Article

Special Issue: *Cross-Cultural Studies in Well-Being*

# Annihilation of Desire in Jain Ethics as a Challenge to Western, Subjectivist Notions of Well-Being

**Kathryn Phillips and Katherine L. Schaefer**

*Writing, Speaking and Argument Program, University of Rochester, Rochester, NY 14627*

**Abstract** | Many accounts of well-being aim to be maximally accommodating with respect to the good life by focusing on what people take to be good for themselves. Some popular Western philosophical views attempt to do so by focusing on the subjective phenomena of desires and preferences, thereby ostensibly avoiding complicated questions about metaphysical commitments; similarly, clinical conceptions aim to be metaphysically neutral. We test these notions of well-being by investigating Jainism and its commitment to a metaphysics of reincarnation and the existence of souls. Assuming that well-being is a broad prudential value that identifies what is good for a person, we argue that Jain well-being is best understood as a value souls possess, rather than bodies, that actions that contribute to well-being depend on where that soul is on the path to eventual bodily liberation, and that ultimately well-being is epitomized by the annihilation of desires. Turning to Western clinical ethics—Beauchamp and Childress' influential principlism in particular—we explore how a Jain who is on the path to eventual bodily liberation via a fast to the death might be treated, and the difficulties inherent in applying an ethics framework that remains neutral about the existence of souls, or the effects of acts on those souls. We conclude that no account of well-being is complete without an account of its fundamental metaphysical commitments.

**Editor** | Gregg D. Caruso, Corning Community College, SUNY (USA)/Owen Flanagan, Duke University, USA.
**Correspondence** | Kathryn Phillips, Writing, Speaking and Argument Program, University of Rochester, PO Box 270058, Rochester, NY 14627; **Email:** Kathryn.phillips@rochester.edu
**Citation** | Phillips, K. and Schaefer, K.L. (2019). Annihilation of desire in Jain ethics as a challenge to western, subjectivist notions of well-being. *Science, Religion and Culture*, 6(1): 67-76.
**DOI** | https://dx.doi.org/10.17582/journal.src/2019.6.1.67.76

## Introduction

In an attempt to develop universal accounts of well-being, contemporary Western philosophy, psychology, and medicine often turn to subjectivist accounts such as preference or desire-satisfaction theories. Well-being is a prudential value focused on what is good for a person and, in principle, can be understood as distinct from moral or religious values such as considerations of the good life (Crisp 2016; Tiberius 2006). For instance, Tiberius identifies a maximally broad starting point for investigating well-being (2006, 494) by saying: "it is an open question whether well-being is identical with, or requires, happiness, *eudaimonia*, or a good life." While this can be a starting point, most accounts of well-being minimally try to account for the apparent connection of well-being with similar values and many fully fleshed-out theories include a tight connection between well-being, moral values and the good life. Subjectivist theories attempt to accommodate many different varieties of the good life and moral values through neutrality about metaphysical commitments—different accounts of the good life are understood in relation to different

desires and preferences. We will argue that by failing to take into account metaphysical commitments, such views fail to accommodate cultures whose commitments subordinate embodied existence, including desires and preferences.

One reason to doubt that Western theories of well-being have managed to avoid metaphysical commitments is that many such views seem committed to a material or bodily component of well-being, which excludes worldviews that take the body to be at odds with what is good for a person. The Western medical tradition is strongly committed to bodily wellness, while recognizing that bodily well-being may be sacrificed to some other value. This reasoning suggests a metaphysics where persons are necessarily embodied, and there is no commitment to a structure that de-emphasizes bodily wellness. A second, related reason to doubt the universalizability of apparently a-metaphysical accounts of well-being is that conceptions of the afterlife contribute to particular understandings of the good life. If, for instance, the good life is overcoming the suffering that is worldly existence, and achieving or experiencing well-being is dependent in some sense on striving for or experiencing the good life, then we cannot give an account of well-being that does not depend on some particular account of the universe and persons' place within it. One might argue that subjectivist preference or desire-satisfaction theories overcome this hurdle by allowing that whatever the particular person's beliefs are determine their preferences. However, in the case of the Jains—a religious group that holds that the eventual end goal of multiple reincarnated lives is to escape karma, desires, and the cycle of rebirth—what is good for a person is specifically moving beyond preferences or desires. Put another way, the difficulty that arises for desire or preference-satisfaction views from thinking about an ideology like Jainism is that desires and preferences are the trappings of embodiment, and embodiment is a hurdle to be overcome. A third difficulty for subjectivist theories is that, as we will see from Jainism, metaphysical commitments determine which entity well-being attaches to: the body, or the soul. Thus, even quite broad subjectivist views cannot account for well-being as understood and practiced across all cultures because they assume a conception of the world in which personhood entails having preferences or desires, and that satisfaction of them is good for the person.

