

# The DSC Triangle Model of Buddhist Palliative Care: Doctrine, Spiritual Pillar, and Community at Wat Kham Pramong

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## Abstract

This qualitative case study examines Buddhist spiritual care for terminal cancer patients through the case of Wat Kham Pramong in Sakon Nakhon Province, Thailand. It addresses three objectives: to examine how the temple responds to patients' spiritual needs, to identify the Buddhist teachings and practices relevant to those needs, and to assess the approach's qualitative impact in terminal care. Drawing on scriptural analysis, narrative review, participant observation, and semi-structured interviews with five care-team informants and five terminal patients, this research article develops the DSC Triangle Model. The model consists of Doctrine, Spiritual Pillar, and Community. Relevant teachings and practices include impermanence (*aniccam*), suffering (*dukkham*), non-self (*anattā*), mindfulness meditation on death (*marañānussati*), *Buddho* recollection, daily chanting, the herbal medicine and guilt-letter ceremony, and final-day spiritual support. Patient narratives, care-team explanations, and field observations indicate qualitative patterns of movement from fear, resistance, anxiety, unresolved burden, and isolation toward greater acceptance, inner peace, relational connection, and a more meaningful final stage of life. These responses varied according to physical condition, psychological readiness, religious familiarity, family support, and ability to participate. The article contributes a case-derived framework for understanding how Buddhist doctrine, embodied spiritual practice, and community support interact in temple-based palliative care without claiming universal or statistically measurable effects.

## Keywords

Buddhist palliative care, DSC Triangle Model, Wat Kham Pramong,  
Spiritual needs, Terminal cancer patients, Theravāda Buddhism,  
Temple-based spiritual care

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## Introduction

End-of-life care is not only a medical question. For terminal cancer patients, the final stage of life often brings physical decline together with fear, anxiety, unresolved burden, attachment, concern for family members, and the need for peace and meaning. Modern palliative care has made important progress in relieving symptoms and improving quality of life. However, a patient whose physical symptoms are medically managed may still suffer deeply from fear of death, regret, emotional unrest, or the inability to let go. This shows that spiritual care is not a secondary concern. It is part of the full care of a person approaching death.

The difficulty lies not only in recognizing that spiritual care is important, but also in clarifying what spiritual care actually involves in practice. Terminal patients may need help interpreting death, calming the mind, reconciling unfinished burdens, loosening attachment, and facing separation from family members. These needs cannot be fully met by general encouragement. They require a meaningful framework, concrete practices, and a supportive environment. In many discussions of palliative care, spirituality is affirmed as part of holistic care. However, the relationship between spiritual needs, specific religious resources, and observed patient experience is not always explained in detail. This creates a gap between the broad affirmation that spiritual care matters and the more precise question of how such care is actually structured.

In Buddhist traditions, illness and death are not understood merely as biological events. They are also occasions for reflection on impermanence, suffering, attachment, intention, and the cultivation of the mind. Buddhist teachings offer a way to understand bodily decline within the broader context of conditioned existence. Buddhist practices such as chanting, recollection, meditation, symbolic ritual, and compassionate presence provide concrete means through which patients may work with fear, anxiety, guilt, and attachment. Buddhist spiritual care, therefore, involves both meaning and practice. It is not limited to religious consolation, nor is it reducible to general psychological comfort. It concerns the transformation of the patient's relationship to illness, death, family, and the final stage of life.

Previous scholarship has already shown that Buddhist thought contributes to end-of-life care, death acceptance, spiritual well-being, and ethical reflection in terminal care. Studies on Buddhist bioethics have clarified how Buddhist views of intention, compassion, and non-harming shape end-of-life decision-making (Keown 1995; Keown 2005). Research on Buddhist death acceptance has shown that acceptance of death among Buddhist patients is not a single belief, but a gradual process involving thought, speech, action, and embodied expression (Thanasilp et al. 2020; Upasen and Thanasilp 2020; Upasen et al. 2022). Studies of Thai palliative care have also identified spiritual care needs, the role of religious belief, the importance of communication, and the relationship between Buddhist practices and spiritual well-being (Sukcharoen, Sakunpong, and Sripa 2020; Wisarith, Sukcharoen, and Sripinkaew 2021; Pokpalagon, Chaiviboontham, and Phinitkhajorndech 2024). Research conducted specifically at Arokhayasala Hospice at Wat Kham Pramong has also examined why cancer patients choose inpatient complementary care and has documented a care regime combining herbal medicine, meditation, chanting, Dhamma, breathing exercises, and other supportive activities (Poonthananiwatkul et al. 2016). The present article extends this line of research by examining how Buddhist doctrine, embodied spiritual practice, and communal support operate together as an integrated care model. These studies provide an important foundation for the present article.

