAN HOSPITAL**

.....
Ms. Rendan
Candidate

.....
Assoc. Prof. Luechai Sringernyuang,
Ph. D.
Major advisor

.....
Lect. Natthani Meemon, Ph. D.
Co-advisor

.....
Lect. Thammarat Marohabutr, Ph. D.
Co-advisor

.....
Prof. Banchong Mahaisavariya,
M.D., Dip. Thai Board of Orthopedics
Dean
Faculty of Graduate Studies
Mahidol University

.....
Assoc. Prof. Luechai Sringernyuang, Ph.D.
Program Director
Master of Arts Program in Health Social
Science
Faculty of Social Sciences and Humanities
Mahidol University

Thesis
entitled
**MEANINGS OF DYING AND DEATH AMONG PATIENTS AND
PRACTITIONERS:
A QUALITATIVE STUDY IN TIBETAN HOSPITAL**

was submitted to the Faculty of Graduate Studies, Mahidol University
for the degree of Master of Arts (Health Social Science)

on
May 3, 2013

.....
Ms. Rendan
Candidate

.....
Lect. Darunee Phukao, Ph. D.
Chair

.....
Phra. Wichit Dhammachito,
Ph. D.
Member

.....
Assoc. Prof. Luechai Sringernyuang,
Ph. D.
Member

.....
Lect. Natthani Meemon, Ph.D.
Member

.....
Lect. Thammarat Marohabutr, Ph.D.
Member

.....
Prof. Banchong Mahaisavariya,
M.D., Dip. Thai Board of Orthopedics
Dean
Faculty of Graduate Studies
Mahidol University

.....
Assoc. Prof. Wariya Chinwanno, Ph. D.
Dean
Faculty of Social Sciences and Humanities
Mahidol University

ACKNOWLEDGEMENTS

I would like to acknowledge the steadfast support from my professors and colleagues at the Department of Society and Health, Mahidol University, and the Fort Foundation International Fellowship Program (IFP) providing a way for me to study and obtain higher education in order to better serve the society.

Special thanks go to my thesis advisor Dr. Luechai Sringernyuang, whose patience, guidance, consistent encouragements, made this study complete. I also thank to my thesis co-advisors Dr. Nathani Meemonwhocorrects, supports and guides me and Dr. Thammarat Marohabutrwho helps me. I appreciate for their dedicated and gentle guidance, both academic and personal.

I am more than grateful and thankful to my beloved parents, wangxianming, brother Lawangdundruband all my other relatives and friends, who always encourage, support, and pray for me.

My heartfelt thanks also go to all the participants who spent their invaluable time and shared their experiences and knowledge. Without their cooperation and participation, this study could not be possible to complete.

My friends and family have endured my frustrations and celebrated my joys. To all of them I am deeply grateful. My husband, Kelsangdramdup, bore the brunt of my frustrations and provided emotional support. This work is your accomplishment too.

Finally, I would like to express my sincere thanks to my benefactors and sponsors, namely my family, IFP, and my dear other friends whom I cannot mention their names here for their moral encouragements.

Rendan

MEANINGS OF DYING AND DEATH AMONG PATIENTS AND PRACTITIONERS: A QUALITATIVE STUDY IN A TIBETAN HOSPITAL

RENDAN 5438164 SHHS/M

M.A. (HEALTH SOCIAL SCIENCE)

THESIS ADVISORY COMMITTEE: LUECHAI SRINGERNGERNYUANG Ph.D.,
NATHANI MEEMON, Ph.D., THAMMARAT MAROHABUTR, Ph.D.

ABSTRACT

The People's Hospital of Tibet Autonomous region is the largest hospital in Tibet, situated in Lhasa, capital of Tibet. The objective of the study was to explore the cultural meaning, expectation, practice, cultural sensitivity of dying and death in the hospital. This research was based on a qualitative method consisting of in-depth interviews with 4 lay Tibetans, 4 health practitioners and 1 monk, document review and observation.

The perception of Tibetan patients and relatives in the modern hospital showed clearly the influence of Tibetan culture and belief deeply rooted in Tibetan Buddhism. The meanings of dying and death included impermanent life, preparedness for accumulation of positive karma, the path of spiritual transition, reincarnation or liberation. In contrast, the meanings of dying and death in the view of health practitioners were terminal illness, the failure and ceased function of the organs based on advanced technology. Due to the different constructions between them, unmatched expectation and ignorance of spiritual care emerged when health practitioners provide intervention in the hospital. The culture, the belief and the life of the patients were devalued and intentionally neglected on account of modern medicalized system and training.

Therefore, the researcher strongly recommends seriously taking into account the culture and belief and balancing technical intervention with a humanistic approach to their dying patients in the hospital.

KEY WORDS: MEANING/ BELIEF/ DYING AND DEATH/ TIBETAN
BUDDHISM/ HOSPITAL

82 pages

CONTENTS

	Page
ACKNOWLEDGEMENTS	iii
ABSTRACT	iv
LIST OF TABLE	ix
LIST OF FIGURES	x
LIST OF ABBREVIATIONS	xi
CHAPTER I INTRODUCTION	1
1.1 Justification	3
1.1.1 Dehumanization in hospital	3
1.1.2 Little research in Tibet on death	4
1.1.3 Prohibition to spiritual practice in hospital	4
1.2 Objectives	5
1.2.1 General objective	5
1.2.2 Specific objectives	5
1.3 Research questions	6
CHAPTER II LITERATURE REVIEW	7
2.1 The concept of dying and death in biomedicine	7
2.1.1 Body as a machine	7
2.1.2 Disease/illness explanation	8
2.1.3 Technoscience of death	9
2.2 The concept of dying and death as cultural phenomenon	11
2.2.1 Dying and death in different cultures	11
2.2.2 Dying and death in Tibetan Buddhism	12
2.3 Theoretical concept and application	14
2.3.1 Cultural construction approach	14
2.4 Conceptual framework application	16

CONTENTS (cont.)

	Page
CHAPTER III RESEARCH METHODOLOGY	19
3.1 Research design	19
3.2 Research site	20
3.3 Entering to the research field	22
3.4 Selection of informants	23
3.5 Method and data collection	24
3.5.1 In-depth interview	25
3.5.2 Document review	26
3.5.3 Observation	26
3.5.4 Field note and research instrument	26
3.5.5 Data collection	27
3.6 Data analysis	28
3.7 Validity of data	28
3.7.1 Data triangulation	28
3.7.2 Trust building	29
3.8 Ethical consideration	29
3.8.1 Privacy	29
3.8.2 Confidentiality	30
3.8.3 Informed consent	30
3.8.4 Benefits and reciprocity	30
CHAPTER IV RESEARCH FINDINGS	31
4.1 Tibetan society and Tibetan Buddhism	31
4.1.1 Tibetan society	31
4.1.2 Tibetan Buddhism	32

CONTENTS (cont.)

	Page
4.2 Modern hospitals in Tibet	37
4.2.1 The entrance of medicalization	37
4.2.2 The phenomenon of the hospital	38
4.2.3 A mechanic way	38
4.3 The practice of dying and death in the community	39
4.3.1 A traditional way	40
4.3.2 A modern way	42
4.4 Meanings of dying and death for lay Tibetans and health practitioners	42
4.4.1 Local terminology for death	43
4.4.2 The way of transition	43
4.4.3 Bardo	44
4.4.4 Health practitioners	45
4.5 Case studies	46
4.5.1 Case 1	47
4.5.2 Case 2	48
4.5.3 Case 3	51
4.6 The expectation of dying and death	54
4.6.1 Death at home	55
4.6.2 Decision making	57
4.7 Sensitivity of belief of dying and death	58
4.7.1 Mechanic intervention of dying	59
4.7.2 Poor quality of services in ICU	59
4.7.3 Prohibition of spiritual care	62
4.7.4 Superstition in the view of health practitioners	63

CONTENTS (cont.)

	Page
CHAPTER V CONCLUSION, DISCUSSION AND RECOMMENDATIONS	65
5.1 Conclusion	65
5.2 Discussion	67
5.2.1 The final outcome of the meanings and practices of dying and death	69
5.2.1.1 Meaning and practice of dying and death	69
5.2.1.2 Ignorance of cultural beliefs of dying and death in modern hospital	69
5.2.1.3 Gaps between lay Tibetans and healthpractioners	71
5.2.2 Outsider and insider	72
5.3 Limitations	73
5.4 Recommendations	74
REFERENCES	75
APPENDIX	79
Interview guidelines	80
BIOGRAPHY	82

LIST OF TABLE

Table	Page
3.1 Table of the informants	24

LIST OF FIGURES

Figure	Page
2.1 Conceptual framework	18
3.1 Tibet Autonomous Region	21
3.2 Lhasa, the capital of Tibet	21
3.3 The People's Hospital of Tibet Autonomous Region	22
4.1 Offering in the morning	33
4.2 Cham	35
4.3 Zegong monastery	41
4.4 Wheel of life	56
5.1 The final outcome of the meanings and practices of dying and death	68

LIST OF ABBREVIATIONS

TAR	Tibet Autonomous Region
WHO	World Health Organization
ICU	Intensive Care Unit
EEG	Electroencephalograph
ECG	Electrocardiograph
CPR	Cardio Pulmonary Resuscitation

CHAPTER I

INTRODUCTION

Death and dying are universal experiences for people from all different cultural groups around the world. It is accepted that this collective experience is intertwined with issues that involve mind, body, and spirit in the context of each person's unique culture. In Tibet there is a particular perspective based on their culture and religion. Tibetan culture developed under the influence of many factors. Development of Tibetan culture has been influenced by contact with neighboring countries and cultures, namely Nepal, India and China, but the Himalayan region's remoteness and inaccessibility have preserved distinct local influences. It seems obvious that Buddhism has exerted a particularly strong influence on Tibetan culture since its introduction in the 7th century (Powers, 1995c). Tibetan Buddhism deeply influences their daily life, especially, the belief and practice of dying and death.

In the past, modern hospital did not exist in Tibet. Therefore, people only relied on their own practice regarding disease and death. In Tibetan culture, in case of a natural death that pertains to sickness or senility when the patient with his own intuition will feel the nearness of their death, their children will then be called to attend and explain how they would like their children to help them die. Their children are also advised how to share their legacy and property in a proportionate way. While preparing to leave the body, a monk or a teacher is invited to help them at the prime moment of dying. As per the wishes of their parent, the children will invite the monks to do the rituals for a peaceful dying. These are the eight prayers and chanting of the Medicine Buddhas (Skt. Bhaishajya-guru, Jp. Yakushinyorai); Amida "Buddha and White Tara initiation (Tara means a female Buddha in Vajrayana Buddhism known as the 'mother of liberation'); making statues, thangkas (a painting on silk with embroidery, usually depicting a Buddhist deity, scene, or mandala of some sort), and doing a retreat to help in extending the life if possible. This includes releasing animals,

doing prayers, giving alms (food, clothes etc) to the poor, and so on” (JSRI, 2007). The reasons of such activities are to save the life of the dying persons.

However, nowadays, owing to medicalization and scientific belief, the scientific and western medicine plays the main role in most of health care system. Many diseases have almost completely disappeared in developed nations, and the very rare occurrences can easily be controlled with antibiotics. The fact that this dramatic change has taken place more or less simultaneously with the rise of modern medicine has led to the widespread belief that it was brought about by the achievements of medical science. This belief, although shared by most doctors, is quite erroneous (Capra, 1983).

In the past, hospitals took on different forms in different cultures and societies. Previous to the 18th century they were institutions of charity and welfare, and warehouses for the poor. The modern hospital gradually changed from an institution of charity and welfare to a place of high technology (Geest, 2004).

Technology has taken a central role in modern medical care. The increasing dependence of medical care on complex technologies has accelerated the trend toward specialization and has enforced the doctors' tendency to look at particular parts of the body that forget to deal with the patient as a whole person (Capra, 1983).

The age-old art of dying is no longer practiced in our culture. The fact that it is possible to die in good health seems to have been forgotten by the medical profession. In the past, one of the most important roles of a good doctor was to provide comfort and support for dying patients and their families. However, physicians and other health professionals today are no longer trained to deal with dying patients and find it extremely difficult to cope with the phenomenon of death in a meaningful way. As death is seen as a failure, when people die, their bodies are carried out of hospitals secretly at night. Health providers seem significantly more afraid of death than other people, whether sick or healthy (Capra, 1983).

Biomedicine has been spread approximately one century in Tibet. The establishment of a British hospital at Gyantse in Southwestern Tibet, marked the formal introduction of biomedicine into that Himalayan state in 1904 (McKay, 2005). Since the people's hospital was built, the numbers of patients have been increasing in hospital per year. Especially, in recent years, the medical insurance is offered from 60

to 80 percent in both of urban and rural areas. Besides, in those modern hospital settings, lay Tibetans still carry their culture and belief to gain medication.

1.1 Justification

Death and dying are an inevitable issue, but as a natural concept rather cultural concept, especially in the hospital. Nobody can avoid death and dying. They can happen to everybody any time accidentally. Every day, people around the world facing with dying and death accept and handle those on their beliefs, education, socio-economic and cultural background. It might be difficult to understand how people in different cultures and in different locations deal with death and dying without understanding their cultures and the contexts they perceive and practice in their daily lives. The lack of understanding and respect on each culture can lead to many obstacles to handle those hotly debatable issues that are as a result of cultural misunderstanding and misinterpretation, nowadays. Therefore, this study investigates the differentiation of perception of death and dying in order to grasp behavior, practice, and expectation for terminal life care.

1.1.1 Dehumanization in hospital

The World Health Organization's (WHO) definition of health includes four domains of well-being: physical, mental, social and spiritual(Chan et al., 2006). The WHO reported that '...until recently the health professions have large followed a medical model, seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and to faith-in healing, in the physician and in the doctor-patient relationship. Nonetheless, this mechanistic view of patients is no longer satisfactory. Patients and health practitioners have begun to realize the value of elements such as faith, hope and compassion in the healing process. . .' (Komala & Ganesh, 2006). The spiritual dimension is the most neglected domain in daily nursing practice (Waugh, 1992). People have been confused about the connection and distinction between spiritual care and religion (Bentur, Resnitzky, & Sterne, 2010). Many researchers have acknowledged that spirituality involves an individual's search

for meaning in life, wholeness, peace, individuality and harmony (Chan, et al., 2006). The ultimate existential issue is death. Like all other philosophical and existential questions, the matter of death can be avoided as much as possible. The lack of spirituality that has become characteristic of our modern technological society is reflected in the fact that the medical profession, like society as a whole, is death-denying. Within the mechanistic framework of medical science, death cannot be qualified. Death becomes simply the total standstill of the body-machine (Capra, 1983).

1.1.2 Little research in Tibet on Death

Knowledge of the culture and society of Tibet has been greatly restricted by the inability of Western scholars, particularly social scientists, to conduct field research there. Anthropologists have had to be content with studying Tibetan speaking populations living in Nepal and India, but there is little research in Tibet. This situation changed when the People's Republic of China implemented its new "open door" policy, making field research in Tibet a real possibility for the first time in 1985 (Goldstein & Beall, 1987). One ethnographic research was conducted by Geoff Childs, an American anthropologist between 1995 and 2000 to the Nubri Valley in Nepal. He described death related to Tibetan culture and Buddhism in daily life (Childs, 2004). The medical research has a few conducted in Tibet, even though it is more acceptable. Tibet Autonomous Region (TAR) also has its own medical schools for both biomedicine and traditional Tibetan medicine. Basic principles of biomedical science have been offered at the university level. Unluckily, very little clinical research has been done in the country (Adams et al., 2005). The research conducted in Tibet is limited. Moreover, little research done does not focus on a specific issue about the meanings of dying and death neglected among patients and practitioners.

1.1.3 Prohibition to spiritual practice in hospital

Tibetan Buddhism more pays attention to spiritual practice for dying and life. Most lay Tibetans are Buddhists. Nevertheless, in hospital setting the lay Tibetans as Buddhists are not allowed to practice spiritual related activities. For example, once one of the family members dies, it is a Tibetan cultural practice to leave the body of

the recently deceased undisturbed for a period spanning anywhere from several days to one month. Most funerary rites in Tibet involve the recitation of what is called in the west the Tibetan Book of the Dead (*BadorTodrol*), which serves as a set of instructions on how to navigate the *Bardo*, or intermediary world prior to rebirth, for the deceased (McKissick, n.d.). On the other side, most medical practitioners who are Tibetan and share the same culture with their patients put small focus on the spiritual care. It may fail to achieve satisfied holistic health care. Thus, this study may shed some light on the necessary of the care of spiritual dimension.

1.2 Objectives

1.2.1 General objective

This study attempts to understand cultural meanings of death and dying among patients and relatives in hospital.

1.2.2 Specific objectives

1. To investigate cultural meanings of death and dying among patients and relatives in the hospital
2. To explore the expectations of death and dying related to the meanings of death and dying
3. To observe the practices of death and dying related to the meanings of death and dying.
4. To observe hospital services provision and how it is sensitive to the cultural meanings of death and dying

1.3 Research questions

1. What are the cultural meanings of death and dying among patients and relatives in the hospital?
2. What are the expectations of death and dying related to the meanings of death and dying?
3. How sensitive is the hospital service provision to the cultural meanings of death and dying?