Our goal in this paper is to use our analytic tools and knowledge of Western clinical practices, focusing on medical issues with psychological overtones, to investigate the role of metaphysical commitments on well-being. We are not here concerned in particular with the question of the metaphysics of value—whether there are objective values or not—but rather metaphysical commitments that shape what we take to be valuable.

As Western, mostly secular scholars coming from the traditions of analytic philosophy and clinical biology, we want to begin by recognizing the shortcomings in our direct knowledge of Jain or Indic culture, or expertise in religious studies and related fields. This issue is made still more complicated by the fact that translations of original Jain texts into English are rare. Probably the most foundational work in English is P.S. Jaini's *The Jaina Path of Purification* (1979). Jaini, himself a Jain and a Professor of Buddhist Studies, wrote the book with the intention of providing a resource that was easily accessible to beginning scholars, but also provided extensive footnotes containing source texts in Sanskrit and Prakrit. His later works (one of which we quote below) expanded on this work and on the subject of Jain ethics and well-being. We have relied extensively on his works as well as books and ethnographic investigations of Jain communities that themselves note their great indebtedness to Jaini's work. Akin to Jeffery Long's approach in *Jainism: An Introduction* (2009), we here attempt to focus on a philosophical rather than a historical or anthropological understanding of Jain well-being with the aim of testing various notions and applications of well-being, though we rely heavily on such work to develop our understanding of Jain commitments.

Taking a closer look at Jain well-being in the first section, and Western medical ethics as it might apply to Jains in the second, we will argue that no conception of well-being is complete without an account of its metaphysical commitments such as the nature of personhood and the nature of the universe with respect to the afterlife.

## Jain Well-Being

Approximately 4.5 million people worldwide subscribe to the Jain belief system (Pew Forum 2012). The vast majority of them live in India, although there are small communities in Kenya (~70,000), the UK

(~17,000), and North America (~100,000) (World Atlas 2017). Jain thought first developed in India, during the end of the Vedic period, in concert with Hindu and Buddhist writing and thought. Jainism shares many of the key ideas of Hinduism and Buddhism, including the idea of *samsara* (the cycle of death and rebirth), *karma* (material attached to the soul when one does harm), *moksa* (liberation from embodied existence), and *ahimsa* (non-violence) (Dundas 1992, 12-13). However, the Jain belief system elevates *ahimsa* to a level beyond that seen in Hinduism and Buddhism.

Asceticism and world renunciation play a fundamental role in Jain belief. While Jainism consists of two main branches (the Svetambara and Digambara) with different particular practices, it is often best known for its renouncers whose ascetic practices aim at achieving *ahimsa*—complete nonviolence. These practices include fasting, avoiding electricity (because it is alive), wearing a face mask to avoid inadvertently inhaling living creatures, travelling only by walking and sweeping a path to move life forms aside, and eating only a strict vegan diet consisting of food freely offered to them (Vallely 2002). According to Jain doctrine, it is Jain renouncers who are capable of liberation from the suffering of embodied existence (*moksa*). This liberation depends on a particular ritual, the *sallekhana*, which is alternately described as fasting to death or meditating to death: death from self-starvation (Laidlaw 2005). However, asceticism is not the whole story of the community, and while Jainism is often best known for its renouncers, the number of these in Jain society is quite small compared to the large laity. The laity participates in ascetic practices outlined by the lay vows, which aim at a more moderate version of *ahimsa* (Dundas 2002).

Jains are committed to the idea that all living creatures are souls (*jīva*), somewhere along the cycle of death and rebirth (*samsara)*, and embodied by karma. During embodied existence beings necessarily experience—and inevitably inflict upon each other—suffering because

> [a]n incalculable number of living beings fill a finite cosmos, all of which can be arranged according to the number of senses they possess, from the single to five sensed. Because the smallest of the beings (insects, air, earth, water, fire, etc.) possess the sense of touch, causing them harm is unavoidable. (Vallely 2002, 66)

Harm attaches material—*karma*—to the soul of the perpetrator and affects the cycle of death and rebirth. It is not until a soul is "finally freed of its enslaving karma, [that] the enlightened and liberated soul floats to the top of the universe to exist forever as a self-sufficient monad absorbed in the four infinitudes" (Cort 2001, 7). Souls that have completed the path of liberation achieve the ultimate goal of *ahimsa*.