Nevertheless, a research gap remains. Existing studies recognize the importance of spiritual care and Buddhist practices in palliative care. However, they do not clearly explain which Buddhist teachings and practices are most relevant to terminal patients' spiritual needs, how these teachings and practices are integrated into a coherent care model, and how that model works in practice, through a detailed case-based explanation. This gap is significant because Buddhist care for terminal patients should not be treated merely as a list of helpful practices. It requires an

explanation of how teachings, embodied practices, and supportive relationships work together to address the actual burdens of terminal illness. A case-based analysis is therefore needed to show not only that Buddhist care may be meaningful, but also how its internal structure can be described and assessed.

Wat Kham Pramong in Sakon Nakhon Province, Thailand, provides a concrete case for examining this question. The temple has become known for providing care to cancer patients in a Buddhist environment shaped by chanting, meditation, traditional herbal medicine, ritual support, family participation, patient community, and compassionate caregiving. The care provided there is not only directed toward the body. It also addresses fear of death, emotional unrest, unresolved guilt, attachment, concern for family members, and the wish for a meaningful final stage of life. Within the wider Thai palliative-care context, Wat Kham Pramong complements rather than replaces medical palliative care by providing a culturally familiar Buddhist environment in which doctrinal interpretation, daily spiritual practice, and communal support address spiritual distress, acceptance of death, family concerns, and meaning-making alongside the medical management of physical symptoms. The case, therefore, allows examination of how Buddhist teachings and practices are integrated into a coherent care model and how this model operates in practice. The article treats Wat Kham Pramong not merely as a place where Buddhist rituals occur, but as a contemporary Buddhist care environment in which doctrine, practice, and relationships are organized around terminal illness.

This article develops the DSC Triangle Model through a case study of Wat Kham Pramong and argues that Buddhist spiritual care for terminal patients at the temple is structured by an integrated relationship among Doctrine, Spiritual Pillar, and Community. Doctrine refers to the doctrinal meaning and interpretive direction provided by Buddhist teachings, especially impermanence (*aniccam*), suffering (*dukkham*), and non-self (*anattā*). The Spiritual Pillar refers to embodied spiritual practices such as daily chanting, mindfulness meditation on death (*marañānussati*), *Buddho* recollection, the herbal medicine and guilt-letter ceremony, and final-day spiritual support. Community refers to the relational and supportive environment formed by volunteer monastic guidance, caregivers, family participation, patient community, and the shared environment of temple life. By examining spiritual needs, Buddhist responses, model formation, and patient-based observed outcomes, this article develops the DSC Triangle Model as a qualitative framework for understanding Buddhist spiritual care for terminal patients at Wat Kham Pramong.

The discussion first clarifies the methodology and source materials, then identifies terminal patients' spiritual needs, explains the formation of the DSC Triangle Model, and examines patient narratives, care-team explanations, and field observations as qualitative evidence of how the model operates in lived experience.

## **Methodology and Source Materials**

This article is based on a qualitative case study design. The purpose is not statistical generalization, but interpretive understanding of how Buddhist teachings, spiritual practices, and communal support are integrated into a coherent care model for cancer patients facing serious illness and end-of-life concerns. Wat Kham Pramong was selected because it provides a concrete case in which Buddhist doctrine, temple-based ritual practice, family participation, patient community, herbal care, and end-of-life preparation are brought together within a single care environment. The case study approach is suitable because the article seeks to explain the formation and practical operation of a care model rather than to measure prevalence or make causal claims.

Data collection consisted of five main sources. First, a scriptural analysis was conducted of relevant Buddhist texts in the Sutta Piṭaka of the *Tipiṭaka* concerning death, illness, suffering,

impermanence, non-self, mindfulness of death, ethical care, and support for the critically ill. Second, a narrative review synthesized academic literature on Buddhist perspectives on death, palliative care, death acceptance, spiritual care needs, and Buddhist practices in terminal care. Third, participant observation at Wat Kham Pramong documented daily chanting, meditation, the herbal medicine and guilt-letter ceremony, patient-family community life, and other temple-based care routines. Fourth, semi-structured interviews with five care-team informants explored how Buddhist teachings are applied, how patients are guided, what challenges arise, and how care is adapted for different patients and families. Fifth, semi-structured interviews with five terminal patients examined illness experience, participation in spiritual practices, attitudes toward death, family concerns, and perceived changes in mental or spiritual condition. For clarity and consistency in presenting the interview evidence, the five terminal patients are identified as Patient 1–5, and the five care-team informants as Care-team Informant 1–5.

Data analysis followed different procedures according to the type of source material. Scriptural materials were analyzed through repeated reading, thematic coding, and doctrinal interpretation. Relevant passages were first identified according to recurring topics such as illness, dying, suffering, impermanence, non-self, mindfulness of death, detachment, compassion, and care for the sick. These passages were then grouped into doctrinal themes in order to clarify how Buddhist teachings interpret the existential conditions faced by seriously ill patients. The analysis further examined how these teachings could correspond to the spiritual needs identified in the case study, especially fear of death, anxiety, attachment, guilt, family concern, and the search for peace and meaning.