CHAPTER II

LITERATURE REVIEW

This study tries to explore the meanings of death and dying in medical setting. This chapter explains theoretical concept on cultural constriction approach and concept of dying and death in biomedicine. At the same time, the overview concept of dying and death as cultural phenomena and the empirical literature review and the application to the particular title chosen are discussed briefly. Then, a conceptual framework of the hypothesized relationship between the study variables is illustrated.

2.1 The concept of dying and death in biomedicine

2.1.1 Body as a machine

By the influence of biomedicine, human body is supposed as machine. The human body composed of head, neck, trunk, and four limbs, is ultimately the subject of all research and scholarship directed towards analyzing the social dimension of medicine, health and illness. Biomedical discourses and practices often territorialize the body, rendering it into a ‘body-with-organs’ by focusing largely on its anatomical aspects. At other times, other discourses and practices may prevail, ‘reterritorializing’ the body with different meanings. The body, therefore, is regarded as an always unfinished project, and the body-self is viewed as mediating notions of ‘health’ and ‘illness’.

Since the industrial revolution, the mechanical metaphor had been frequently used in discourses on the body that the imagery of the body as a workshop s full of instruments and tools, including the lungs as blacksmith’s bellows. The body is represented in both medical and lay forums. When the mysteries of the human body were finally revealed by medical dissection, ages-old metaphorical understandings of the body’s interior were not unduly disturbed, because such pre-established beliefs

served to shape the perceptions of the newly exposed interior. For example, the concept of the heart as a 'pump', which can 'break' and which contributes to low or high blood 'pressure', has been so naturalized as to be rendered a dead metaphor, or an expression which we no longer recognize as a metaphor. The mechanical metaphor includes the idea that individual parts of the body, like parts of a car or plumbing system, may 'fail' or stop working, and can sometimes be replaced. Hence, the importance of the technological imperative in biomedicine: the dependence upon the use of machinery to fix machinery. It was a logical conceptual leap in the late twentieth century to imagine the body as a computerized system. There developed a symbiotic metaphorical relationship between computers and humans, in which computers were anthropomorphized (Lupton, 2003a).

There is evidence to say that the practitioners who believe in biomedicine just treat the body as machine in order to fix and repair the disorder in the system of human organ. The negligence of human body can lead the practitioners to disregard the patients' illness experiences. Everything as for disease/ illness treatment comes from the understanding and the power of biomedicine.

2.1.2 Disease / illness explanation

No one can be free from illness experiences around the world. It is totally believed that the illness process begins with personal awareness of a change in body feeling and continues with the labeling of the sufferer by family or by self as "ill." Modern physicians diagnose and treat diseases, meaning abnormalities in the structure and function of body organs and systems, whereas patients suffer illnesses that means experiences of disvalued changes in states of being and in social function; the human experience of sickness. In the Western medical paradigm, disease is malfunctioning or maladaptation of biologic and psychophysiologic processes in the individual. In addition, disease is abnormalities in the structure and function of body organs and systems (Kleinman, Eisenberg, & Good, 2006). (Joralemon, 1999) cited the statement of Engelhardt (1981) defining a disease that was "considered responsible for epilepsy, blindness, vertigo, loss of hearing, headache, impotency, memory loss, rickets, and irregular action of the heart". But illness represents personal, interpersonal, and cultural reactions to disease or discomfort. Illness is shaped by cultural factors

governing perception, labeling, explanation, and valuation of the discomfoting experience, processes embedded in a complex family, social, and cultural nexus. Because illness experience is an intimate part of social systems of meaning and rules for behavior, it is strongly influenced by culture: it is, as we shall see, culturally constructed.

Illness is culturally shaped. The way we perceive, experience, and cope with disease is completely based on our explanations of sickness, explanations specific to the social positions we occupy and systems of meaning we employ. These influence our expectations and perceptions of symptoms, the way we attach particular sickness labels to them, and the valuations and responses that flow from those labels. The way we communicate about our health problems, the manner in which we present our symptoms, when and to whom we go for care, how long we remain in care, and the way we evaluate that care are all affected by cultural beliefs. Illness behavior is a normative experience governed by cultural rules: we learn “approved” ways of being ill. It is not surprising then, that there can be marked crosscultural and historical variation in how disorders are defined and coped with. The variation may be equally great across ethnic, class, and family boundaries in our own society. And doctors’ explanations and activities, as those of their patients, are culture-specific.

Biomedicine is primarily interested in the recognition and treatment of disease (curing). So paramount is this orientation that the professional training of doctors tends to disregard illness and its treatment. Biomedicine has increasingly banished the illness experience as a legitimate object of clinical concern. Carried to its extreme, this orientation, so successful in generating technological interventions, leads to a veterinary practice of medicine (Kleinman, et al., 2006). Whenever the lay people consult the practitioners, the practitioners almost never consider how the lay people feel and express their illness experiences. They almost all rely on their academic based on what they have studied and technology in order to treat their disease and illness.

2.1.3 Technoscience of death

Modern technology in terms of medical treatment has become a high concern, nowadays. The determinants of the result of diagnosis of any kinds of disease in health care system are dependent on technology whether it can give accurate

information or incorrect information. The belief that patient death is a failure of the physician and medical system is patently false, yet the American public, to some degree, believes that, with enough technology and skill, American physicians can cure all medical illness (Buxton, 2008). In 1968, Harvard Medical School established an ad hoc committee on brain death to establish clinical guidelines (Ember & Ember, 2004). The definition of brain death relies on technology to determine death. The diagnosis of death by western medical practitioners who hold a 'flatline' on the electroencephalograph (EEG) that means cessation of heart beat and brain activity (Tsomo, 2001). On the other hand, with the definition of brain death the artificial respirator or ventilator, which was coming into widespread use in intensive care units in industrialized countries, could keep the heart pumping and the lungs breathing so that the dying would be prolonged. Therefore, the issues of defining death has become more problematic (Ember & Ember, 2004 ; Lupton, 2003a).

Engelhardt then pursues the argument to what for him is a logical conclusion: that lack of upper brain function alone signals death, and therefore patients in persistent vegetative state are no longer alive. He then continues, "The brain-oriented concept of death offers medicine a way of distinguishing between patients, i.e., the persons to whom medicine has obligations, and the collection of human organs (i.e., mere human biological life), which can be used to help persons still alive" (Lock, 1996). As a result of using modern technology as a tool and a standard, human beings are passive. All of the decisions are from technology in order to show the result. Technology never considers how human beings think and feel. It also violates human ethics and religious teaching on death. In other words, technoscience results in some conflicts how and when the decisions are made as for death. As for ethical issue, the case of Karen Wuinlan was taken as an example. Since she was kept alive by a respirator/ventilator and displayed no improvement for several months, her parents requested to discontinue the active care and allow her to die. But the hospital refused to execute this request. This case or issue has raised ethical considerations regarding the right of competent patients to refuse medical life support (Littleton et al., 2010).

2.2 The concept of dying and death as cultural phenomenon

2.2.1 Dying and death in different cultures

Looking at different cultures on death, it is completely understood that almost all people want to die at home because of their cultures. On the other hand, nowadays, owing to health care system and modern technology, people die in different places such as at home, in hospital, and hospice.

In the West, it is generally believed that life is linear: There is a beginning and an end. No one returns after death and may move on to a heaven (Warren, 2005). (Collins & Doolittle, 2006) stated that the African American in USA belief death is an end to suffering on earth, if people have high moral and give back others so they could be accepted into the Kingdom of Heaven. (Straus, 1978) defined death as transformation, not termination, of selfhood for those who have lived in the Cheyenne Way: deceased Cheyennes continue to participate in the tribal society. Death is understood as a process, not an event; and the process of death may be reversed. Death should be expected, even courted: it should not be accidental. Isolation, not annihilation, is the greatest fear associated with death in the Northern Cheyenne community (Eyetsemitan, 2002). It was explained that the traditional African belief system is referred to as ancestor worship. Those who are dead, though not physically seen, are alive in a different world and can reincarnate in new births. Asante, who live in Ghana of western Africa, and Chinese, also believe that they become ancestors after death (Bonsu & DeBerry-Spence, 2008; C. Hsu, M. O'Connor, & S. Lee, 2009). Death is a bad luck due to natural belief among Chinese Taoist (C. Hsu, et al., 2009)

Medicalization changed the pattern of the place of death from home to hospital (Clive, 2000; Long, 2003) as a result of modern technology that can treat the patients to prolong the life. Yet almost all people in different cultures, particularly for the Chinese it is an ideal place for death at home that they prefer to die at their home. It means that they are able to band of their ancestors influenced by Taoism (C. Y. Hsu, M. O'Connor, & S. Lee, 2009). Additionally, in postindustrial countries like United State and Japan, it means not only surrounding by family but the suffering of medical technology via avoiding and not become a burden when they are dying (Long, 2004).

Death at home remains a cultural ideal for many patients, but medicalisation hegemonized by technology made it difficult to realize that goal.

However, in a study in South Africa, most of patient death recorded (42.92%) occurred at home. The majority of patients died in the ward (38%). The patients and families in this study had good access to hospice care, and achieved a higher "death at home" rate than that seen in several more developed countries. The review of place of death and length of hospitalization prior to death highlights the need for staff at private oncology units to be trained in and comfortable with palliative care. Attention is also drawn to the very real needs of carers and family members of patients, if death is planned to occur in the patient's home (Manicom, 2011). Another research identifies a peaceful death as a 'good death' in Kwahu-Tafo in Southern Ghana of Africa. Kwahu-Tafo is one of the poorest areas in Africa. Death is always around and takes its toll at all ages due to non-medical interventions. In other words, their illness and dying hide in their bed without medical interventions. In the same manner, Kwahu desire dying and death at home based on their culture (Geest, 2004).

A large proportion of dying people express the desire to die at home, others remain in hospitals or other facilities (e.g. nursing home, hospice). Being hospitalized ensures better access to pain management and other interventions to maximize comfort and minimize suffering. Most dying patients want to avoid severe pain. Physicians can more easily control pain and sedate dying patients in the hospital. Lives can be saved at a moment's notice with Code Blue teams available much more rapidly than in the community. Medications, diagnostic tests, surgical suite accessibility: all are available in hospitals. Nevertheless, the desire is death at home rather than hospital. Despite a lot of benefits in hospital, people want to die at home. This raises the question of the actual desire during their terminal life (Deborah, 2011).

2.2.2 Dying and death in Tibetan Buddhism

Tibetan Buddhism was inherited from the greatest scholastic institutions of northern India during the period of the dissemination of Buddhism and combined with cultural factors that influenced later developments. There are four sect of Buddhism, namely Nyingma, Sakya, Kagyu, and Gelugpa (Powers, 1995b). In terms of death, it is a common Western misconception that Tibetans do not fear death because they believe

in reincarnation. In general, Tibetans like Westerners fear death. They have a pervasive sense that everyone is impermanent and destined to die (Klass, 1997).

Tibetan Buddhism places a particularly strong emphasis on instructions with respect to death. Tibetan literature is full of admonitions to be aware of the inevitability of death, the preciousness of the opportunities that a human birth presents, and the great value of mindfulness of death. A person who correctly grasps the inevitability of death becomes more focused on religious practice, since he or she realizes that death is inevitable, the time of death is uncertain, and so every moment counts (Powers, 1995a).

Death is regarded as a process rather than a unitary event. It means their mind have good preparing to go to their ways which are between death and rebirth, If a person has good and strong practice for preparing of his mind, the facing death will have no fear but peace. The subtle winds and subtle body that continue after physical death are the basis for the only semblance of identity that survives an individual's death (Tsomo, 2001). Death or change is not to be feared, but to be handled calmly and gracefully. Life does not end after the physical body departs. Dying is just a door to new and interesting experiences, which we are able to prepare for in this lifetime. For that reason, "Do not be afraid of death" is the message; it is just a transformation to another existence, like a caterpillar turning into a butterfly (Shapiro, 2007).

As for the time of death, either Tibetan medical practitioners or monks determine the time of death by analyzing the urine of the critically ill patient and by reading the death pulse (Tsomo, 2001). The following cultures reflects how Tibetan Buddhism's concept on death. For example, the northwest coastal region of the island of New Britain in Papua New Guinea is home to about a thousand Melanesian people who refer to themselves as Lusi (the name of their language) or Kaliai (the area in which they live). For the Lusi-Kaliai, death is not an end to existence but a transition from one state of being to another. The final stage of dying that the physical process of dying is almost complete if the dying person's breath smells of death, if the person stares without blinking or shame at another person's face, is restless and must be moved frequently, or loses bladder or bowel control. The spirit usually leaves through the eyes or mouth or, if both are closed, by the anus. Dying is complete when breathing stops, when the heart ceases to beat, and when the eyes and mouth hang

open. Adults are buried 24–36 hours later (Counts & Counts, 2003). Both of determination of death is absent from Technoscience.

The dying process is complex and unique challenges that threaten human's physical, emotional, and spiritual integrity. Applying technology and improving medical achieve delay death, but the fear of death has expended. The way dealing with death is various due to different cultures. Biomedicine fights with death in order to prolong the dying; religion practices the spirit to face and dealing with death so as to overwhelming the dread of death and suffering. Nowadays, it is very obvious that modern technology dominates and diminishes the power and the value of the culture we believe and practice long time ago. All of the decision tends to come from modern technology in terms of disease and health. It means that body becomes object treated as machine. It ignores mind and spirit which are embedded in the body driven. Technoscience only focuses on disease rather than on their psychological suffering. The negligence of psychological suffering and cultural belief and practices can lead to more harmful and negative impacts on the lay people. Without understanding the culture how people perceive and practice the things, particularly on death and dying, it can also make a conflict between the insiders and outsiders. As a result, paying respect to the cultural belief and practice on particularly issues during the research is extremely important.

2.3 Theoretical concept and application

2.3.1 Cultural construction approach

Peter L. Berger is a University professor of Sociology and Theology, College of Arts and Sciences and School of Theology Director, Institute on Culture, Religion and World Affairs. Thomas Luckmann, well known for the book: *The Social Construction of Reality* together with Berger and for *Structures of the Life-World* together with Alfred Schutz, was professor for Sociology at the University of Constance in Germany.

Here is a saying, "No man is an Island." It is believed that society as a human product. Human beings are social beings. Human beings together produce a human environment, with the totality of its socio-cultural and psychological formations. The human organism lacks the necessary biological means to provide stability for human conduct. It is obvious that social order is a human product produced by humans in the course of their ongoing externalization. It can be said that social order is not biologically given or derived from any biological data in its empirical manifestations. Social order is also not given in man's natural environment, though particular features of this may be factors in determining certain features of a social order that is not part of the "nature of things," and it cannot be derived from the "laws of nature." Social order exists only as a product of human activity.

Human being is impossible in a closed sphere of quiescent interiority. Human being must ongoingly externalize itself in activity. All human activity is subject to habitualization. Any action that is repeated frequently becomes cast into a pattern, which can then be reproduced with an economy of effort and which, ipso facto, is apprehended by its performer as that pattern. Habitualization further implies that the action in question may be performed again in the future in the same manner and with the same economical effort. Habitualized actions, of course, retain their meaningful character for the individual although the meanings involved become embedded as routines in his general stock of knowledge, taken for granted by him and at hand for his projects into the future. Habitualization provides the direction and the specialization of activity that is lacking in man's biological equipment, thus relieving the accumulation of tensions that result from undirected drives.

Institutionalization occurs whenever there is a reciprocal typification of habitualized actions by types of actors. The typifications of habitualized actions that constitute institutions are always shared ones. They are available to all the members of the particular social group in question, and the institution itself typifies individual actors as well as individual actions.

All institutions appear in the same way, as given, unalterable and self-evident. An institutional world, then, is experienced as an objective reality. At the moment, it is important to emphasize that the relationship between man, the producer, and the social world, his product, is and remains a dialectical one. It is already

possible, however, to see the fundamental relationship of these three dialectical moments in social reality. Each of them corresponds to an essential characterization of the social world. Society is a human product. Society is an objective reality. Man is a social product. It may also already be evident that an analysis of the social world that leaves out any one of these three moments will be distortive. One may further add that only with the transmission of the social world to a new generation (that is, internalization as effectuated in socialization) does the fundamental social dialectic appear in its totality (Berger & Luckmann, 1966).

The primary focus of social constructionists is examining the social aspects of biomedicine, the development of medico-scientific and lay medical knowledges and practices. It merely emphasizes that these states and experiences are known and interpreted via social activity and therefore should be examined using cultural and social analysis. Most social constructionists acknowledge that experiences such as illness, disease and pain exist as biological realities, but also emphasize that such experiences are always inevitably given meaning and therefore understood and experienced through cultural and social processes (Lupton, 2003b).

2.4 Conceptual framework application

Cultural construction approach can be applied to explain the meanings of death and dying that comes from their cultural context. Cultural construction explains how human beings together produce a human environment, with the totality of its socio-cultural and psychological formations. All human activity is subject to habituation. Habituated actions retain their meaningful character for the individual although the meanings involved become embedded as routines in their general stock of knowledge. Society is a human product. Society is an objective reality.