Central Jain values appear to revolve around freedom from embodied existence—critically, freedom from desires and preferences—which suggests that any account of Jain well-being would need to be formulated around a metaphysics that includes reincarnation and souls. Freedom from embodied existence is ultimately achieved by completing the path to liberation (*moksa-marg*). As Vallely (2011, 65) says, "Life's adversities—disease, loss, envy, greed, and dread—are for Jainism "merely" the consequence of the human condition of embodiment, which must ultimately be surmounted." The *moksa-marg* ideology points towards a well-being that is achieved in this world only by looking to the next.

Despite the apparent centrality of *moksa-marg* ideology, there is broad consensus among ethnographies developed over the last 40 years or so—those that mention well-being at all—that well-being is a value enacted by lay Jains and aligned with our worldly, Western conception of the term. This shift is largely due to John Cort's dissertation work, later turned into the 2001 book *Jains in the World* (see Laidlaw 2007 endnote 9 for a more comprehensive list of supporters of this claim). Flügel (2006, 92) goes so far as to say, "[f]rom the point of view of lay Jains in the world, the problem is rather one of finding a balance between two contrasting but hierarchically interlinked value-orientations: liberation (*moksa*) and well-being. This is indisputable, and now widely recognized in the literature." According to these scholars, to have a more complete understanding of Jainism, especially the lived tradition, we must understand their commitment to what looks like a Western value of well-being. For instance, Cort (2001,187) says:

> The value of wellbeing is not an explicit ideology as is the *moksa-mārg*. Much of the *moksa-mārg* ideology is readily accessible and even obvious to the Jains, for a defining feature of an ideology is

> precisely that it is consciously and publicly enunciated. Wellbeing, however, is not consciously and publicly enunciated on a regular basis, and the tendency of *moksa-mārg* ideologues to denigrate wellbeing means that when it is discussed it is often in order either to dismiss it or to relegate it to a marginal, unimportant position.

Cort (2001, 7) gives an explicitly materialistic account of well-being, claiming that it is "much more a matter of one's material embodiment. It is marked by health, wealth, mental peace, emotional contentment, and satisfaction in one's own worldly endeavors." The materiality of Cort's definition is echoed by Laidlaw, who claims that wellbeing is understood as a value fundamentally informed by an "Anglo-Saxon left-liberal sensibility" (Laidlaw 2007, 157) and from this egalitarian perspective that well-being requires

> **physical robustness and longevity**, psychological health (including feelings of self-worth and dignity), **freedom from bodily and mental suffering**, privacy, personal autonomy and responsibility, family life and relationships, civic inclusion, political enfranchisement, and so on. (emphasis added)

These definitions seem to prize the very things that Jainism suggests are the nexus of our suffering: longevity in this world and satisfaction of our bodily desires regardless of the harm we cause to ourselves and others in this process.

Laidlaw and Cort both argue that the *moksa-marg* ideology and their worldly account of well-being are related and interdependent: "Well-being and the ascetic pursuit of release are contrasting but mutually supporting" (Laidlaw 2007, 166); and "[w]ithout wellbeing there could be no *moksa-mārg*" (Cort 2001, 201). Laidlaw gives the example of an opulent feast organized to celebrate the completion of an ascetic pursuit on the part of a lay person. In some sense, the worldly celebration is a reward for the completion of the pursuit while also serving as a demonstration of restraint by showing that appetites for material plenty are in command. Cort claims that accumulation of material wealth leads to comfort, which makes space and time for ascetic pursuits and gives families the ability to support the renouncer.

Flügel seems to agree that lay Jains value worldly well-being, but also provides a way to put some pressure on this view. He says, "the construction of an opposition between the explicit doctrine of liberation and an implicit value of well-being is problematic, because it does not distinguish clearly between ideas and practice" (2006, 104). The focus on lived practice in the work we have reviewed creates the possibility that a worldly, Western conception of well-being is being imposed on Jain practice, rather than starting from a Jain understanding of the world and asking, 'what is good for a person?'