Society itself constructs the form and the structure to influence the people who are staying together in the same place. Its form and structure share each other. The way they do and they behave is more or less influenced and constructed by their society that also makes them follow the same ways retaining the meaningful character.

For example, religious system drives the way they do and behave and nurtures their thinking and beliefs. Moreover, a medicalized system builds its own environment that plays an important role in spreading the practices and beliefs in different ways such as training and education. Its focus is to examine the social aspects of biomedicine, the development of medico-scientific and lay medical knowledge and practices through cultural and social processes. Consequently, it can answer the cultural meanings of dying and death among patients and relatives in the hospital and hospital services provision and how it is sensitive to the cultural meanings of dying and death. The meanings of dying and death include beliefs and practices of lay people, and practitioners.

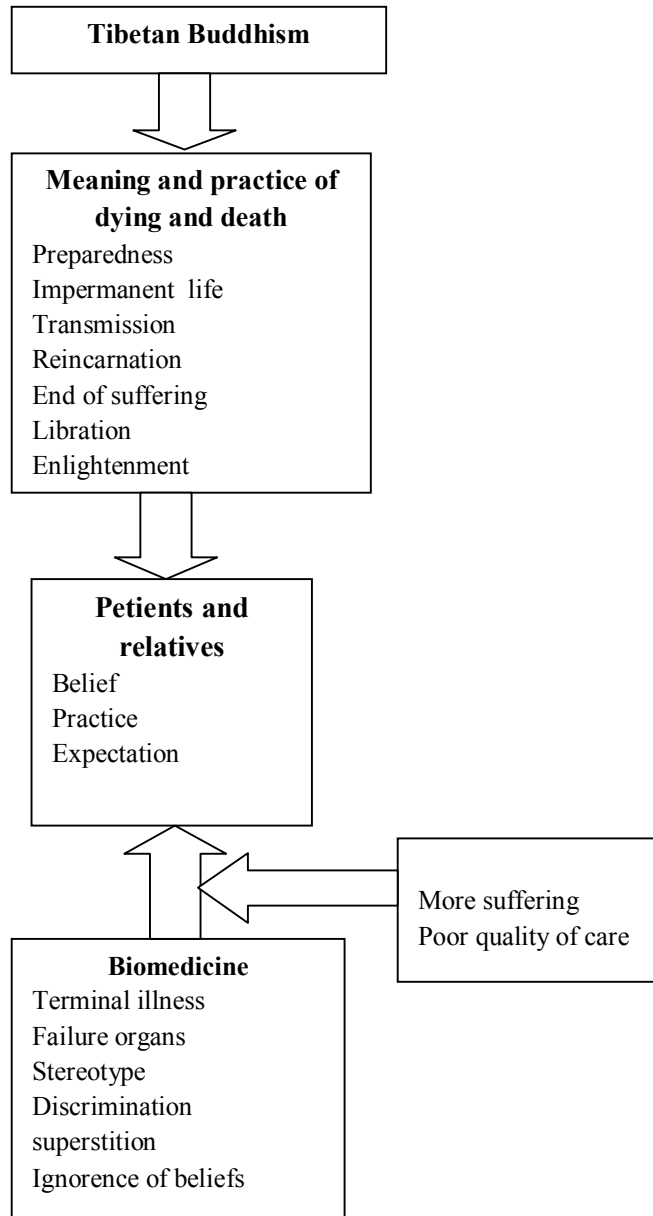


Figure 2.1 Conceptual Framework

CHAPTER III

RESEARCH METHODOLOGY

The aim of the study is to explore the cultural meaning of dying and death in accordance with the Tibetan context. In the study context, dying and death was expected to have particular meanings that relate to its culture in medical setting. In order to understand how the lay Tibetans understood and interpreted dying and death, this study took three months of data collection in the study site.

3.1 Research design

This study is qualitative research approach that helps understand the meaning of dying and death in relation to cultural and social context among the lay Tibetans. Qualitative research approach enables the exploration of the meaning, behavior, belief and expectation of dying and death. This study also applied observation and in-depth interviews to gain information and insight into the perception of dying and death and their expectation.

Qualitative approach was the most appropriate way for me to get closer with the lay Tibetans and the health practitioners to explore a sensitive topic of dying and death relation among them. To be able to see and know how they perceived, I tried to accept any manner and to stay with them in possible places such as wards, restaurants and houses as a researcher. For that reason, I was capable of collecting fruitful and more accurate data reflecting close reality of their perception, expectation and social meaning to dying and death. Moreover, I could clearly differentiate between the emic view and the etic view of dying and death. In order to comprehend the meaning of dying and death, it was necessary to stand from insiders' view. The emic helped me understand what and how people felt. As a result, the explanations were used and applied.

3.2 Research site

This research was conducted in the people's hospital of Tibet Autonomous region, located in Lhasa, Tibet. Lhasa is a central of culture, politics, economy, religion of Tibet. As known, the increasing number of dying and death takes place in hospital by medicalization. There were three main reasons why this particular hospital was selected. First, the People's Hospital of TAR is an integrated hospital with strong technical strength and since the founding of 60 years. The people who have health problems and come from six districts almost always consult this hospital so as to achieve their goals because it is the largest and one of the most prominent hospitals in Tibet. In the hospital, there is a simple statistic to show that the highest death ratio is in Intensive Care Unit (ICU), which located in fifth floor of a surgery building, except emergency department. All most of rescue tools or life-saving tools are centralized in ICU include ECG monitor, respirator, defibrillator, sputum aspirator and so on. Most of severe patients from different departments are sent to ICU in order to observe well and rescue as possible as doctors or nurses can during their high serious condition. In other words, this hospital could reflect all the complexities in terms of diversity of patients and modern medicine practices for the study because different patients came to consult this hospital.

Second, I had worked in the people's hospital for 18 years, so I was familiar with this environment and the health practitioners. As they knew me who I was, I was easy to get permission for conducting my research from the leaders of the hospital. In addition, I am still a member of the hospital. Except some new practitioners, I know most of them due to my long working experiences along with them. Third, I could save time to be familiar with the environment. Moreover, I did not worry about my stay and the food. In short, I have been working here since 1994. I am acquainted with it and I have some friends who know me very well. As a result, I no longer needed to build trust among the practitioners.



Figure 3.1 Tibet Autonomous Region



Figure 3.2 Lhasa, the capital of Tibet



Figure 3.3 The people's hospital of TAR

3.3 Entering to the research field

To be able to conduct my research in the people's hospital of Tibet Autonomous region, I visited my friends, the chief of my department, and colleagues who gave me important and useful advice to make a contact with lay Tibetans and health practitioners. According to their suggestions and my view, I visited the president of hospital. As he was so busy dealing with the matters of the hospital, I briefly reported my study to him. He straightforward gave me his permission and told me to ask the academic department if I needed some cooperation to do my research. I felt very happy with his helpful words.

As a medical doctor, I was much more familiar with doctor's provision than nursing. In order to be familiar with the provision of nursing, I went to the nursing department and greeted a chief of nursing and get permission from the chief of nursing department. Then, I explained my research to her before she agreed to allow me to collect the information in nursing area.

Finally, I entered the ICU, a key department of the hospital, and met two chiefs in order to introduce my research to them. In addition, I was given permission for taking photographs at the area of ICU. Both of them stated their willingness to cooperate with any angles of the work. All preparations for initial fieldwork were ready with my full of great expectation.

3.4 Selection of informants

I contacted the lay people who were patients and relatives. In general, I talked with over 15 patients and relatives who were staying in the hospital. Many patients and relatives who speak their dialect came from districts to seek their medical treatment because some of them's illness could not be treated by their local hospital. The pronunciation of their dialect is different from Lhasa language though the written form of the language is the same. The problems we had among us were language barriers, and cultural beliefs on incurable diseases like cancer. When I talked with them, we could not understand each other due to the different dialects that made us unable to go deep into the interviews. Another issue is that they do not want to talk about death. In general, Tibetans believed that if they talked about negative things, it became truth in reality. For example, if I asked some relatives about death, it was believed that I seemed cursed ("momo", meaning "bad words to cause bad outcome") the patient to die. In other words, if they talk about death issue, the words and the talks lead the patients to die soon according to their belief so that they avoid talking about its issue. Finally, the informants I had chosen were Tibetan and Chinese adults who were over 18 years old. Four informants were hospitalized patients and their relatives who had some experiences in serious conditions in the hospital. Other four informants are doctors and nurses who have rich experiences to take care of dying or death and willing to share their experiences. And they had high education and work over ten years in the hospital, especially some work in special department like ICU. All of the informants are Tibetans except a health practitioner who is a Chinese. Rewrite this sentence In addition, the last key informant is a monk, who is able to comprehend dying and death in Tibetan Buddhism's point of view.

Table 3.1 The table of informants

Case	Name	Age	Sex	Marital Status	Education	Occupation	Religion
C1	Nyiman	39	Female	M	Bachelor	Physician	TB
C2	Dekyi	54	Female	M	No	Farmer	TB
C3	Dundrup	41	Male	M	No	Farmer	TB
C4	Pubu	28	Male	M	High School	Farmer	TB
C5	Xiao Ming	40	Female	M	Diploma	Nurse	None
C6	Lhamo	37	Female	M	Bachelor	Nurse	None
C7	Tendzin	45	Male	M	Master	Surgeon	TB
C8	Tashi	43	Male	M	Bachelor	Physician	TB
C9	Tsering	44	Male	S	Teacher	Monk	TB

Lay people are from C1 to C4, C5~C8 are health practitioners; C9 is a specialist of Tibetan. Moreover, in education section, No means “the persons who did not attend formal education,” and in religion section, No means “The persons who do not have any religious belief or atheists.”

3.5 Method and data collection

Two methods employed in this study included In-depth interview, observation, and document review. During the previous days, as a nurse I tried to learn nursing and talk with patients who were in serious condition, relatives, and nurses in order to understand their feelings and search my informants who willingly told me about their stories. At the same time, I also observed the practices of health practitioners with the medical environment to understand the meaning of the death and dying based on their medical perspectives. Additionally, I observed the places in which relatives stayed and waited for meeting or send some stuff into ICU and the structure of hospital. I also used document review to more clarify the view of Tibetan Buddhism on dying and death and the meaning of dying and death from different

views. Field notes are my most important tool through my whole process of data collection.

3.5.1 In-depth interview

There were two types of informants in the study; namely lay Tibetans from different backgrounds and health practitioners in the hospital. First, the lay Tibetans were patients and relatives who had directly or indirectly experienced of dying in the hospital. For example, the patients had direct experiences of dying when they suffered from the diseases. At the same time, the lay Tibetans might have indirect experiences of dying and death when their relatives suffered from illnesses and dying. The duration and the frequency of the interviews were varied depending on each person. I interviewed Nyiman four times. It took one hour in the first time, two hours in the second and the third times and three hours in the last. Dekyi was interviewed three times. I visited her to know each other half hour. After that, I interviewed her and it took three hours in the second time and one hour in the third time to make sure all of the information from her. Dundurp was interviewed six times because he took care of his relative. Sometimes, during the interviews, I felt that his emotion was not good so that I did not want to make him be sad. In general, each interview took one hour. I interviewed Pubu only two times because he shared his feelings and experiences openly to me. Each interview took two hours.

For health practitioners, they had rich experience to provide care for dying and death. They preferred to carry interviews in the rooms in the restaurants except a surgeon who was interviewed in his office in the hospital though invited to have meals together. Each person was interviewed three times because they were busy. Whenever they had time, I was informed to meet them again. It took one hour each time.

For a key-informant, he is a monk, a teacher of the scriptures of Tibetan Buddhism in a monastery. My friend working in the temple introduced me to him in order to be able to talk with a monk about the study related topic. He warmly welcomed me to have conversation each other about what I wanted to get the information from him. He has rich knowledge of scriptures of Tibetan Buddhism, so he can interpret the dying and death in Tibetan Buddhism to me deeply. I visited him twice to discuss about the study. Each interview took two hours.

3.5.2 Document review

Document review were books, journals, articles and reports mainly about Tibetan Buddhism, culture, death and biomedicine. They were very much important to deeply understand the meaning and practice of dying and death. Though in-depth interviews were conducted, the normal people could not understand all deep meanings and practices of dying and death in Tibetan Buddhism. For example, when having a long conversation with a monk, some terminologies and meanings were difficult to comprehend for me even though I am a devoted Tibetan Buddhist. In order to make sense what a monk explained to me, document review were useful.

3.5.3 Observation

Observation was greatly useful in qualitative research that made it unique and opened avenues to important types of information to obtain or access. It was used to comprehend their behaviors, life experiences, beliefs and situations directly or indirectly in their houses as well as in the hospital area whenever possible. Furthermore, the observations included the practices, and daily social activities of them.

3.5.4 Field note and research instrument

I took "jotted notes" with some important words in order to trigger my memory of each event when I did each interview. It was not easy to take notes during my observation because it would be considered inappropriate and inconvenient at that time. Once I returned home I tried to recall all conversations and my observation with the jotted notes as possible as I can and add details for my field notes. In terms of instrument, I was required to use recording when I did interviews, but all rejected to do it because it made them nervous or it was sensitive way they thought. Only one informant allowed me to take pictures in her house. Likewise, I got permission from the chief of nursing in ICU to take pictures. Those pictures showed the environment of ICU, the condition of severe patients, the tools of medical treatment and nursing.

3.5.5 Data collection

As already aforementioned at the beginning of chapter three, the study took three months in the study site. The health practitioners in the research field were my co-workers when working along with them for 18 years. As soon as I arrived at the research field, I made a contact with them about how the interviews could be done. All the procedures and the aim of the study were explained to them. After that, the health practitioners helped me introduce to the patients and relatives whom I wanted to meet. Likewise, all the processes of the study were explained to lay people through the help of the health practitioners and relatives. Some interviews took three times and some took more than three times because they were busy dealing with their jobs. For most lay Tibetans, I spent time building trust and confirming the information from the interviews.

As a physician, I have never concerned the social context, which patients live before standing the view of anthropology. I treated my patients through their symptoms, pathological sign, organs, and diseases in a medical way. I had no 'free time' to listen to the feelings of the dying; I concentrated on effective intervention of treatment for dying; I neglected the death in the ward. It was difficult to change my medical "hat" to anthropological "hat" when I started to do my qualitative research. I tried to change my medical "hat" to be an insider in order to understanding the meaning that people gave their world. I started to talk, listen, and observe the people who were social being in the hospital by my anthropological 'lens'. I learned to listen to their stories not to just focus on their medical histories. I tried to understand their beliefs and expectation by their social and cultural context. Those stories, which I have never touched as a medical doctor, are not only about pain, edema, heartbeat, medicines etc.

As a physician who did the anthropological research, I had both the advantages and disadvantages of my position. For example, the advantages were that I easily gained the permission for my research because I was a member of the hospital. I was not a stranger to do the observation of situation in the hospital and interview the health practitioners. In the other hand, some patients and relatives thought I was a medical staff of hospital management to evaluate the ward, so it made me spend more time to build the trust between us. However, it also encouraged some relatives to

express all their complaints about the hospital. As a physician to spend time and listen to their stories and complains, that was surprised and solace for patients and relatives. One day, one of relatives introduced me to other relatives to said: “ She is a Lama...” As known, Tibetans believe and pay fully respect to a Lama who is a teacher of spirit.

3.6 Data analysis

Data analysis was done regularly during data collection in the field. Field note writing was used to get detailed information. In-depth interviews and observation were reviewed daily whether the data answered the questions. And then, the original languages of Tibetan or Chinese were written into Chinese. After that, Chinese was transcribed into English. All of the data were classified into each section by using the table, which isthematic analysis. Finally, the coded data were shortened in line with the main themes of study. The main themes of the study were in general to interpret and analysis data by cultural interpretive perspective, to analyze case by case after expending my jotted notes. This type of the analysis made me improve my collecting skill and guide my interviews deeply. Finally, some data were presented; some by their originally local dialectical quotations along with translations. The discussions, feedback and comments followed the research writing.

3.7 Validity of Data

3.7.1 Datatriangulation

Triangulation of data with more than one method, namely in-depth interview, observation, and secondary resources was to improve validity of data. During the data collection, my identity was revealed as a graduate student from Health Social Science Program at Mahidol University in Thailand. Prior to conducting the interviews, I had let them know about my study objectives to be able to understand the meaning, expectation, practice and sensitivity of culture of dying and death and to consider the role and importance of religious belief and culture in Hospital.

3.7.2 Trust building

As the research consisted of sensitive issues such as death and dying, building trust between a researcher and research participants was a great importance to make sure the quality of data in the research. No matter how much sensitive the issues were, I was able to build trust and acceptance among us because of my long working experiences in the Hospital for 18 years. Most of the health practitioners already knew who I was. This friendship and work partnership made me much easier to build mutual-trust among us. For lay Tibetans, I tried my best to make trust building by my friends who were health practitioners to introduce me to the patients whom I wanted to contact them. Nonetheless, before conducting my research, the patients and relatives whom I chose were strangers so that I took many times to contact and to have deep conversations until I could build real trust between us. For example, some patients and relatives thought I was a medical staff of hospital management to evaluate the ward, so it made me spend more time to build the trust between us. In other words, I spent time together with them and accompanied with them as a helper. I made an attempt to listen carefully to what they wanted to share me every time as possible as I could. Therefore, they were able to share their sorrow, anger, bitterness or happiness with me, not as a researcher but as a native person. In this way, I built good rapport and gained trust from them.

3.8 Ethical consideration

3.8.1 Privacy

With respect to in-depth interviews, I let informants give a choice of the place in which they felt comfortable and convenient. They preferred to be interviewed in their houses and the special rooms in the restaurants. Only one informant was interviewed along with her family. The rest were interviewed without other people during the interviews. The doors and the windows were closed down. Not only were the collected data kept secret and private but these were also used only for the study.

3.8.2 Confidentiality

Confidentiality requires private data identifying the subjects was not reported. I kept my informant in anonymousness and protected their right, dignity and privacy, and used pseudonyms in both field notes and report, or changing names, places, and other identifying features in a final report.

3.8.3 Informed consent

Participants willing to participate in the study were selected. All the procedures of the informant consent were clearly explained to them. In principle, at first, I explained about my research, its objectives, purpose of the study, my identity and brief outline of the interview in a way that participant could understand without using technical terms and answer any question of participants if they are not clear. I also explained that he/she could stop the interview at anytime or refuse to answer questions unless they wanted to reply. After they clearly understood the procedures, the written informed consent was asked before the beginning of the interview and discussion. In reality, a verbal consent was used.

3.8.4 Benefits and reciprocity

The reason I conducted the research was to be able to understand their real life experiences, and suffering, struggle and so on. Getting chance of sharing their inner feelings and life experiences with someone else who listened to them in an empathetic way without judgmental attitude relieved their emotional suffering. In addition, I helped them as much as I could by sharing knowledge or giving advice for their emotional and physical well being in the hospital. For medical practitioners, I invited them to have meals together. For lay people, I gave small gifts to them. Furthermore, it is certain that the study is expected to benefit to health practitioners and general people, especially dying and their families. It is expected to inform the health related institutions to have a great concern to the dying, death and their families for humanized care rather than suffering and be neglected by medical practitioners

CHAPTER IV

RESEARCH FINDINGS

The research findings were mainly based on secondary resources, data collections and observation that described the overview of Tibetan society and Tibetan Buddhism, cultural meaning, practice and belief of dying and death in the hospital. The information of the society and the beliefs existing in Tibet might help better comprehend how the meaning, practice and belief of dying and death were deeply rooted in Tibet despite the fact that the hospital did not encourage this culture and belief. Therefore, in line with the research objectives, the research findings were presented.

4.1 Tibetan society and Tibetan Buddhism

Understanding the general information of the study area is an important issue of the familiarity of the inside of the society and religion. Therefore, Tibet society and Tibetan Buddhism are briefly discussed due to limited resources.

4.1.1 Tibetan society

Tibet is called “Po” by Tibetans, meaning “native land”, which is part of roof of the world. The unique natural environment and distinctive culture with the inseparable Tibetan Buddhism attract the world. The Tibet Autonomous Region (TAR), which was created in 1965. Tibet or Xizang for short, spans over 1,200,000 square kilometers (460,000 sq mi). Lhasa, the capital of Tibet, is a central of culture, politics, economy, and religion of Tibet. There are six districts in TAR consisting of Shigatsa, Chamdo, Ngari, Luoka, Nyingtri, Nagchu. Under Tibet society, population, education, geographical structure, agriculture and product are mainly described in short.

In terms of population, according to official announcement of 2011 national census, “there were about 3 million populations, including 559,423 populations in Lhasa. 80 percent of the populations live in rural. The population was composed of Tibetan, Chinese, and other ethnics. Among the population, Tibetans are 90.48%, the Chinese are 8.17%, and other ethnic groups are 1.25%. The life expectancy was 67 years old.” As for education, in line with the national census data from 2000, “The illiteracy rate among Tibetans was 47.55%. In 2011, the illiteracy rate decreased one percent compared with the census data in 2000.”

On the subject of geographical structure, the average altitude of Tibet is 4,000meters (13,123 ft). Though the plateau, the air is thin and dry in the whole Tibet except for some southern areas. Especially in the northern area, in which nomads live, the temperature often drops to minus 30 degrees in the winter. Fortunately, the strong sunshine illuminates this snow land to range all seasons. Therefore, Tibetans like to spend spare time under the warmly sunshine to sip butter tea or barley beer. Because of the harsh climate, Tibetans absorb sufficient energy and nutrition from their daily diet.

Agriculture is cultivated in the relative low land, including barley, wheat, beans, potatoes, cabbage, and tomatoes. The nomads who live on the extreme high land raise yaks, sheep, and goats. Also they mostly produce meat, butter, milk, and yogurt from domesticated animals. If they have surplus productions, they can be sold in the market.

4.1.2 Tibetan Buddhism

In fact, Tibetan Buddhism is a broad issue. However, only particular information such as history, karma, life event related to death including birth, festival, reincarnation, impermanent life and enlightenment is explained in short. Regarding the history of the beginning of Tibetan Buddhism, in the seventh century, the Tibetan King SontsenGampo sent the scholar TonmiSambhota to India to devise a script for the Tibetan Language in order to facilitate the translation of Sanskrit Buddhist texts. After that, the king continued to send some young scholars to India to study Buddhism. Therefore, Buddhism transmitted to Tibet during the eighth and tenth centuries(Tsomo, 2001). The three biggest monasteries of Tibet are located in Lhasa; namely Drepung, and Ganden monastery. And the most sacred and oldest temple Jokhang was built in Lhasa in seventh Century.

With respect to Karma, in general families, every early morning, after cleaning their faces and hands, Tibetans contain purified water into seven silverwares or copperwares to place in front of Buddha or deities' statues with their murmuring mantras in their home. Later, they walk around the monasteries of temples with tuning prayer wheels and murmuring mantras for accumulating merit. In general, in a family, the youngers encourage the elders to spend time for religious practice such as meditation and pray in order to prepare for death and accumulate merit or positive Karma for next life. In terms of Karma, there is a statement:

Karma has four main characteristics. The first is its increasing effect: goodness heralds further goodness and evil heralds further evil. Secondly, karma is definite in the long run, goodness always produces joy and negativity always produces suffering. Thirdly, one never experiences a joy or sorrow that does not have an according karmic cause. And lastly, the karmic seeds that are placed on the mind at the time of an action will never lose their potency even in a hundred million lifetimes, but will lie dormant within the mind until one day when the conditions that activate them appear (Lecso, 1986).



Figure 4.1 Offering in the morning

The negative karma causes suffering. For example, smoking would accumulate negative karma that leads to get sick. Smoking, it is believed, is bad. It is one of the negative karma which can cause suffering. All life experiences including birth, death, and illness are considered Karma. In other words, all are related to Karma.

Tibetans who live outside of central city Lhasa believe that they must pilgrimage to Lhasa and pay homage to the Buddha before the end of their present life. Tibetans who pilgrimage to Lhasa cover long distances on foot or prostration, stretching themselves full-length on the ground, to gain religious merit and thus to improve their positive karma. Every action includes speaking, thinking, emotion and all creates a new karma. All actions must be taken into account prior to doing.

“I believe I get retribution from my karma. I fed my son only seven days after giving a birth to him and also I did not try my best, so nowadays I get sick. I knew it was important that a mother fed children, but I did not do it.” (Patient Nyima)

“I believe that my illness is because of my bad karma from my past life. In the present life I try to do good things in order to reduce my bad karma and accumulate good karma for my next life.”(Patient Dekyi)

As for life event related to death, Tibet society desperately links to Tibetan Buddhism. Most of Tibetans believe and practice Tibetan Buddhism in their daily life, including birth, marriage, festivals, move, ailment, and death. Tibetans believe that each significant event needs to be consulted by some specialists of monks. For example, they require a name for neonates and auspicious days for their wedding through a reference of their date and time of birth. Especially for illness and death, they consult them to make a final decision.

“Before surgery was done on me, my family asked a monk what types of religious rituals should be done to succeed in surgery. According to the monk’s suggestions, my family did all for me in the temple. Therefore, I was not afraid to do surgery” (Patient Dekyi)

“I felt very hard to make a decision. At last, I rejected to do surgery because I was full of anxiety until the next early morning. In the morning, I called my relatives to ask a monk who lives in our village how i should do

and whether my brother can survive or not. The monk told me that he should be done surgery. If the surgery is done, he can survive. However, his illness would take long time so that your family should be patient. Therefore, I quickly told the doctor that I agreed to do surgery for my brother.” (Patient’s relative Dundrup).

Among them, the ceremonies related to death are described. In the traditional festivals, Lamas who are teachers of spirits or monks perform powerful ceremonies in the monasteries for the all well-being of sentient beings in order to drive out evil forces and create positive Karma. For instance, during the first lunar month of New Year, “*Cham*” is one of common ritual dances and performed by monks in the monastery. There are different characters that represent demons like a Yama, the lord of death and fierce. The ritual shows Yama or some deities who are too scared to look, but those demons will be encountered after every person dies.



Figure 4.2 Cham

Because reincarnation is fundamental to the Tibetan beliefs, birth is one of the four transitions through the cycle of life. Rebirth will take a person one step closer to liberation. Each individual has the responsibility to go through numerous

reincarnations before reaching the transcended state of enlightenment. Birth, when viewed from a Buddhist perspective encompasses the state in which people can choose the families to which they will be born and what life experiences they will have (Wilson, 2012). Death should not be viewed bad. Rather, it is a special chance to begin and pursue new life.

“Tibetan Buddhists believe that death is a good opportunity for liberation from the cyclic existence which includes five domains such as the god (Lha), the jealous god (lha ma yhe), the human (Mhy), the animal (Tuendru), the hungry ghost (Yeda), the hell domain (Nyewa). For last life we accumulated good karma to become human being in this life. It is a very value opportunity because we have mind as a human being. Based on our mind, we can learn and do good things for accumulating good karma through this opportunity.” (Monk Tsering)

With respect to death, because of reincarnation belief, the deceased pursue rebirth through the procedure of death ritual. After a person has died, the body is wrapped in white cotton by male relatives and arranged in the corner of room. Friends and relatives visit, bearing gifts of white scarves and butter tea or barley beer. An astrologer of Tibetan Buddhist is consulted on the precise auspicious moment for the disposition of body. Normally, the dead body, which Tibetans call “ro” or “pembo” means ‘litter and no mind like earth or stone.’ It is kept at home four to ten days before departure to the burial ground.

The body’s final departure from home to burial ground with smoke billowed from a fire of juniper branches and a bunch of offering of incense to the deities above. The sky burial is still practiced in Tibet. Offering the body as food to the vultures becomes the final act of compassion as a Tibetan Buddhist. For Tibetan Buddhists, the sky burial illustrates the impermanence of human life and the certainty of death. Therefore, everyone is encouraged to witness this process at least one time so as to understand the impermanence of life and effort in pursuit of enlightenment.

“I know some Tibetan idioms and Buddhism beliefs. Some elder people always say if you are living, you have to die.” (Patient Nyima)

“Tibetan Buddhists believe that nothing is permanent in the world. Life is impermanent and all living organisms are from birth to death. We are just

on our long journey. Where we will live in depends on our “Lye” (karma).” (Monk Tsering)

In addition, in Tibet, shamanic practices never stop, even though the government invokes tight regulation on it (C. et al., 2003). Tibetans believe there is an individual La which means spirit, life-force, or life-essence. The La is not only related to human being, but also to animals, natural elements, and places. Normally, Tibetans plant a tree which is called “*La shing*” to represent the fortune of some one’s life. There is a strong believe that the “*La shing*” can lead to harm or weak one’s life. In order to release the harm from the La, some shamanists offer rituals to protect them (Tsomo, 2001).

“My initial symptom just is stomachache, but all doctors who I meet cannot give me a clear diagnosis and cannot cure it. At the same time, I consult an astrologer who tells me that my “La” (spirit or lifeforce) leads to my sickness. In order to release me from the spirit or lifeforce, I do rituals. Around one year, I obtain my diagnosis that I get gallstone and liver abscess in the people’s hospital of TAR.” (Patient Dekyi)

As Tibetan Buddhism has been deeply rooted in Tibetan society, its practices and beliefs are inseparable from the activities of the society. Nowadays, traditional beliefs and modern health care system are seen contrast.

4.2 Modern hospitals in Tibet

The entrance of medicalization, the phenomenon of the hospital and a machinic way in this section are presented briefly to comprehend the activities and situations of modern hospitals.

4.2.1 The entrance of medicalization

As before I mentioned that biomedicine was introduced to Tibet by the British in 1904, it was expanded for majority Tibetans by Chinese to start in 1952. Therefore, biomedicine is referred to as “*phyilosman*” (outside medicine) or “*gyasman*” (Chinese medicine). There are four distinct levels of health care facilities

available in Tibet: the prefectural or municipal, the county, the township, and the village levels. Tibet is comprised of seven prefectures, each with varying numbers of counties, townships and villages. Every prefecture has at least one modern hospital, every county has one medical center and over 600 townships have medical stations.

In Lhasa, there are seven government hospitals and one private hospital. Among them, except Mentsikhang (Traditional Tibetan Hospital), all practice the modern medicine. In fact, the modern medicine is combined with Tibetan traditional medicine in Mentsikhang, nowadays. For example: the modern medical technologies for examination, including blood tests, X-ray examinations and electrocardiograms, have been introduced in the Mentsikhang. Most of young generations of Tibetan medical doctors rely on those technologies to diagnosis, nowadays.

4.2.2 The phenomenon of the hospital

Among the eight hospitals, the People's Hospital of TAR has developed into a set of medicine, teaching, research, prevention, emergency, health care as one of the largest comprehensive three A-level hospital in Tibet, marks the most representative of the hospital, the health development, health service scope covers the whole area, taking over one tenth of the medical care among whole Tibet.

Most of the patients who came to consult at the hospital were from the remote areas that are far from Lhasa. Some came to Lhasa on foot and it took over two months to reach Lhasa because they came to pilgrimage in accordance with Tibetan Buddhism. At that time, some people got sick so they had to stay at the people's hospital of TAR. Some patients came to the people's hospital of TAR to seek better and higher care services if they could not get recovery from their local hospitals.

“After the accident, I send my brother to Luoka district hospital to do some examinations by spending 3500.00 RMB. Despite the fact that he cannot be treated in district hospital, I have to transfer him to the People's Hospital of TAR in Lhasa.” (Patient's relative Dundrup)

4.2.3 A mechanic way

The people's hospital was established in 1952. Its hospital's covering area is 16,000sq meters. In order to improve health care services, in 2005 a new surgery

building, garden, and parking were established by investing 1.4 billion RMB in the hospital. In 2012, 6.5 million was invested to build an outpatient building.

There are eighteen clinical departments and three technological departments. The total bed is 650 and total staffs are 1005, including 626 doctors and nurses, yet the shortage of medical practitioners was still a complicated issue. With reference to the departments, a chief of nursing department said to me: “There are not enough nurses in each department, especially in Intensive Care Unit (ICU). Fourteen nurses deal with twelve beds and the ratio is 0.75 between nurse and bed. According to the Ministry of Health, the ratio should be 0.2~0.3.” Also medical doctors had to treat 70 to 80 patients per day in the outpatients. Therefore, in 2012, the outpatients and emergency patients were 477,000 person-time. The admissions were 15111 patients and surgeries were 5498 times. As a result, medical practitioners must do their jobs like robots in order to accomplish their duties.

“You see what are doing every day. We have to fill in many forms that also cannot be incorrect, lots of treatment, driving out relatives and so on. If there is something wrong, the heads of nursing must scold us. Almost every day they come to check all the works and the procedures so that I feel too stress. Recently, patients are put into the ICU. Actually, all patients are not needed to put into ICU.” (Nurse XiaoMing)

There is a general view in Tibet. People believe that some acute diseases can be treated by modern medicine “*Gyasman*” in the people’s hospital and some chronic diseases can be treated by Tibetan medicine “*Bod pa’isman*”. For example, many patients move to Metsikang after doing surgery in the people’s hospital in order to recover from their illness. If they move to Metsikang, they can also reduce their financial burden. On the other hand, if the patient passes away right away, only two options are available to choose to bury the body of the dead person.

4.3 The practice of dying and death in the community

In terms of the practice of dying and death in the community, only two types of ways which are a traditional way and a modern way are discussed in short to grasp

how a traditional is practiced and why a modern way is encouraged to practice in the community.

4.3.1A traditional way

There are five ways of disposing of the dead bodies: water burial, sky burial, fire burial, earth burial, and embalming. In the "water burial," the body is dumped in a lake or river. The "fire burial," or open cremation, is a luxury only the rich can afford or some famous Lama. The "earth burial" is practiced but rare. Embalming and mummifying the body is a practice reserved for revered lamas like DaLai Lama. Sky burial is the main practice in Tibet until now (Tsono, 2001).