Starting with the question 'what is good for a Jain,' rather than where well-being is in Jain communities, we might begin to answer it by looking at what is common among lay Jains and renouncers—*ahimsa*:

> When one speaks of a Jaina community…one is referring to a group of people who have consciously undertaken to lead a way of life in accordance with the basic tenet of non-violence by removing the volition toward attachment and aversion. Thus, to some extent, all members of the Jaina community, both lay and renouncer, may be said to practice non-violence. (Jaini 2000, 5)

This commitment is fundamentally organized around their notions of souls and the cycle of death and rebirth. What is good for a Jain depends on where they are in this cycle and what helps them along the path to liberation given their particular position along the cycle. What this means is that well-being is contextualized by where a person is along the path to liberation and actions that would be good for some are not good for others. For instance, the practices of a renouncer may not be good for a person who is not yet ready to take on such a role, whereas opulent festivals appropriate to the laity are not appropriate for the renouncer. At the same time, there is a certain unity of what is good for Jains, and in fact all souls, articulated in the Jaini quote above—minimizing violence and moving along the path to liberation are central constituents of what is good for a Jain. This is Jain well-being.

In addition to how well-being is relative to the person's place on the path to liberation, it also seems that if we take Jain metaphysics seriously we ought to understand 'persons' as referring to souls. Recall Jain metaphysics suggests that souls (*jīva*) inhabit all material objects and go through a cycle of death and

rebirth (*samsara*) on a path to liberation. Furthermore, the *jīva* is

> pure consciousness with innate will which enables it to act, while at the same time being totally without form. It is the *jīva* which experiences and is responsible for all intellectual and spiritual operations and not the body, which is merely a conglomerate of atoms. (Dundas 2002, 94)

On the face of it, this suggests that a mere physical incarnation of a soul, a human, may not be the entity well-being attaches to. Furthermore, the preferences and desires of this world can get in the way of working towards what is good for a person—they can send one in the wrong direction as one works towards liberation.

By starting with the question 'what is good for a Jain?' we are led to an understanding of well-being where worldly commitments are minimized. Jain metaphysical commitments yield an account of well-being in which the soul is the possessor of well-being, actions leading to well-being depend on the soul's particular karma, and well-being is constituted by the appropriate relation to eventual liberation which is identified with the absence of desires and preferences.

## Well-being in Western Medical Decision-Making

Suppose an American Jain has chosen to fast to death, and an alarmed non-Jain neighbor asks for evaluation. This scenario is plausible: even in India, the legal system is questioning whether *sallekhana* should be considered different from other forms of suicide (Laidlaw 2005), suggesting discomfort with voluntary starvation. In Western countries, where Jain ideals are less well-understood and where the renouncer will not be part of a cloistered community (Laidlaw 2007), the risk is even higher. This situation is likely to be evaluated within a professional medical ethical framework—*principlism*—overlaid with a system of legal definitions. We claim principlism depends on a Western notion of well-being, and will analyze this situation in detail, with the goal of highlighting difficulties inherent in the use of an ethics that fails to account for metaphysical commitments and consideration of harms and goods coming from these commitments.

In 1979, Beauchamp and Childress first proposed that it might be possible to make "substantative and universalizable" (Gillon 2003, 307) claims about medical ethics, on the basis of respect for four *prima facie* principles derived from a "common morality," (Beauchamp and Childress 2009, 3) or a set of norms shared by all persons. These principles are *autonomy, beneficence, non-maleficence, and justice* (13), and refer to the normative requirements to, respectively, (1) respect the right of an individual to self-rule over his body and to respect the decision-making capacity of those competent to make decisions; act with an intent (2) to benefit and (3) not to harm people; and (4) promote fairness in distribution of risks and benefits. They argued that "a *prima facie* obligation must be fulfilled unless it conflicts with an equal or stronger obligation" (Beauchamp and Childress 2009, 15) and that analyzing any healthcare-related moral dilemma by balancing the four principles will allow the moral agent to specify the particular commitments of the relevant norms and eradicate or minimize the conflicts between them. They further argued that it is important that no one principle be favored above the others.

This framework is widely influential in the West in large part because it offers—via the concept of "common morality,"—the possibility of considering medical ethics situations in ways that are not innately tied to a particular cultural or religious worldview. It also holds the promise of allowing Western practitioners to avoid "moral imperialism" (Gillon 2003, 307). Reasonably, much of the ongoing refinement of this framework centers around the extent to which a framework that reflects Western values can be applied to cultures that do not share these values. As (Bowman 2004, 664-665) says:

> Western medicine came to its dominant position…in part as a by-product of society's virtually unquestioning faith in scientific positivism. To date, bioethics has been tied directly to Western medicine, which has close links with science and technology and assumes itself to be separate from religion, politics, economics, and morality. Particularly in its early stages, the primary intellectual and professional leaders of bioethics were philosophers, theologians, lawyers, physicians and biologists and this discipline built its position using the rules of scientific analysis that were compatible with the positivism of philosophers and lawyers.

As he further argues, in a world where the majority of people live within a religious framework, principlism is an explicitly secular approach that depends upon a particular worldview that assumes that knowledge comes from sensory experience in this physical world. As such, it tends to focus most easily on benefits and harms that are unambiguous—those to the body and to some extent to the psyche—but much less on those of the soul, which are not directly observable (Wreen, 1991).

In practice, questions tend to arise when *autonomy* and *beneficence* conflict. If the clinician attempts to intervene over the stated wishes of the patient in the name of beneficence, it is termed *paternalism* (Beauchamp and Childress 2009). Hard paternalistic actions override the person's true autonomous decisions, and are generally not seen as acceptable. In contrast, soft paternalistic actions override a decision made with a lesser degree of autonomy, attempting to prevent "[s]ubstantially nonvoluntary actions" (217), or those made in situations that impair decision-making capacity.

The primary difficulty here is determining the degree to which the patient is capable of and actually expressing an autonomous choice, and depends on what one means by "autonomy". Beauchamp and Childress (2009, 101-102) focus on *liberty* and *agency*:

> At a minimum, personal autonomy encompasses self-rule that is free from both controlling interference by others and limitations that prevent meaningful choice, such as inadequate understanding. The autonomous individual acts freely in accordance with a self-chosen plan...In contrast, a person of diminished autonomy is in some material respect controlled by others or incapable of deliberating or acting on the basis of his or her desires and plans.

They further argue that autonomy need not mean separate from influence or community concerns; a person who freely chooses to subordinate his wishes to that of a group or to accept religious restrictions is autonomous.

It can be difficult for a clinician to assess autonomy, and the concepts of *capacity* and *competence* come into play. In this paper, we will follow Applebaum's (2007, 1834) approach of using the "terms 'competence' and 'capacity'…interchangeably…since the oft-cited distinctions between them — competence is said to refer to legal judgments, and capacity to clinical ones — are not consistently reflected in either legal or medical usage." Whatever one calls the concept, it is meant to strike a balance between respecting a patient's autonomy and protecting an incompetent patient from harm. However, as Beauchamp and Childress (2009, 114) note, there is a serious "gatekeeping function of competence judgements," as they determine the extent to which an attempt to overrule a patient's decision will be seen as acceptable. In practice, calling for an evaluation frequently reflects a conflict between the clinician's and patients' judgments.

Current tests of competency involve assessing the ability of the patient to:

- Communicate a choice
- Understand the relevant information
- Appreciate the situation and its consequences
- Reason about treatment options (Appelbaum 2007).

Difficult cases tend to center around the last two criteria, in cases where altered mental states might play a role in decision-making. In practice, *appreciate the situation and its consequences* means that people being evaluated are expected to be aware that they have a disease, and understand the probable outcomes of the disease. Failure to acknowledge what the physician sees as a disease may be grounds for an incompetency judgment (Applebaum 2007). The *reason about treatment options* requires that the patient articulate reasoning around the decision-making process, and is complicated, because of the role of emotions and values in reasoning (Charland 2015). These are hard to assess, and assessors necessarily have to contend with their own possibly contradictory values. Thus, clinical and legal assessments have tended to focus on bare ability to express reasoning patterns including acknowledgement of facts. This simplification leads to situations where clinicians are sure that patients who have a *bona fide* mental illness are nevertheless deemed competent. For instance, a rich literature has grown up around the clinical diagnosis of anorexia—starving oneself to death—and exploring the subtle ways in which this illness can disrupt reasoning, in an attempt to find grounds for deeming anorectics incompetent (reviewed in Charland 2015).