According to '*BardoTodrol*' (The Tibetan Book of the Dead) was written to guide the recently deceased through the transition from death to nirvana or rebirth, describes the three *bardos* of death in minute detail and wrote by Padmasambhava who is a kind of deity and great religious teacher from India to instruct the spirit to rebirth (Gielen, 2004). Most lay people hardly recognize the end of the present life and difficult to give up attachment. For example, the relationship with their love ones, the treasure they possess in the present life, and the unfinished job. In addition, the families and relatives' grief make more attachment for the deceased. All of factors cause that the deceased emerge the negative emotion leads to unfavorable rebirth. Hence during the prior to twenty one days, it is important of the "*Pho Wang*" that a lama performs a ritual in order to instruct the deceased on how to interrupt all those attachment to the body (Klass, 1997).

Zegong monastery is one of famous of practicing of sky burial in Tibet. One day the early morning after raining, I followed my one cousin who is knowledgeable about Tibetan Buddhism to arrive Zegong monastery in order to witness sky burial. It was harvest season in Tibet, under the blue sky the land was yellow and snow covered on the top of mountains. As soon as I got off from a car, I saw some boxes or bags on the middle of ground in front of monastery. My cousin told me that they were corpses which would do sky burial this morning. After a while, monks came and sit nearby the corpses.



Figure 4.3 Zegong monastery

They were murmuring and one of them who wear yellow kasaya shouted. My cousin explained they were practicing “*Pho Wang*” ritual for the dead in order to guarantee that every dead obtain the ritual from a Lama. In general, only the high level of monks was able to offering the ritual because it needed special skill. It was believe that the Lama was able to guide the consciousness or spirit separating from the body to go into *Bardo* after the Lama shouted. In fact, the “*Pho Wang*” ritual should practice as soon as possible after death, but there are few Lamas in their area in which people die lead to loss of the opportunity.

“Sometimes it is hard that some relatives require me to allow to do Buddhism rituals for their dead in ICU after some Tibetan patients die. They tell me they must do some rituals for the dead as soon as possible. The ritual is called “PhoWang”, but I am not very much clear about it.”
(Nurse Lhamo)

After the ritual, the corpses were sent by a tractor on the top of mountain that is sky burial ground. I almost took twenty minutes to reach the ground with short

breath. There is a big land around fence, which can obstruct other animals to invade into the ground. A small temple is in front of the Mandala in which the place the monks cut the fleshes and offer the piece of fleches to many vultures. During the cutting, the white smoke billowed from a fire of juniper branches surrounding the ground and monks were murmuring along with families or relatives. The eight corpses were cut and their bones were hammered into dust mixing with barley flour through over one hour. After consume the corpses, the vultures cleaned their peak on the grass and tried to fly away.

“The problem is that he is treated by lots of medicines together with surgery that may make the vultures unable to eat out all his flesh in the sky burial if he dies.” (Patient’s relative Dundrup)

It has been strong belief that if the vultures eat out the whole corps, it means that the spirit pursues reincarnation soon. It was also believed that the practice separates the living from the physical body that housed the now ended incarnation of the spirit(Klass, 1997).

4.3.2 A modern way

The government set up two modern crematoriums in 1999. One is in Lhasa and another is in Chamdo district. Machine is used for the dead body to be cremated. The government encourages all people in Tibet to practice this way because it is thought that the way cremation is a scientific, civilized, and healthy way. Moreover, Tibetans should get rid of the outmoded customs. In addition, the Ministry of Civil Affairs of People’s Republic of China claimed 1.6 thousand people in Tibet died in 2006, only 0.04% practice modern cremation and 85% still practiced sky burial. The other crematorium in Chamdo district was closed because of less population and old costumes(Institution, 2013).It can be said that the culture is tried to be diminished. Getting rid of the culture leads to the ignorance of spiritual care.

4.4 Meanings of dying and death for lay people and health practitioners

Local terminology for death was described to understand different meanings of death in Tibetan language and presented to show the overviews of the empirical data which reflected the meanings and practices of dying and death which portrayed the way of transition to reincarnation.

4.4.1 Local terminology for death

The interviews revealed different types and terms for death in Tibetan language. There are seven different types and terms; namely “*Shi*,” “*De*,” “*Shabari*,” “*Guxing le tebari*,” and “*Cizulbari*”. The meanings of each term are important to described in brief.

1. “*Shi*” means useless. All deaths for all living organisms like trees, human beings, and animals are locally called shi. They are destroyed and useless after they died. If shi is used for human beings, this word is very rude so that in general, this term is avoided using for the death of human beings.

2. “*De*” means exhaust or previous time. It is normally used in writing as well as in expressing respect. The meaning is same with “*Shabari*” “*Gong bazulbari*”, but they can be used to show respect to the dead and their families.

3. “*Guxing le tebari*” means liberation to paradise; The word only applies to Lama, the teacher of spirituality, who does not go into the cycle of life and can liberate from the suffering to paradise after the Lama die.

4. “*Cizulbari*” means the lifespan exhaust; “*Ci*” means lifespan. Normally, an astrologist is consulted to calculate the lifespan of the dead person. If it shows a person’s lifespan ends, anyone cannot drag the person from death even a medical practitioners.

4.4.2 The way of transition

Tibetans realized death was an inevitable issue, but death is not over. Tibetans pursue birth, death and rebirth based on their Karma and the emotion of moment of death. They believe that death is an end of their Karma or end of their lifespan in this life, but they can pursue their next lives through the process of dying

and death. Based on Karma, they accumulate for the next life. The dying and death is a process that the consciousness or spirit goes into the bardo after separating from the body. The death text “BardoTodrol” guides the consciousness to pursuing rebirth or liberation in the bardo.

“agn ma Kaqie, tan de lu le du; Qi ma kayong, Tan de sym le du.” It means if you want to know what he did in his last life, you can see what his result in his body now; If you want to know what he will have in his next life, you can see his mind now.”(Monk Tsering)

Tibetan Buddhism states the dying and death that the physical body is composed of four elements such as earth, water, fire, and air, that the elements dissolve one by one into each other until the final dissolution of air, and the dead’s consciousness or spirit locally called “*Nam shes*”, which starts to separate from the body to travel into bardo, which is a period between death and rebirth(Gielen, 2004). After the dissolution of the basic elements, the outer signs are a complete loss of all physical abilities, loss of a sense of purpose, a change of the color of the tongue from pink to gray, and a loss of the ability to the taste(Powers, 1995c).

4.4.3 Bardo

Bardo is a journey after death or a stage of the dying process. There are three luminal stages in the journey of bardo: (a) the moment of dying, (b) the bardo of reality, and (c) the seeking of rebirth. A monk or Lama chants the ‘*BardoTodrol*’ in order to tell the deceased what is happening to them and instruct them to deal with the journeys to liberation or reincarnation. As a result, peaceful death is vital.

“I believe there are spirits, so I allow them to do rituals for their spirits. At the moment of death, it is important to pray and chant the Bodhisattva’s scripture (BardoThodol) in order to obtain peaceful death.” (Physician Tashi)

The first bardo of death is the moment of dying. In this moment, all of one’s senses and elements dissolve, and one’s true nature as mind-only emerges. If the deceased recognizes his or her true nature, then he or she will be immediately liberated from rebirth and will attain nirvana; if one’s true nature is not recognized, then the deceased will enter the second bardo of death, the bardo of reality. If the deceased did

not prepare themselves for death through meditation during their lifetime, then he or she will pass this stage and proceed directly to the seeking of rebirth. In the bardo of reality, the deceased is transfigured into a body of light and then encounters numerous terrifying deities and apparitions. If these frightening sights are recognized as merely projections of one's own mind, then the deceased will attain liberation from the wheel of rebirth. But if the deceased cannot control their fear and does not recognize these apparitions as merely their own mind, then they will pass into the final bardo of death, the seeking of rebirth, Tibetan Buddhism teaches that most people wake up in this bardo after death. Upon awakening, the deceased will not realize that they are dead and will try to communicate with their families. Yet, they cannot be seen or heard by the living. Frustrated by their inability to communicate to loved ones, the deceased may cling to their families for weeks; this stage could last up to 49 days. During the first 21 days of this process, the deceased can be guided by their families' prayers, so the *Bardo Thodol* (Tibetan Book of the Dead) is read to them in the hopes that it will facilitate a favorable rebirth. In addition, the deceased experiences a life review in which he or she feels all of the pain or joy that they caused others during their life. After all these things have taken place, the deceased will finally feel a strong attraction to one of the six realms of rebirth into which he or she will be reborn.

Tibetan Buddhism indicates that the dying and death is a process searching reincarnation or liberation rather than a unitary event. Thus, the belief and practice are rooted into Tibet culture and society. The health practitioners who did not believe in Tibetan Buddhism or who believe Tibetan Buddhism have different perspectives on beliefs and practices.

4.4.4 Health practitioners

Dying is the terminal illnesses and failure of organs. Biomedicine fight for dying in order to keep the function of organs regularly. In the place of the influence of biomedicine, doctors diagnose and treat patients' organs by technologies and medicines which are normal and common. The condition of dying or death depends on technology.

“Some patients’ illness is too serious to survive, even though we treat them very well by great skills and advanced technologies.”(Nurse Xiao Ming)

It is supposed that the main reason of the death of the patient is as a result of the failure of the physician because lack of the skills of treatment makes the patient die. In reality, health practitioners only focus on the strategies of the battle against death, prolonging the act of dying rather than renewing useful life (Jalland, 2006). All practitioners thought that the advance technology and medical skill are the most significant factor for the terminal patients.

” Sometimes I think young patients should not die at the hospital. When we fail to rescue them, I feel my medical skills are not good enough.” (Nurse Xiao Ming)

“The medical treatment should be given as soon as possible and correct treatment to save their lives.” (Surgeon Tendzin)

For biomedicine, death is ceasing of respiration and blood circulation, stopping of function of organs, and ‘flatline’ on the EEG. The diagnosis of death by western medical practitioners who hold a ‘flatline’ on the electroencephalograph (EEG) that means cessation of heart beat and brain activity (Tsomo, 2001).

“I am not afraid of the dead. I think he or she is still human being. The differences are that his or her respiration and blood circulation stop.” (Nurse Lhamo)

As a result of using modern technology, human beings are passive. All of the decisions are from technology in order to show the result. Technology never considers how human beings think and feel. It also violates human ethics and religious teaching on death.

“I can do nothing after the ECG shows a “flatline.” As a doctor, I tried my best to rescue patients with my whole knowledge and skill. However, after they die, I cannot do anything.” (Physician Tashi)

4.5 Case studies

Among the informants, only three case studies were presented to show the overviews of the empirical data which reflected the meanings and practices of dying and death. In other words, lay Tibetans perceive the dying and death to a special way

based on Tibetan Buddhism. Case one and two portrayed the suffering from mechanical treatment and the negligence of cultural beliefs and practices under modern health care system. Case three about the life of a medical doctor reflected the importance of cultural beliefs and practices in a modern hospital after being suffered from breast cancer. The detail of lay Tibetans' beliefs and health practitioners' practices show the following cases:

4.5.1 Case 1

Dekyi is 54 years old, a mother of three children and semiliterate farmer. She said: *"I get illness over a year. I go to see some medical doctors who work in local private clinics or government hospitals many times. My initial symptom just is stomachache, but all doctors who I meet cannot give me a clear diagnosis and cannot cure my health problem. At the same time, I consult an astrologer who tells me that my "La" (spirit or life force) lead to sickness. In order to release me from the spirit or life force, I do rituals. Around one year, I obtain my diagnosis that I get gallstone and liver abscess in the people's hospital of TAR. However, there is no bed for me in the hospital because I have no connection with any health practitioners who can help me be able to get the bed. Fortunately, one unfamiliar and sympathetic person helps me to get a bed in surgery department. My family does many Buddhism rituals in the monasteries in order to succeed in my surgery. After my surgery, doctors send me into a scare house, which is called ICU. There is a big tube (respiratory machine) in my mouth when I am sent into ICU. For that reason, I cannot speak. After several minutes, I feel too hard to breathe because the tube presses me. When my son and daughter come to 'watch' me for a short time, I try to wave my hands to let them know my problem, even though my hands are tied. Nevertheless, my children cannot understand me. I have to try myself to lose a tie on my hand and move the tube after several minutes. And then I can breathe very well. I almost die. I feel that if it was not moved, I would die. That day is a terrible day in my life because there is no family who can stay with me. Also a patient who is nearby my bed is*

moaning the whole night. All machines around me are noisy. I struggle to think that when I can leave from this room, my illness might be too severe, and I will die in this room instead of sleeping within the whole night. Actually, I am not afraid of death. Death is an end of my “Lye” (karma) with my family in this life. I always go to temple to worship Buddha for helping me to reincarnate in a good place (realm) instead of becoming an animal or a hungry ghost. I believe that I accumulate a negative karma from my last life. In the present life, I try to do good things in order to reduce my negative karma and accumulate positive karma for my next life. No matter how I try to do good things, I want to die at home if I die. In my village, there is a tradition that people had better die their home because the death cannot move to other place through many doors. If the death moves and through many doors, the spirit is not able to find its path to rebirth leading to become a ghost. On the other hand, I really do not want to make a big burden for my children. We have not enough land because my all three children who were born after land division (1980). I just can do some household work after I get illness. Though my family can rely on our land and domestic animals can survive, I have to pay for my medical treatment by extra money. It is huge money for me that I pay 60,000RMB, which not include examinations and treatment before I stay in the hospital, for the people’s hospital of TAR. But the government medical insurance returns to me only 15,000 RMB. All those expenses are dependent on my son who tries to earn money from out land work.”

4.5.2 Case 2

Dundrup is a 41 year old and uneducated Tibetan farmer. He lives in Luoka which is one of the districts of Tibet and far from Lhasa about 180 Km. He is taking care of his younger brother who gets accident. He fell down from a five meter height building in ICU of the hospital.

Dundrup said: *“After the accident, I send my brother to Luoka district hospital to do some examinations by spending 3500.00 RMB, because he cannot be treated in district hospital. As the failure of*

the treatment, I have to transfer him to the People's Hospital of TAR in Lhasa.

I pay 1750.00 RMB for an ambulance of the district hospital. When my brother enters the ward of the people's hospital, I pay 5000.00 Yuan for deposit, and then he is operated for his pancreas at the first day. After his surgery, his surgeon puts him into ICU. On the second day, I am informed to add 9000.00 Yuan. Up to now, I have paid over 70000.00 Yuan for hospital. The cost of hospitalization includes bed, nursing, medicines, all kinds of treatments of technologies, examinations, paper nappy, tissue, and some miscellaneous things."

"As we cannot afford to pay for all, I borrow money from my relatives and friends who worry about that I will not able to return their money. We do not have much money because we have a few animals and a small land that are just enough for survival. My brother has two children who are attending primary school and his wife's parents who live with them. If we need money, we have to go outside to work when we are free from our land work. We have to work 11 hours for 60 RMB per day. I bring blankets, quilts, and some pots to stay in the hospital. I have no money to stay in a hotel. At night, I sleep on the floor in the hospital, even though the temperature is -10 C~ -4 C."

"I tried to find a connection with the persons who can help me easily enter the hospital and reduce our financial burden. Finally, I find that my brother's son has a classmate with a son of relative of nurse who works in this hospital. She helps me to reduce some payments that are unnecessary examination or treatment."

"When I sent my brother to here, the doctors and nurses told us how dangerous and serious my brother's condition is. I had to give my signature for each thing such as the allergy of narcotic, the accident surgery, and the agreement of staying in ICU. During that time, I have stress for making a decision. If I give up doing anything for him, I will regret in the future. Finally, I try to make a good decision as soon as I can. On the other hand, I think I spend such a plenty of money if I cannot

obtain anything. How should I do? I still try to hold a hope because I do not want to happen the bad thing to him (He does not want to say “die”). It is true that the doctor push all responsibilities to us. The doctors do not take any responsibility whether the patient has any problem. After my brother is sent into surgery department, until the second day afternoon I see him in ICU. The nurse in ICU tells me that I cannot stay in ICU. Each day I just can meet him with half-hour. Actually, other time I should stay in a room located in another building that is behind the building of ICU. When some nurses or doctors call me to come, I have to arrive at outside of the door of ICU within ten minutes. Therefore, I have to stay in the room or around this building. One night, I am so worried so I then sleep outside of the door of ICU. Once a nurse or doctor calls me, I am so upset and run from first floor to fifth floor. One day I receive a call and run to the door of ICU within one breath, yet they call me to add the deposit. Once a doctor who is a Chinese explains the condition of patients, I cannot understand him because of the language. During that time, I cannot sleep and have no taste to eat food. Because I cannot leave far from the hospital, I have to give a little money to other patients’ relatives who can help me bring it to a temple as an offering. After several days, I see that he gets better and can speak. At the same time, I also feel better. And then I leave from the hospital for a short time to go around Potala palace to pray for my brother. Sometimes I watch some persons who do exercise in the morning, so I feel much better.”

“I feel very difficult because this is the first time I come to Lhasa; I am not educated and just know a little Tibetan, I have no relatives in here, and I cannot speak Chinese. That night after checking, the doctor tell me about my brother’s condition which is so bad and had to do surgery if I agree. There was nobody whom I can ask how to make a decision at that night. I felt very hard to make a decision so I rejected to do surgery. I am full of anxiety until the next early morning. In the morning, I called my relatives to ask an astrologer who lives in our village how I should do and whether he can survive or not. The astrologer tells me

that surgery should be done to be able to survive his life, but his illness will take long time and his family should be patient. Therefore, I quickly tell the doctor that I agree to do surgery for my brother. All doctors who I contact during that time told me that my brother's condition is too serious, so no one can promise that he can be rescued. After I sent my brother into surgery department with full of my signatures, I call two sons of my brother-in-law's sister who lives Nyingtri district which is far from Lhasa 403 Km and drives their car to come here. I have to prepare for his death. If he dies, they can help me to take his body to send to the Zegong monastery by their car for sky burial. I also prepare most of stuffs for his funeral ritual. The problem is that he is treated by lots of medicines and also done surgery that may cause that vultures cannot eat out all his flesh in the sky burial if he dies. I am his elder brother and normally I do most of decision in our family. I cannot accept the bad thing happening to him because he is very young. But if it happens to him, I think if he dies, I feel very sad. I and his family ignored this and did not do any ritual to protect him before. Although his surgeon told me that his surgery is okay, he still stayed under serious condition. Therefore, I did not let the two sons leave from me. Therefore, they have to stay with us until my brother gets better."

In Tibet, there is a belief that the bad luck can happen to a person whose age is twelfth. Tibetans calculate the first year for age during a mother's pregnancy. The calculation of the age is as follows. The age of bad luck is 13,25,37,49,61.... The number has the meaning whether bad luck can happen or not.

4.5.3 Case 3

Nyiman was born in 1974, LuoKa which is far from central city Lhasa. She is a native Tibetan. Her parents are farmers from Luoka district. In 1985 she was sent to LiaoNing province of China to study in middle school. After three months, she had to come back to LuoKa district her hometown because of her illness. However, she resumed her studies in her hometown. After graduating middle school, she studied clinical medicine in West of China medical University In Sichuan province of China between 1992 and

1997. After she graduated, she came to Lhasa and got a job in People's hospital in Tibet. Now She lives with her husband and her son who is 10 years old in their own house. She is still working in the hospital as a resident doctor.

She is so busy with her job in her daily life. She has to do night shift in the hospital and usually works seventy hours every week. Except of her job, she needs to cook and take care of her son and husband who is an editor in Tibetan achives. In fact, her husband is busier than her. He has no time taking care of their only son. Sometimes, if she and her husband had vacation at the same time, they went to their hometown to visit their parents who live in Cuouw away from Lhasa 1942 Km.

She said "Normally, if I has free time, I visit temples because I believe Tibetan Buddhism. Luckily, my husband understands Tibetan Buddhism and believes it too. He always explains to me when we have free time so that I understand basic teaching of karma in Tibetan Buddhism.

I have got breast cancel for three months. Providing that my illness is too serious, it can be cured I think. I can accept my all treatments in the hospital until now. Many different technologies including CT, type-B ultrasound, pathology were used to check and treat my health problems. Every person who is a nurse or doctor has tried their best to help me to treat my illness in this hospital because I am a physician in this hospital as well. If I go to other hospitals, I will have no such special conditions.

I believe I get retribution from my karma. I fed my son only seven days after giving a birth to him and also I did not try my best, so nowadays I get sick. I knew it was important that mothers should feed their children, but I did not do it. Although it may relate with inheritance, since my grandmother also got the problem with her breast that my mother told me. However, I cannot tell this idea to my husband because my husband told me that I should feed our son at that time.

After my operation and during my chemical treatment, a monitor ECG was used. I saw some abnormal but no one did observe the

monitor. I knew my situation. The head of department told me about my sickness because of being a doctor.

In terms of beliefs, I know some Tibetan idioms and Buddhism beliefs. I always remember the saying of the elder people, 'if you are living, you have to die.' I believe that if a young person dies, this life is the rest of his last life. In other words, his life is too short. I always tell my patients who are young like him. After I knew I got cancer, in general I cannot accept it.

I did not want to do chemical treatment, even though I did not fear to do surgery. I felt too bad for this treatment. I saw many patients who became weak after this treatment. Also I was worried I might have pain and had to keep in the bed, and then I would not be able to do anything. If I die, my husband would search a new wife. The owner of our house is my husband, so I was worried about my son who would not get this house.

I was not afraid of surgery, but I was really scared that I would have no hair due to the chemical treatment. I did not want to live without hair. If other people look at me, they will know my serious illness like breast cancer. They would look down on me because I cannot do anything in this society. Another reason is that I felt difficult to tell men about my illness because breast is a female organ. I think general people always think that if female's organs get illnesses, it is related to sexually transmitted diseases. Therefore, I felt too bad.

After my colleagues and leader explained and encouraged me to accept the only option that I could choose, I did make my decision to use chemical treatment. Even though I did this decision, I felt not comfortable until now.

In reality, I am satisfied with the hospital care. I felt I still worked in hospital but not as a patient. If my colleagues come to me and tell something about my department, I feel much better and can reduce discomfort from my body during my chemical treatment. I have to do six times for chemical treatment. I have finished three times at present.

When I did the treatment, I felt fatigue and painful on my whole body. Those syndromes existed around two weeks after each treatment.

I want to stay with my child when I get illness. If I die, I want to be alone because I do not want to make my family sad. Especially, my mother is very old. She is not strong enough.

The religious rituals are an importance of reducing our feelings when people get illness. I do rituals if I need without disturbing all treatments from hospital. I can do rituals in my house or temples because I know those things that are not allowed to do in the hospital. I would not make nurses and doctors difficult because I work in the hospital. I know the rules of the hospital.

I think it is very important to say good-bye to my family because this is the final opportunity to leave some words to them. As a patient, I have been suffering from cancer, including both body and mind. I can understand and know how much pain and sorrow I undergo. I think every decision should be told to the patients. On the other hand, the health workers should listen to the patients' requirements when they are conscious. When the patients are about to die, they prefer some places rather than in the hospital.

For me, I want to die at home. If nothing is useful for my illness, why I should accept those terminal treatments in the hospital is clear. As a doctor, I experienced that an elder patient required his children to take him to go home many times when he was dying, but his children did not do it until he died in the hospital. I felt very sad for the elder patient because no one cared about his final requirement when he had no longer had power to manage his life."

4.6 The expectation of dying and death

Shortly after they realize that they are dying, the patients and the relatives prepare and determine for the quality of reincarnation. Therefore, death at home and

decision-making which are the final expectations for liberation or next life are in general discussed.

4.6.1 Death at home

Tibetans generally believe that they must die at home rather than at the hospital because home is the place of their whole life to live, to eat, and to die. Hospital is just a place of treatment when they get sick. Once they are sure that they could not get recovery from their illnesses, they ask permission from the medical doctors to leave from the hospital to their home. The reasons they prefer to die at homes are almost all the same.

It is a critical period for determining the quality of the rebirth. If the body is interfered in any way following death, the spirit may be prematurely ejected and begin wandering about in a confused manner, unable to locate the path to its next body. It determines realms in which the spirit rebirth is. And the emotional atmosphere surrounding him also is vital at the vital moment. Hence, Tibetans believe it is better to die at home without interference at the moment of death.

“I want to die at home. In my village it is said that people had better die at their home because the dead cannot move to other place through many door. If the dead moves through many doors, the spirit will fail to find its path to rebirth.”(Patient Dekyi)

Buddhism holds to the idea of multiple lifetimes. In this view, one has had innumerable past lifetimes and faces innumerable future existences until the process is ended by enlightenment. It is a critical period that is a death journey for Tibetan Buddhists. The spirit pursues the favorite rebirth. It is called the wheel of life or the cyclic existence for sentient beings which include six realms such as Hell realm, hungry ghost realm, animal realm, human realm, demi-god realm, and god realm. The realms exist not only on this earth's sphere but also in other world systems throughout the universe. Of all the realms of existence, the most beneficial form is that of the human being. The three lower realms of existence--"hell being," hungry ghosts, animals-- are associated with intense suffering and decreased mental capabilities. The divine realms--demi-gods (asuras), gods--are felt to be disadvantageous on the basis of their being associated with such pleasantness that there is no impetus to spiritual

development. Thus, it is felt that a human rebirth is the most beneficial. However, its attainment is felt to be most difficult (Lecso, 1986). The realm of rebirth depends on karma which is one's accumulation on previous life and the emotional atmosphere surrounding one's at the vital moment.



Figure 4.4 Wheel of life

“It is the time or the moment of dying and death that we should not disturb according to the “Bardo thodol”. At the moment of death is in unconscious of his mind. If it is disturbed, the mind will emerge “Nyeba” anger and leave from body through a bad way lead to rebirth in a bad place such as hungry ghost or hell domain. One of very important ritual a Lama always do at the moment of death, that is the Lama performs the “Pho Wang” to the dead in order to instructing the dead on how to break attachment to the body and help the mind leave from the body through the top of head of the dead.” (Monk Tsering)

At the moment of death, the dead's love one and specialists of Tibetan Buddhist create the positive atmosphere in order to remain calm during the stage of the

dying process. It is vital for determining the quality of the rebirth. If the body is disturbed in any way following death, the spirit may be prematurely ejected and begin wandering about in a confused manner, unable to locate the path to its next body.

“I think all Tibetans prefer to die at their home. Most of the Tibetans believe when a person dies, it is important not to interfere their body in the moment of death. If the moment of death is disturbed, the dead’s spirit would go to some bad places. Moreover, the dead’s spirit would be difficult to reincarnation. In the hospital, doctors and nurses use many machines or tools to rescue the dying, and then the action of move or press cannot be avoided at the moment of death.” (Physician Tashi)

The specialists offer the ‘Pho Wang’ ritual to the dying in order to guide that the spiritualities release from the corpse without attachment and pursue liberation or rebirth. Liberation in nirvana is the goal of many lay people. Indeed, some people offer prayers or erect sacred monuments to assist their loved ones in reaching this nirvana. That liberation can more easily attain an awakened state of mind, and thereby release them from the cycle of suffering characterized by endless births, deaths, and rebirths to achieving enlightenment.

The health practitioners also confirmed that all Tibetan patients preferred to die at home rather than at the hospital due to their traditional beliefs. Almost all doctors did not know why they wanted to die at home except a physician who is devoted to Tibetan Buddhism. They just thought that the Tibetan people were completely influenced by cultural belief and practice until now.

“I know some ethnic customs that they cannot die outside of their home, but I do not know the reasons. I see some patients’ children who do not want their parents to sustain from some treatments in the hospital because some treatments are impaired. Therefore, they cannot bear.”(NurseXiao Ming)

4.6.2 Decision-making

Making decision when an urgent and important issue happens to the patients is extremely vital to be able to do what they really want to do for their present life. Patients thought that the decision should be informed by their families and

doctors. Furthermore, the relatives and the doctors should listen to the patients' requirements. When they were conscious, they suffered both including body and mind. And they understood and knew how much pain and sorrow they underwent.

On the other hand, the health practitioners and the families have completely different views on the patients who are serious and undergo treatments.

“All decisions upon the patients must be made by the families or relatives. As a doctor, I normally give them information about the conditions of the patients. Whether I should tell the patients or not, all depend on families.”(Surgeon Tendzin)

However, the patients expected that the health practitioners told them about what condition or illness they had in order to make a better decision or earlier decision by them and their families. For example, the patient Dekyi preferred to prepare for her next life rather than pay more money for her useless treatment in the hospital. In reality, almost all decisions were made by families or relatives especially for the dying. The patient Nyima was interviewed that she emphasized every decision that should be told to the dying and accept the patient's requirement because she underwent the suffering that she had never experienced before as a physician.

“As a doctor, I experienced that an elder patient required his children to take him to go home many times when he was dying, but his children did not do it until he died in the hospital. I felt very sad for the elder patient because no one cared about his final requirement when he had no longer had power to manage his life.”(Patient Nyima).

On the other hand, the monk had a different view. He thought it depends on who a patient was.

“If the patients do not understand Buddhism, you had better not tell them the truth that they get serious disease or will die. Otherwise, you will make double suffering to them including physics and mind.”(Monk Tsering)

4.7 Sensitivity of belief of dying and death

Mechanic intervention of dying, poor quality of care, prohibition of spiritual care, and superstition in the view of health practitioners are described particularly to illustrate the system of modern hospital with respect of dying and death.

4.7.1 Mechanic intervention of dying

There is only one emergency center around Tibet located in the people's hospital of TAR. Whenever the people have emergency cases such as accidents or any kinds of problems, they can contact its emergency center that opens twenty four hours through telephone. It serves for all that need help as possible as it can to pick up by an ambulance and to send them to the hospital.

There were few ECG monitors and ICU in each department before 2000. Patients who are severe or dying were arranged for their beds in the wards which were very close to nursing stations in order to monitor by nurses. Nurses check vital sign including temperature, pulse, respiration, blood pressure, and consciousness frequently and note down the number they get in the case history. If the patients' illnesses are more severe and serious, more treatments and examinations are done.

Nurses prepare for rescuing anytime and place a rescue cart nearby the patients. In the cart, there are significant medicines for supporting a vital sign. After 2000, the several ECG monitors set up in the ICU of some departments for severe patients in order to gain the quality of services. Once the vital sign of patients are abnormal, the rescue process is launched such as Cardio Pulmonary Resuscitation (CPR), and defibrillation to save their lives. At the critical time, doctors inform the patients' families about what happens to the patients. If their families reject to rescue their patients, they have to give their signatures to doctors.

“Prolong life treatments waste plenty of resources in ICU to keep and save the life of the dying. In fact, the procedures and treatments are useless.”

(Surgeon Tendzin)

4.7.2 Poor quality of care in ICU

There are twelve patients in ICU. Most of whom are unconscious with respiratory machines so that they all are under ECG monitors. Doctors and nurses are so

busy noting what they observe and treat to the patients. Some of them are given treatment. For the nursing, the huge paperwork moves the nurses from the nearby patient's bed to the table. Most of patients are controlled on the each bed with belts on their ankles and wrists.

“If they are not controlled, they will remove their tubes on their bodies and Intravenous infusion.” (NurseLhamo)

“As soon as I entered ICU, I saw my mother who was tied on the bed and the plastic tube which was in her month. In addition, many different colors were shown in the screen nearby my mother. I felt horrible. I could not speak out any words. I felt my throat was blocked by something. I just stood in front of my mother's bed with two or three minutes and rushed to outside of ICU. My sister had same feeling like me. The situation of ICU looked like some American movies that some people who are wearing uniform and do some tests on human body. At that time, I thought my mother would die in ICU because of the severity of her illness.” (Patient's relative Pubu)

In ICU, it is a main aim that medical practitioners must keep the lower bacterial environment for patients staying in prone to infectious conditions. Nurses check the level of bacterial in air and on every item. If there are many persons in ICU, the level is higher and easier to lead to infection to patients who are under serious condition. Therefore, before sending patients into ICU, the medical practitioners must tell the patients' relatives or family that they are only allowed to meet their patients for half hour per day. Additionally, despite the fact that the cost of nursing and treatment are very expensive, the family or relative have to accept all kinds of treatment or nursing and give their signatures in order to take their responsibility. In other words, the family or relatives have to agree on all rules before sending their patient into ICU.

“I did everything that a surgeon required. The requirements are to buy some stuff outside of the hospital. Lots of signatures are required to give in the hospital in order to take my responsibility to my mother.” (Patient's relative Pubu)

It is said that it has reduced many medical disputes since the ICU was built. In the past, there are many medical disputes in surgery departments before the ICU was built. When doctors and nurses operated rescue in their departments, there were many problems they had to struggle. For example, the space of ward is too small, many items put in the ward including pots, bowls, blankets and so on. The relatives were full of the ward when medical practitioners rescued a patient. In addition, after surgery, they could not do very well with nursing because of poor condition that was less qualified equipment and professional skills of nurses. When a patient is dying, doctors and nurses rescue with some equipment and medicines. At the same time, they call his relative and warn his situation, but the relatives are not allowed to go into ICU because of avoiding the interference of the patient's treatments. If the rescue succeeds, his relative is allowed to see him for a short time. Unfortunately, if he dies, his relative is informed the situation of the patient who has already died.

“If a doctor or nurse has to use some impair treatments in order to rescue the life of the dying, the relatives do not allowed health practitioners to adopt those treatments that lead to failure of rescues. Thus ICU is useful for some patients who are in serious condition and can be treated. In ICU, relatives cannot disturb the treatments because the relatives are not allowed to stay in ICU. Therefore, some impair treatments cannot be questioned by relatives.” (Surgeon Tendzin)

Even though nursing and treatment are provided for the patients in the view of health practitioners, the patients, in contrast, believe that the nursing and treatments only focus on the patients' physical being rather than holistic being.