Now let us consider the Jain renouncer. At first glance, it looks as if there would be no problem with autonomy. As the Jain outlook assumes that renunciation is entirely a matter of internal motivation (Vallely 2002), it is highly unlikely that she is being pressured into her final fast. In addition, if she has been a Jain renouncer for a reasonable period of time, we can assume that she wholeheartedly accepts the worldview and any pressures that her community or worldview might impose, and—in having vowed to starve to death—clearly understands end result of the fast on her personally.

However, there might be reason to question her autonomy or competency. First, consider the last of Beauchamp and Childress' criteria: not *incapable of deliberating or acting*. At the beginning of the fast, the Jain considers herself in possession of autonomy and agency, as well as being able to deliberate and act, but as the fast progresses, the situation changes.

As (Laidlaw 2005, 191) puts it (emphasis added):

> The Jain fast must therefore not be directed to some purpose outside the self. Indeed even to say that it is 'aimed at achieving' spiritual purification or enlightenment is somewhat problematical. Such progress involves, among other things, **the diminishing of all capacity for desire, dislike or fear**. So, although the fast must begin with a very definite act of volition—a public declaration of intention and adoption of a vow—as the fast proceeds, **this volition is itself extinguished**.

On one level, she is clearly capable of acting: she is refusing food. However, late in the fast, "volition is itself extinguished," which does call into question what "acting" means. In addition, the process of deliberation may be considered somewhat problematic by Western standards. If one has diminished all capacity for desire, dislike, or fear—of any emotions and of attachment to values—does one meet Beauchamp and Childress' (2009) standards for capability to deliberate? This situation seems similar to patients who refuse nutrition and hydration at the end of life, and could be handled in a similar way: through the use of an advanced directive before embarking on a fast (Applebaum 2007). However, this is a matter of practical application, and does not negate the underlying issue: if the situation were brought up, a difference of worldviews as to what constitutes autonomy might cause a problem.

Next, consider the capacity/competency criteria, starting with *communicate a choice*, and *reason about treatment options*. Stories of renouncers emphasize continuous meditation rather than communication (Laidlaw 2005) and so she might not communicate, but would almost certainly be able to do so if motivated by involuntary treatment. However, *appreciate the situation and its consequences* is more complicated. In cases of ambiguity about the renouncer's religious commitment, the clinician might well wish to assess the patient's state of mind further, and would seek an involuntary commitment to that end (Bowers 2014). And since courts have ruled that failure to acknowledge illness is grounds for declaring the patient incompetent, the renouncer might find herself deemed unable to refuse treatment.

But on what grounds might the clinician diagnose an illness? It is not our intention to decide what a clinician is likely to do in any situation, but to highlight the possibilities that the definition leaves open. Taken this way, on the surface, "diminishing of all capacity for desire, dislike, or fear" sounds like the medical definition of *apathy:*

> an absence or suppression of emotion, feeling, concern, or passion; an indifference to stimuli found generally to be exciting or moving. This condition is common in patients with neurasthenia, depressive disorders, and schizophrenia. (Mosby 2016, 122)

Combined with a stated wish for death, a patient who said that she had extinguished all desire might well be deemed to have suicidal depression.

A diagnosis of anorexia is also possible. Earlier diagnostic criteria required that the patient express "an intense fear of gaining weight or of becoming fat," (Becker, Thomas, and Pike 2009, 620), thus differentiating religiously-motivated fasting from anorexia. However, after explorations of restricted eating showed that non-Western patients who otherwise met the criteria of voluntary restricted eating and severe underweight did not always express this fear, the requirement was eliminated (American Psychiatric Association 2013). The change allowed more genuinely ill people to be treated, but did open up the possibility that religious fasting could be considered a disease.

In the end, this situation remains ambiguous. What the Jain renouncer sees as a great good, the clinician might see as sign of mental illness and cause for a soft paternalistic approach. This analysis starkly highlights a concern that principlists struggle with: the possible over-reliance on autonomy as the only acceptable way to justify deliberate harm to the body. While Beauchamp and Childress (2009, ix), in the preface to the seventh edition of *Principles,* argue that they think it is "profoundly mistaken" to assume that "the principle of respect for autonomy dominates and overrides all other moral principles and considerations," some clinicians have in fact called explicitly for some form of this weighting. For instance, (Gillon 2003, 307) argues that "respect for autonomy should be 'first among equals'." In addition, (Petersen 2013, 266), in his critique of principlism, also argues that in practice "'respect for autonomy',…has overshadowed other principles."

We argue that this is not simply an error of practice but is in fact a necessity: it is the only way within the principlist framework to include a metaphysical view that does not acknowledge bodily integrity as a default good. In attempting to reject moral imperialism, principlists have rejected the possibility of considering the beneficence (or harms) of goods stemming from metaphysical commitments that they cannot evaluate and may not share. In practice, this forces them into an over-reliance on autonomy as the only way to permit decisions that cause severe harm to the body. This issue shows up clearly in the canonical 'Jehovah's Witness' case used in medical education (Beauchamp and Childress 2009). A Witness who is conscious upon arrival at the hospital can refuse the blood transfusion that would save his life; a Witness who is a child (and considered to have less capacity to consent to refusing medical procedures) or who is only intermittently conscious may well find himself provided with a blood transfusion that to his eyes imperils his soul. (A similar conundrum can also apply to Christian Scientists, for slightly different reasons.) In practice, clinicians deal with this problem through cross-cultural education around cases where such metaphysical commitments come into play, and by educating people on the need for advanced directives (Applebaum 2007). However, the need for advanced directives itself highlights the difficulties that principlism is having in accounting for a worldview independent of knowledge of the patient's metaphysical commitments.

This overreliance on autonomy is especially stark in the case of persons with worldviews like Jainism that deemphasize or explicitly denounce volition: autonomy allows Jains to refuse treatment, but autonomy may demand a kind of agency that Jains reject. We argue that this particular example, and by extension, any non-Western religion that holds as a value being liberated from the suffering of desire and embodied existence, puts pressure on the principlist project in a way that the canonical Jehovah's Witnesses example does not. Both Western medical ethics and Jehovah's Witnesses prize bodily wellness and see it as a good; similarly, they both understand that it may not always be the highest good. This shared understanding seems to make it easier to encompass fairly well-understood exceptions, even if the relative value of each good is not evaluated equally by all. Furthermore, being a long-time adherent of a religious group with clear prohibitions on action can generally be assumed to be a yes or no question: you either do or do not hold to the tenet, which makes it (in the presence of information about the individual) relatively easier to assess whether the desire expressed is a function of illness or true religious belief.

In contrast, the Jain worldview asks that one accept that bodily wellness is not just a value subordinate to achieving a good afterlife, but is in fact something that has negative value: it is the ultimate cause of suffering. This conflict for clinicians is so stark that they may well see it as evidence of illness. To make matters worse for the clinician, Jain thought—in contrast to the situation with the Western religions discussed above—does not suggest that valuing bodily wellness is a yes-or-no question. In contrast, it reflects each individual's position on a spiritual path that can be hard to assess: lay Jains do hold to fairly Western notions of bodily well-being, while renunciant Jains believe the opposite.

While Jains can be accommodated by Western clinicians, especially if they have the right paperwork, something we hope to have highlighted here is that the Western framework itself depends on certain metaphysical assumptions: namely a secular metaphysics that denies either sufficient knowledge or existence of the afterlife and so can be cashed out in terms of following the autonomous patient's preferences.

## Conclusion

We have argued that Jain well-being cannot be un-

derstood independent of the Jain commitments to the cycle of death and rebirth (*samsara*), souls (*jiva*), non-violence (*ahimsa*), and liberation (*moksa*). If we start by asking 'what is good for a Jain' our answer is necessarily metaphysically-laden because the answer depends on these concepts. In the second section we asked how a Jain who chooses a final fast to death could be evaluated using Beauchamp and Childress' principlist framework. The resultant questions regarding whether a Jain would be assessed as autonomous suggest at a minimum that current thought around the role of religion in this decision-making framework should be expanded to include examples of non-Western religion, putting pressure on our current literature surrounding the framework. In addition, we argued that Western medicine takes bodily wellness as a default good—assumed unless otherwise proven and only able to be overridden in cases of explicit permission—suggesting an underlying secular metaphysics that can cause problems in practice. We conclude that no account of well-being is complete without an account of its underlying metaphysical commitments.

## Acknowledgements

We thank Drs. Richard Dees and Valerie Tiberius, and our reviewers for helpful discussions and comments.