“After my surgery, doctors send me into a scare house called ICU. There is a big tube (respiratory machine) in my mouth when sent into ICU, so I cannot speak. After several minutes, I feel too hard to breathe because the tube presses me. When my son and daughter come to 'watch' me for a short time, I try to wave my hands to let them know my problem, even though my hands are tied. Nevertheless, my children cannot understand me. I have to try myself to lose a tie on my hand and move the tube after several minutes. And then I can breathe very well. I almost die if it is not moved. That day is a terrible day in my life. There is no family who can

stay with me. Also a patient who is near my bed is moaning the whole night. Furthermore, all machines around me are noisy.” (Patient Dekyi)

The final service in the hospital can do if some patients’ families require to send their dying patients to home before they die by a little payment. There is almost nothing to do for death in the hospital. It is a place that the dead can be put in a morgue of hospital after a patient dies. It costs \$85 per day. However, this service offers to the dead who are non-Tibetans. Tibetans do not keep the deceased in the hospital in general. If Tibetans die, their families must take the dead to their house as soon as possible to start to do their Buddhism rituals.

“Normally, their families take the dying to leave from the hospital when their illnesses are very serious. Among them, almost all are Tibetan.”
(Nurse Xiao Ming)

4.7.3 Prohibition of spiritual care

On the other hand, biomedicine represents a science in Tibet. People who are devoted to Tibetan Buddhism consider that religion is contrary with biomedicine. There is no space to practice and talk about religions and belief in the hospital. Thus, the way they practice their beliefs in the hospital was covert. According to my interview, all health practitioners state that they respected patient’s customs or belief and allowed patients or relatives to do some rituals under the rules and regulation of hospital. However, in my observation, the belief and practice were totally converted and ignored by health care system.

“I think they were different between Tibetan’s custom and Chinese medicine (biomedicine), so the hospital did not allow us to do some religious rituals. Therefore, she has never asked a doctor or nurse about those things.”(PatientDekyi)

“It was hard that some relatives required me to do Buddhism rituals for their dead in ICU. They told me that they had to do some rituals for the dead as soon as possible. They called the ritual “PhoWang”, but I was not very clear. At that situation, I could not reject their desire. Therefore, I felt very nerves and watched whether some leaders came or not, so they made an attempt to do and finish it within ten minutes. If a

leader of the hospital knew it, the leaders would not only scold me, but also thought that my view was wrong.” (Nurse Lhamo)

“I can do rituals in my house or temples because I know those things that are not allowed to do in the hospital. I would not make nurses and doctors difficult because I work in the hospital. I know the rules of the hospital.” (Patient Nyima)

The lay people knew that the practices of religious rituals were forbidden in medical areas, but they still tried to do it secretly. One day, during my observation, I saw a patient who was sent to general ward from ICU. Normally, the doors of ward are never locked even at night. When I went into his ward, which was the biggest ward in the surgery department which has ten beds, I saw that all patients silently looked at a person. He was murmuring, holding a scripture which was wrapped by a yellow cloth, and spreading barley on the patients' body. I realized that he was launching Tibetan Buddhism ritual for patients. I asked a relative with my low sound who he was and what he did. He replied that he was a Lama from Nagchu district and did rituals for the patients in order to recover quickly and be cured. However, the Lama did not wear his kasaya. The rituals for all ten patients just took several minutes before he hurriedly left from the ward in order to avoid to be seen by health practitioners.

4.7.4 Superstition in the view of health practitioners

Dying and death in hospital are culturally sensitive. However, there were two types of people. The first groups were the lay people who need to perform rituals and religious practices. In general, before coming to consult at the hospital, they practiced all religious performance instructed by the specialists of religion. Their instructions included the choices of treatment whether the patients should go to hospital or to perform religious practices such as reading the scripture of the Buddhist book to get recovery from their sickness. To release the animals bought in the shops and not to kill the animals to reduce their negative Karma. For some patients who were more serious, they directly went to the hospital soon after they met the monks.

As known, all the health practitioners were medically well trained so that they were completely influenced by the way of biomedicine. As a result, they did not consider about other treatments and ritual practices except medical treatments when

the patients came to the hospital. All of the treatments upon patients were relied on the hands of the health practitioners. They practiced only one way in accordance with the machines used for treatments. The technologies were used to get the evidence of the diseases of the patients. Other practices were totally denied. They themselves thought that they were very systematic and scientific.

“As a scientific doctor, I speak out my words to the patients and relatives that cannot relate to some religions or beliefs. Biomedicine is scientific but religion is just nothing for treatment.”(Surgeon Tendzin)

On the other hand, health practitioners stated that they valued and respected the customs and the religion of the patients. However, they did not follow and practices religious activities upon the patients. The words and the deeds were totally different.

“I never see the spirit so that I cannot believe in it. One day when I was working in ICU of my department, an old man’s illness got worse and his wife fed the “holy” water to him and was praying for him, but she did not tell me about his husband’s situation. I found this situation and felt very angry, because the time was very important to rescue the patient. I thought if she knew his situation at that time, I could rescue him. In fact, the holy water cannot rescue his life.”(Nurse Xiao Ming)

CHAPTER V

CONCLUSION, DISCUSSION AND RECOMMENDATIONS

This particular section mainly focus on conclusion, discussion and recommenations. Conclusion consists of the aim and methodology of the research and the findings which are the meanings of dying and death among lay Tibetans and health practitioners in a modern hospital. Themeaningand practice of dying and death, ignorance of cultural beliefs and the gaps are described in discussion section between lay Tibetans and health practitioners in brief. In this part, the study of limitation and recommendations are also presented. The orientation of religious beliefs and culture should be put into the medical training for the medical practitioners in the modern hospital in order to achieve holistic health care.

5.1 Conclusion

The aim of the research was to explore the cultural meaning, expectation, practice, and cultural sensitivity of dying and death inmodernhospital. The study based on qualitative method consisted of in-depth interview, observation and secondary resources. There are nine informants including patients, relatives, health practitoners and monk. This research was conducted in the people's hospital of Tibet Autonomous Region in Lhasa, the capital of Tibet.

In this research, the perception of lay Tibetans who are patients and relatives in the modern hospital showed clearly the influence of Tibetan culture and beliefswhichare deeply rooted in Tibetan Buddhism. The meanings of dying and death are impermanent life, preparedness for rebirth, spiritual transition for reincarnation, and liberation from all sufferings. In the present life, Karma is the most important factor to predict the next life because all results of the actions rely on Karma. In order toachieve their goals, the special rituals must be done for the success for the whole process.

Tibetan people who are devoted to Tibetan Buddhism and Tibetans on the meanings of dying and death in hospital have a significant belief on dying and death. It is believed that death is a process of transmission to next life within forty-nine days after their present life ends. In order to transmit their next life, the monks recite the *Bardo* text, which guides the ways of next life. Because of this solid and strong faith in transition to a good realm, providing they are afraid to encounter death in their present life, they have well prepared to face death. In other words, they are not too much afraid to face death because they are sure where their spirits go after they die. This well-preparedness makes them able to overcome their fear of death. For example, the painting of the cyclic existence for sentient beings was painted on the wall of monasteries or temples in Tibet. It instructs lay Tibetans to choose and to pursue the realm by well-preparedness during the present life.

Dying and death in Tibet have its unique meanings. Tibetan culture and Tibetan Buddhism are inseparable with respect to the belief and practice of death. They understand that death is just normal and simple because everybody on earth has to die one day. However, they will reincarnate soon after their present life ends. Death is also considered a opportunity of the end of suffering. Tibetans live in the present and impermanent life for achieving the liberation from all suffering or enlightenment. For instance, it is a strong belief that the natural mind emerges if the dead can recognize at the moment of death, leading to liberate from the cyclic existence.

Lay Tibetans voluntarily prefer to die at their own home rather than at the hospital because before they are about to die, they have to do the ritual locally called "*Pho Wang*" which smoothly leads them to be able to separate the spirit from the body. The practice of "*Pho Wang*" before they die is extremely important to accept their present condition with reference to death. The separation between the body and the spirit helps them easily allow their life to go into reincarnation. At hospital, they are not allowed to practice the rituals though the rituals are required and desired by the patients. At the moment of death, interference must be avoided because it could make the dead confuse and lose the path when they head to *Bardo* state in which they stay prior to reincarnation. Thus, the ignorance of spiritual care in the hospital could make them more sufferings for their present life.

On the contrary, the medical practitioners' beliefs and practices are constructed by biomedicine. It is believed that the meanings of dying and death are terminal illness, the failure and ceased function of organs. Due to the different constructions between them, unmatched expectation and ignorance of spiritual care emerge when medical practitioners provide intervention in the hospital. In short, the result shows that all decisions with respect to the meanings of dying and death are completely dependent on advanced technology.

The practitioners stated that they paid respect to the patients' desire to practice the rituals in the hospital. Almost all patients have a full desire to do the rituals that help them recover from their sufferings. In fact, even though the patients are not permitted to do the rituals by the hospital, they secretly do the rituals which play an important role in treating and recovering from their illnesses. It means that the practice of the rituals is prohibited to do that. The words and the deeds of medical practitioners in the hospital are contrast. Under health care system, the medical practitioners thought that the practice of rituals in hospital is superstitious and unscientific because it is not useful for physical treatment.

5.2 Discussion

By looking at the empirical data about the meaning and practice of dying and death, particularly in the hospital located in Tibet, the culture and the belief should be clear to be able to have mutual understanding and acceptance between them. Therefore, the meaning and practice of dying and death, ignorance of cultural belief of dying and death in modern hospital, the gaps between lay Tibetans and health practitioners, and outsider and insider of my study experience are mainly discussed.

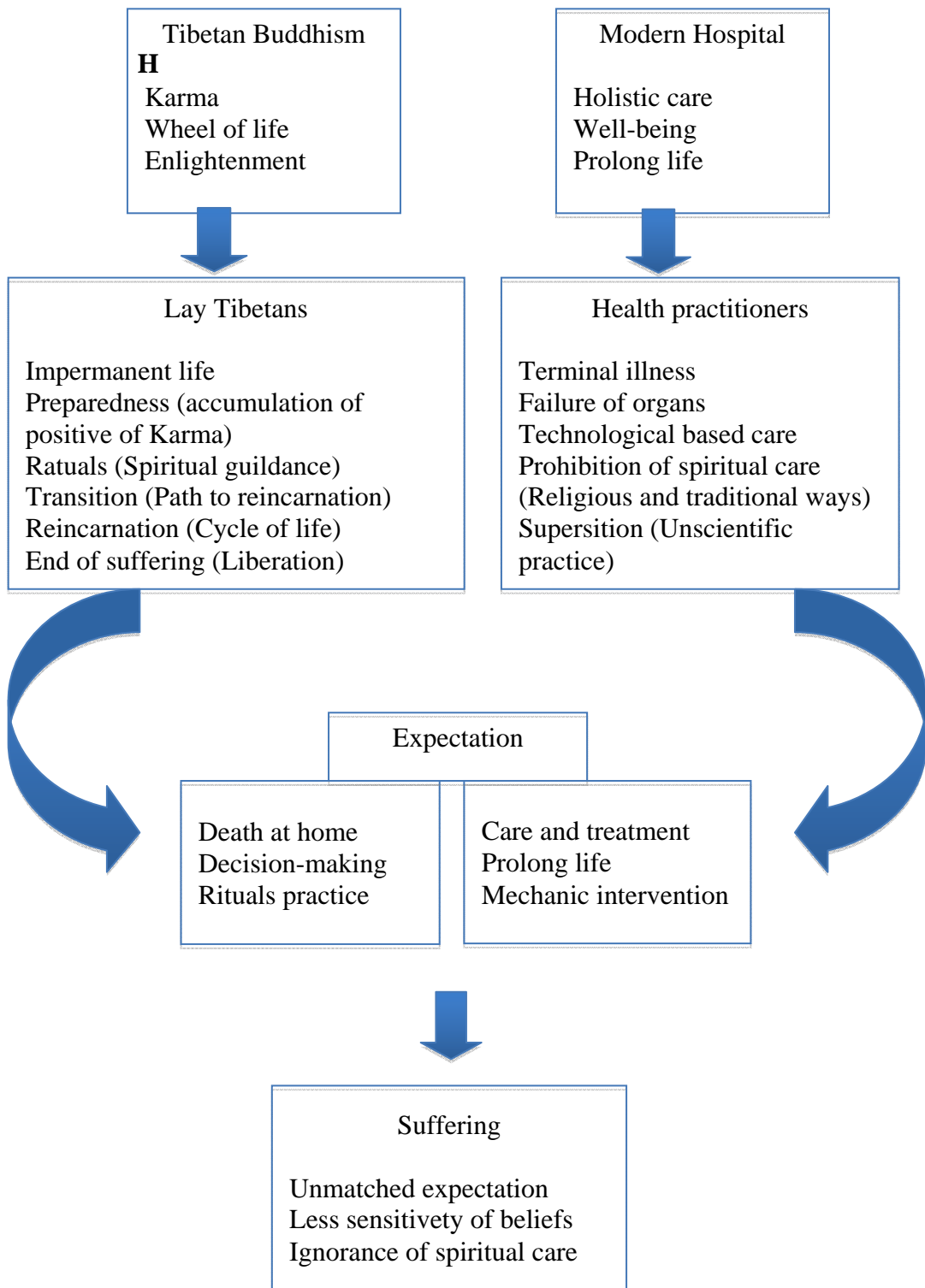


Figure 5.1 The final outcome of the meanings and practices of dying and death

5.2.1 The final outcome of the meanings and practices of dying and death

5.2.1.1 Meaning and practice of dying and death

The meanings of dying and death are an urgent need to comprehend vividly nowadays. Every culture has its own meaning on each topic. Lay Tibetans' beliefs are strongly influenced by Tibetan Buddhism in their daily life including birth, married, festival, illness, and death. They believe the wheel of life in Tibetan Buddhism which means 'uncountable past and future life.' The meaning of life is impermanent or temporary. Present life must be accumulated by doing good things to achieve positive Karma for next life. In other words, present life is the most important opportunity to learn Buddhism, think, practice the mind and do good things to minimize negative Karma. Death is a period of transition to liberation or reincarnation. At the moment of death, a vital time, all attachments of the dying person must be released to realize his or her temporal life to pursue enlightenment. In other words, Tibetans believed that death is a process of transition to reincarnation or liberation. After death, the paths and the place the dead will go and stay are completely different from each other.

However, health practitioners believed that the dying life is terminal illness. Moreover, death is the failure and ceased function of the organs or the cease of blood circulation. All decisions on whether the patients already died or not rely on technology. Not only does mechanic intervention neglect spiritual care such as religious and traditional practices but also it makes the patients more suffer. In addition, the condition of dying or death depends on technologies. All practitioners thought that the advance technologies and medical skill are the most significant factor for the terminal patients. Moreover, death is ceasing of respiration and blood circulation, and stopping of function of organs. As a result of modern technology, human beings are passive. All of the decisions are from technology in order to show the result.

5.2.1.2 Ignorance of cultural beliefs of dying and death in a modern hospital

It is risk that medical practitioners impose their beliefs into their intervention without comprehended laypeople's beliefs. Biomedicine constructs a

different meaning on life and death as a result of modern technology that can treat the patients to prolong the life. According to biomedicine, human body is supposed as machine. The practitioners just treat the body as machine in order to fix and repair the disorder in the system of human organ. Furthermore, it is completely believed that dying is the terminal illnesses and failure of organs. They diagnose and treat patients' organs by technologies and medicines.

On the subject of health care system, in fact, the culture, the belief and the life of the patients are devalued and intentionally neglected due to modern medicalized system and training. Its system rather makes the patients suffer from their illness than help them reduce their sufferings. The patients and the relatives who prefer to do their own cultural beliefs are considered stupid and outdated. Furthermore, health education does not encourage the traditional beliefs to introduce in the hospital. Health practitioners show their respect to lay people's beliefs from their words, but rather not from their hearts. They do not understand what the lay Tibtens believe so that they fail to accept the beliefs of the lay Tibtans to put into practice in reality in spite of the fact that their words utter the respect on the cultural beliefs.

It is true that they will never consider to accept and to practice the beliefs in the hospital until they understand why lay people believe. For the health practitioners, they strongly hold their scientific way to thinking and practicing. For that reason, they intentionally ignore the beliefs and the practice of its cultures and religion. It can be said that all cultural beliefs and practices will be diminished sooner or later unless they are encouraged to be promoted. Under the health care system, the mechanism way of medical practitioners lead to ignore and less concern of cultural believe in the modern hospital. In order to achieve truly quality care, modern hospital should realize the importance of cultural believe embed in lay people's life. Health practitioners should take into account lay people's religious belief and culture in the biomedicine area to minimize their suffering. The lack of culturally/linguistically appropriate health education leads to poor comprehension and lower quality care. The orientation of general cultural beliefs and linguistics training should be provided for health practitioners.

5.2.1.3 Gaps between lay Tibetans and health practitioners

There had unmatched expectation between lay Tibetans and health practitioners; namely education, language, power relationship and religious background. Firstly, with respect to education, there were 46% illiterate and 80% population living in rural areas in Tibet. Obviously, most patients were from rural areas so that they had to cover long distance to seek their medication in the biggest hospital. As the rural dwellers, they were unfamiliar with the structure and environment of the hospital in the city. Secondly, as the official language was Chinese, Chinese was used in the government work unit like a hospital. It was difficult to speak and understand for the rural people who could not understand Chinese when they encountered some Chinese medical practitioners in the hospital.