## Reference


- American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders: DSM-V*. Available at: http://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596 (accessed 26 Aug 2017).
- Appelbaum, Paul S. 2007. Assessment of patients' competence to consent to treatment. *New England Journal of Medicine* 357(18): 1834-1840.
- Beauchamp, Tom L., & James F. Childress. 2009. *Principles of biomedical ethics* (Seventh edition). New York: Oxford University Press.
- Becker, Anne E., Jennifer J. Thomas, and Kathleen M. Pike. 2009. Should non-fat-phobic anorexia nervosa be included in DSM-V? *International Journal of Eating Disorders* 42(7): 620-635.
- Bowers, Wayne A. 2014. Civil commitment in the treatment of eating disorders and substance abuse: Empirical status and ethical considerations. In Timothy D. Brewerton & Amy. B. Dennis (Eds.), *Eating disorders, addictions and substance use disorders* (pp. 649-664). Berlin: Springer-Verlag.
- Bowman, Kerry. 2004. What are the limits of bioethics in a culturally pluralistic society? *The Journal of Law, Medicine & Ethics* 32(4): 664-669.
- Charland, Louis C. 2015. Decision-making capacity. In E. N. Zalta (Ed.) *The Stanford Encyclopedia of Philosophy* (Fall 2015 Edition) Available at: https://plato.stanford.edu/archives/fall2015/entries/decision-capacity/ (accessed 26 Aug 2017).
- Cort, John E. 2001. *Jains in the world: Religious values and ideology in India*. Kettering: Oxford University Press on Demand.
- Crisp, Roger. 2016. Well-Being. In E. N. Zalta (Ed.) *The Stanford Encyclopedia of Philosophy* (Summer 2016 Edition) Available at: https://plato.stanford.edu/archives/sum2016/entries/well-being/ (accessed 26 Aug 2017).
- Dundas, Paul. 2002. *The Jains*. New York: Taylor & Francis.
- Flügel, Peter. 2006. Jainism and society. *Bulletin of the School of Oriental and African Studies* 69(1): 91-112.
- Gillon, Raanan. 2003. Ethics needs principles—four can encompass the rest—and respect for autonomy should be "first among equals". *Journal of Medical Ethics* 29(5): 307-312.
- Jaini, Padmanabh S. 2000. *Collected papers on Jaina studies*. Delhi: Motilal Banarsidass Publishers.
- Jaini, Padmanabh S. 1979. *The Jaina path of purification*. Berkeley: University of California Press.
- Laidlaw, James. 2005. A life worth leaving: Fasting to death as telos of a Jain religious life. *Economy and Society* 34(2): 178-199.
- Laidlaw, James. 2007. The intension and extension of well-being: Transformation in diaspora Jain understandings of non-violence. In Alberto. C. Jimenez (Ed.), *Culture and well-being: Anthropological approaches to freedom and political ethics* (pp. 156-179). Ann Arbor: Pluto Press.
- Long, Jeffery D. 2009. *Jainism: An Introduction*. London: I. B. Tauris.
- Mosby. 2016. Mosby's Pocket Dictionary of *Medicine, Nursing & Health Professions* - E-Book (Edition 10). Amsterdam: Elsevier.
- Petersen, Alan. 2013. From bioethics to a sociology of bio-knowledge. *Social Science & Medicine* 98: 264-270.
- Pew Forum. 2012. The Global Religious Landscape—Other Religions. Available at http://www.pewforum.org/2012/12/18/global-religious-landscape-other/ (accessed 16 Oct 2018).

- Tiberius, Valerie. 2006. Well-being: Psychological research for philosophers. *Philosophy Compass* 1(5): 493-505.
- World Atlas. 2017. Countries with the Largest Jain Population. Available at https://www.worldatlas.com/articles/countries-with-the-largest-jain-populations.html (accessed 16 Oct 2018).
- Vallely, Anne. 2002. *Guardians of the transcendent: An ethnography of a Jain ascetic community*. Toronto: University of Toronto Press.
- Vallely, Anne. 2011. Ancestors, demons, and the goddess: Negotiating the animate cosmos of Jainism. In Fabrizio Ferrari (Ed.), *Health and religious rituals in South Asia: Disease, possession and healing* (pp. 64-78). Ann Arbor: Pluto Press.
- Wreen, Michael. J. 1991. Autonomy, religious values, and refusal of lifesaving medical treatment. *Journal of Medical Ethics* 17(3): 124-130.