Thirdly, the rural people spoke their own dialect different from Tibetans who lived in Lhasa, even though a Tibetan fails to understand the dialect. In addition, medical practitioners who lived in urban, were professors in medical area, and held an official language communicated with those lay people. Hence, it was an inevitable result that the medical practitioners might resort to stereotyping lead to biased or discriminatory treatment of patients. Finally, religious background is also an important role in expectation for health seeking care. Lay Tibetans and health practitioners have different beliefs on life and death that lead health practitioners to mainly focus on physical treatment by using modern advanced technologies. As a result of different beliefs among them, health practitioners under the pressure from health care system condemn the beliefs of lay Tibetans in terms of beliefs and treatment.

To sum up, it is apparent that lay Tibetans believe that the meanings of dying and death are impermanent life and the wheel of cycle of life, whereas health practitioners believe that its meanings are the failure and ceased function of the organs. Moreover, lay Tibetans need a spiritual guide from ritual practices for rebirth, whereas health practitioners more focus on physical care rather than on spiritual care which is a very important way for lay Tibetans. Furthermore, health practitioners completely rely on technology to achieve their goals for prolong life in the hospital as long as they can treat the patients. Nonetheless, lay Tibetans prefer to die at home unless they can get recovery from their sufferings. On account of the differences, less sensitivity of beliefs,

the absence of spiritual care in a modern hospital and unmatched expectation lead lay Tibetans to go to the hole of sufferings.

5.2.2 Outsider and insider

The terms' insider and outsider researcher is used to describe a situation where the researcher is a part of the topic being investigated. During my data collection, I tried to be an insider with my informants who were patients or relatives in order to catch the meaning they gave their words through their social and cultural context. So as to grasp their real situation, I tried to quit my medical doctor's 'lens' and stayed with them in which they waited for meeting their patients or medical practitioners. I carefully listened to the words what and how the patients or relatives said. Furthermore, I followed relatives to take their responsibilities in the hospital. I observed them how they bought articles for their patients, consulted the practitioners, and added patients' deposit. From those processes, I made an attempt to understand their perception. However, it was not easy to move out my whole medical lens to comprehend concerning their whole life pictures without any judgment. I realized that my view was deeply influenced by biomedicine. It showed through my words and behavior. As a result, some patients and relatives thought I was a medical staff of hospital management to evaluate the ward, so it made me spend more time to build the trust between us.

At the same time, I tried to move my medical view to become an outsider with medical practitioners. Unless I attempted to change to be a stranger, I could not understand the differences from them. If I looked like a stranger in medical intervention, I believed that I was able to catch the medical practitioners' perception. For example, the medical practitioners just allowed that the relatives stayed with their patients for half hour per day in ICU. I tried to be an insider of relative and outsider of medical practitioner to ask medical practitioners about the reason of limited time. It was hard to be a stranger because I was too familiar with medical area to find the strange perceptions or beliefs. However, I could not get different or special findings from literature review.

In addition, to be an insider with Tibetan laypeople, I developed knowledge that not only will enhance understanding of the experience but also will assist me in

becoming a better medical doctor. And to be an outsider with medical practitioners, I understood the reason why the practice of medical practitioners dehumanized the lay people and why medical practitioners neglected the laypeople's beliefs and practice. No matter how less I had knowledge about the patients' feeling and beliefs, I could recall my working experiences and communication with them after studying medical anthropology. As a medical doctor, I strongly believed that patients should always obey, listen, understand, and follow the medical practitioners because biomedicine was scientific, systematic, helpful, and reasonable for treating diseases. I thought that to consider patients' or relatives' beliefs with their culture was unnecessary. After I studied medical anthropology and conducting the research, that poor comprehension caused unsatisfactory intervention and more sufferings to the patients and relatives unless the health practitioners thought about their feelings and beliefs. Thus, I realized those issues through this research.

5.3 Limitations

With the exception of secondary sources, all participants of the in-depth interviews are directly or indirectly experiencing dying and death in different ways throughout their life. They willingly joined this study and contributed information regarding their experiences, knowledge and opinions on the study. However, as a researcher is a medical doctor who has limited knowledge about the society, the background with the medical environment still influences the way to conduct the data when I do interview and observe the medical practices. Furthermore, this study might not fully understand the extent of individual beliefs and practices, social situations, daily life illness experiences, and self-care practices.

The problems we had among us were language barrier, and cultural beliefs on incurable diseases like cancer. During the talks, we could not understand each other due to the different dialects that made us unable to go deep into the interviews. Another issue is talking about death. If they talk about death issue, the words and the talks lead the patients to die soon according to their belief so that they avoid talking about its issue. Moreover, a small number of informants were selected due to the above

barriers. On the other hand, the original language I translated into English might change the meanings. The limitations of my study are that it only address other cultural beliefs, practices and religions except Tibetan culture and religion .

5.4 Recommendations

1. Modern health practitioners should take into account lay people's religious belief and culture in the biomedicine area to be physically and spiritually healthy when consulting at the hospital. The culture, which has retained traditional rituals is able to overcome the fear of death and is qualified to optimize their lives.

2. The hospitals should balance technical intervention with a humanistic approach to the patients.

3. Traditional beliefs and treatment should be promoted in modern hospitals rather than destroyed.

4. The rituals observed and the death education received are constructive and upgrade the development of a healthy belief for life. They will better try to do good things before they die. Furthermore, the rituals and its education will sharpen and strengthen their life to be able to overcome death and help them build sound mentality.

REFERENCES

- Adams, V., Miller, S., Craig, S., Nyima, Sonam, Droyoung, . . . Varner, M. (2005). The Challenge of Cross-Cultural Clinical Trials Research: Case Report from the Tibetan Autonomous Region, People's Republic of China *Medical Anthropplogy Quarterly*, 19(3), pp. 267–289.
- Bentur, N., Resnitzky, S., & Sterne, A. (2010). Attitudes of Stakeholders and Policymakers in the Healthcare System Towards the Provision of Spiritual Care in Israel. *Health Policy*, 96(1), 13-19. doi: 10.1016/j.healthpol.2009.12.006
- Berger, P. L., & Luckmann, T. (1966). *The Social Construction of Reality: A Treatise in the Sociology of Knowlegde Society as a Human Product*. Garden City, New York: Anchor Books.
- Bonsu, S. K., & DeBerry-Spence, B. (2008). Consuming the Dead Dentity and Community Building Practices in Death Rituals. *Journal of Contemporary Ethnography*, 37, No 6(December), 694-719.
- Buxton, D. (2008). Redefining Medical Success and Failure. *Palliative Medicine*, 11(10), 1343-1344. doi: 10.1089/jpm.2008.0175
- C., M., Goldstein, Jiao, B., Cynthia, M.Beall, & Tsering, P. (2003). Development and Change in Rural Tibet. *Asian Survey*, 43(5), 758-779.
- Capra, F. (1983). The Biomedical Model *the Turning Point Science: Society, and The Rising Culture* (Simon and Schuster ed., pp. 123-163). Toronto: Simon and Schuster.
- Chan, M. F., Chung, L. Y. F., Lee, A. S. C., Wong, W. K., Lee, G. S. C., Lau, C. Y., . . . Ng, J. W. S. (2006). Investigating Spiritual Care Perceptions and Practice Patterns in Hong Kong Nurses: Results of a Cluster Analysis. *Nurse Education Today*, 26(2), 139-150. doi: 10.1016/j.nedt.2005.08.006
- Childs, G. (2004). *Tibetan Diary: From Dirth to Death Beyond In a Himalayan Valley of Nepal*: University of California Press.

- Clive, S. (2000). Changing Patterns of Death and dying. *Social Science & Medicine*, 51(6), 917-930. doi: 10.1016/s0277-9536(00)00071-x
- Collins, W. L., & Doolittle, A. (2006). Personal Reflections of Funeral Rituals and Spirituality in a Kentucky African American Family. *Death Studies*, 30(10), 957-969.
- Counts, D. A., & Counts, D. (2003). The Good, The Bad, and The Unresolved Death In Kaliai. *Social Science & Medicine* 58(2004), 887-897. doi: 10.1016/j.socscimed.2003.10.040
- Deborah, G. T. (2011). Chapter 17 - Late-Life Death and Dying in 21st-Century America. In R. H. Binstock & L. K. George (Eds.), *Handbook of Aging and the Social Sciences (Seventh Edition)* (pp. 235-247). San Diego: Academic Press.
- Ember, C. R., & Ember, M. (2004). *Encyclopedia of Medical Anthropology: Health and Illness in the World's Cultures*. New York: Kluwer Academic/Plenum Publishers.
- Eyetsemitan, F. (2002). Cultural Interpretation of Dying and Death in a Non-Western Society: The Case of Nigeria. *International Association for Cross-Cultural Psychology*.
- Geest, S. v. d. (2004). Dying Peacefully: Considering Good Death And Bad Death in Kwahu-Tafo, Ghana. *Social Science & Medicine*, 58, 899-911.
- Gielen, U. P. (2004). A Death on the Roof of the World: The Perspective of Tibetan Buddhism. In C. M. Parkes, P. Laungani & B. Young (Eds.), *Death and Bereavement Across Cultures* (pp. 73-97).
- Goldstein, M. C., & Beall, C. M. (1987). Anthropological Fieldwork in Tibet Studying Nomadic Pastoralists on the Changtang: Case Western Reserve University.
- Hsu, C., O'Connor, M., & Lee, S. (2009). Understandings of Death and Dying for People of Chinese Origin. *Death Studies*, 33(2), 153-174.
- Hsu, C. Y., O'Connor, M., & Lee, S. (2009). Understandings of Death and Dying for People of Chinese Origin. *Death Studies*, 33(2), 153-174.
- Institution. (2013). The Development of Crematoriums Under the Special Situation in Tibet (M. o. C. A. o. t. P. s. R. o. China, Trans.): 101 institution.

- Jalland, P. (2006). Medicine and Dying in the Twentieth Century *Chaging the Ways of Death in Twentith-Century Australia* (pp. 193).
- Joralemon, D. (1999). What's So Cultural about Disease *Exploring Medical Anthropology* (pp. 1-15). Boston: Allyn and Bacon.
- JSRI. (2007). Tibetan Buddhist Practices for Dying (pp. 1-3): Jodo Shu Research institution.
- Klass, R. E. G. D. (1997). Tibetan Buddhism and the Resolution of Grief: The Bardothodol for the Dying and the Grieving. *Death Studies, 21:4, 377-395*(4), 18.
- Kleinman, A., Eisenberg, L., & Good, B. (2006). Culture, Illness, and Care: Clinical Lessons From Anthropologic and Cross-Cultural Research *The Annual of Internal Medicine, IV*(1), 140-149.
- Komala, K., & Ganesh. (2006). Spirituality in Health Care Organisations. *Journal of the Indian Academy of Applied Psychology, 32*(2), 119-126.
- Lecso, P. A. (1986). Euthanasia: A Buddhist Perspective. *Journal of Religion and Health, 25*(1, Spring), 53.
- Littleton, V., Meemon, N., Breen, G.-M., Seblega, B., Paek, S. C., Loyal, M., . . . Wan, T. T. H. (2010). An Ethical Analysis of Professional Codes in Health and Medical Care. *Ethics & Medicine: An International Journal of Bioethics, 26*(1), 25-48.
- Lock, M. (1996). Death in Technological Time: Locating the End of Meaningful Life. *Medical Anthropology Quarterly, 10, No. 4*,(Dec), 35.
- Long, S. O. (2003). Studies Becoming a Cucumber: Culture, Nature, and the Good Death in Japan and the United States. *Journal of Japanese Studies, 29*(1), 33-68.
- Long, S. O. (2004). Cultural Scripts for a Good Death in Japan and the United States: similarities and differences. *Social Science & Medicine, 58*(2004), 15.
- Lupton, D. (2003a). Representations of Medicine, Illness and Disease in Elite and Popular Culture *Medicine as Culture, Illness, Disease and the Body in Western Societies* (second ed., pp. 54-83). London: SAGE

- Lupton, D. (2003b). Theoretical Perspectives on Medicine and Society *Medicine as Culture: Culture, Illness, Disease and the Body in Western Societies* (pp. 5-21). London: SAGE.
- Manicom. (2011). Where Do our Patients Die? A Review of the Place of Death of Cancer Patients in Cape Town, South Africa. *Palliat Support Care*, 9(1), 31-41.
- McKay, A. (2005). “The Birth of a Clinic”?: The IMS Dispensary in Gyantse (Tibet), 1904–1910. *Medical History*, Vol 49, 135–154.
- McKissick, L. (n.d.). Tibetan Buddhist Spiritual and Religious Beliefs at End of Life: Cross-Cultural Implications in Western Clinical Contexts: MA Candidate, School of Social Service Administration.
- Powers, J. (1995a). Death and dying in Tibetan Buddhism. In First (Ed.), *Snow Lion Publications*. Ithaca, New York: Snow Lion Publications.
- Powers, J. (1995b). The Schools of Tibetan Buddhism *Introduction to Tibetan Buddhism* (First ed.). Ithaca, New York: Snow Lion Publications.
- Powers, J. (1995c). Tibetan Buddhist Doctrines and Practices *Introduction to Tibetan Buddhism* (pp. 291). New York.
- Shapiro, A. (2007). The Tibetan Book of the Dead. *International Journal of Buddhist Thought & Culture*, 9(September), 111-122.
- Straus, A. S. (1978). The Meaning of Death in Northern Cheyenne Culture *Journal of the Pains Conference* 23-79.
- Tsomo, K. L. (2001). Death, Identity, and Enlightenment in Tibetan Culture. *The International Journal of Transpersonal Studies Psycho-analysis*, 20 151-173.
- Warren, B. J. (2005). The Cultural Expression of Death and Dying. *TCM* (January/February), 44-47.
- Waugh, L. A. (1992). *Spiritual Aspects of Nursing: A Descriptive Study of Nurses' Perceptions*. Queen Margaret University. Retrieved from <http://etheses.qmu.ac.uk/878/1/878.pdf>
- Wilson, D. R. (2012). Birthing Traditions in Tibetan Culture. *International Journal of Childbirth Education*, 27(January).

APPENDIX

INTERVIEW GUIDELINES

1. Important demographic, family and historical backgrounds of the informant

1.1 Age, gender, nationality, marital status and family background

1.2 History of settling in the area- where was the informant born? Is she/he native to Tibet? If not, how and when did she/he come to settle in Tibet? Does she/he live permanently? If not how often does she/he come to stay? When, and for how long of each? If she/he does is not resident of Tibet, what are the purposes of coming/staying in the area?

1.3 With whom, does the informant live alone or family? With his/her owned residence or apartment?

1.4 How does she/he earn his/her life? What are sources of income? How much income she/he earn a month?

2. Daily Life

2.1 How is daily life of the informant? What does she/he do in the day and night time? When, where does she/he eat, sleep, work, and spend free time? Does she/he stay in Lhasa for the whole year or only in a certain period?

2.2 Are there any daily life activities of the informant relating to visiting temples and walking around Lhasa? Does she/he regularly go? If so, how many hours does she/he spend there? If not, how often and why he/she visit temples?

3. Health , Illness and terminal services experiences and perception

3.1 How does the informant view his/her health status? Has she/he been ill during the past six months? If so, what illness, how serious it was and how was it cured? Where did she/he go for treatment? Have informant checked his/her illness by any technology? How does informant feel?

3.2 In his/her perception, what caused him/her the illness? How does she/he know?

3.3 Has the informant ever stayed in Intensive-Care Unit? If so, how many days stay there? What illness did informant get? It is severe or not? Did he/she know and understand their health situation? Who did told informant those information? Who did made a decision for their all hospital services? Who did allow to visit informant and how long time they can stay and talk with informant per day?

3.4 Has the informant ever undergone relatives dying or death in the hospital? If so, what are he/she experience? How did health practitioner offer their services? Are there some disagreements between health practitioner and informant and dying or death relatives? Why?

3.5 Does informant satisfy with hospital services? If not, Now what does he/she really need for their hospitalized relatives? What does he/she need from health practitioners? Is the condition of ward comfortable for he/her? If not, what he/she want? In the informant's view, are the terminal services satisfying in the hospital? If not, what are their expectations for the terminal services provision they need?

BIOGRAPHY

NAME	Rendan
DATE OF BIRTH	12Match 1971
PLACE OF BIRTH	Lhasa, Tibet
INSTITUTE ATTENDED	Medical University of West China, 1991-1994, Diploma of Clinical Medicine Medical University of West China, 2002-2004, Bachelor of Clinical Medicine Mahidol University, 2011-2013 Master of Arts (Health Social Science)
SCHOLARSHIP RECEIVED	Ford Foundation International Fellowship Program (IFP)
RESEARCH GRANT	IFP
ADDRESS	The People's Hospital of Tibetan Autonomous Region, Cardiovascular Department, Lhasa, Tibet E-mail: wangrendan@gmail.com