The narrative review was analyzed through content analysis. Existing studies were reviewed and grouped by recurring themes, including Buddhist death acceptance, spiritual well-being, palliative care, ritual practice, Thai Buddhist care settings, and temple-based support for patients. This process helped clarify what existing scholarship has already established and where the present article makes its contribution. In particular, the review showed that previous studies have discussed Buddhist attitudes toward death, spiritual needs in palliative care, and Buddhist or Thai approaches to care, but have less often explained how doctrine, embodied spiritual practice, and community support operate together within a single integrated, case-derived model.

Participant observation notes were analyzed through descriptive and thematic organization. The notes were first grouped according to observed activities and settings, such as morning and evening chanting, meditation, *Buddho* recollection, the herbal medicine and guilt-letter ceremony, patient-family interaction, shared meals, informal conversations, communal activities, and the temple's general care environment. These observations were then examined in relation to three questions concerning what practice or interaction was taking place, what Buddhist meaning or value it expressed, and which patient's spiritual need it appeared to address. This process made it possible to distinguish practices that primarily conveyed doctrinal meaning, practices that embodied spiritual cultivation, and social settings that sustained emotional and relational support.

Interview materials were analyzed through thematic coding. Care-team interviews followed a three-level coding process. Open coding first identified recurring explanations of Buddhist teachings, practical guidance, ritual use, patient concerns, family involvement, cultural adaptation, challenges in integrating spiritual and medical care, and observed changes in patients' states of mind. Axial coding then linked these initial codes to broader analytical categories, including doctrinal guidance, spiritual practice, ethical care, ritual function, caregiver communication, patient autonomy, and practice limitations. Selective coding synthesized these categories to clarify how the care team understood the temple's Buddhist palliative approach and explained the relationship among teachings, practices, and patient support.

Patient interviews were analyzed using the same three-level coding process, with a focus on patients' own experiences. Open coding identified recurring themes such as spiritual needs, fear of death, death acceptance, emotional unrest, coping strategies, ritual participation, meditation,

*Buddho* recollection, family concern, guilt, letting go, meaning-making, and perceived changes in mental or spiritual condition. Axial coding then connected these themes to broader experiential patterns, including the cultivation of inner peace, the reinterpretation of illness and death, the easing of attachment, the role of Buddhist belief in emotional stability, the importance of family and community support, and the limits created by pain, weakness, or different levels of readiness. Selective coding synthesized these patterns into the outcome pathways discussed below, especially facing death and calming emotional unrest, letting go and releasing unresolved burden, and receiving relational support for a meaningful final stage of life.

After these analyses were completed, themes from scriptural analysis, narrative review, participant observation, care-team interviews, and patient interviews were compared across sources. This cross-source synthesis showed that the materials repeatedly converged on three analytical functions: interpreting illness, suffering, and death through Buddhist doctrine; translating Buddhist teachings into embodied spiritual practices; and sustaining patients through family-, caregiver-, peer-, and temple-based communal support. These recurring functions provided the methodological basis for formulating the DSC Triangle Model. The following section explains in greater detail how these analytical functions developed into the three dimensions of Doctrine, Spiritual Pillar, and Community.

Because the study involved interviews with terminal cancer patients as a vulnerable population, ethical safeguards were maintained throughout the research process. Ethical approval for patient interviews was obtained from the Institutional Review Board of the Hospital of Excellence in Thai Traditional and Complementary Medicine for Cancer at Sakonnakhon, IRB No. 02/2025, and the terminal patients voluntarily provided informed consent before interviews. Care-team interviews were conducted with appropriate institutional permission and voluntary agreement.

## **Spiritual Needs of Terminal Cancer Patients**

Based on the palliative care context and the literature reviewed in the thesis, this article understands the spiritual needs of terminal cancer patients through six closely related dimensions: fear of death, anxiety and emotional unrest, attachment and the inability to let go, unresolved guilt and the need for reconciliation, concern for family members, and the need for peace and a meaningful final stage of life. These dimensions are not presented as isolated categories. They provide an interpretive framework for examining how Wat Kham Pramong responds to the spiritual needs of terminal patients through Buddhist teachings and practices.

Previous studies on advanced cancer coping, Buddhist death acceptance, spiritual care needs, Thai palliative caregiving, and the relationship between Buddhist practices and spiritual well-being support this framework. Research on patients with advanced cancer shows that terminal illness produces not only physical symptoms but also fear, uncertainty, emotional struggle, and changes in coping patterns (Greer et al. 2020). Studies on Buddhist death acceptance show that acceptance of death among Buddhist patients is shaped by religious understanding, embodied practice, and gradual psychological change (Thanasilp et al. 2020; Long and Thanasilp 2021; Upasen and Thanasilp 2020; Upasen et al. 2022). Studies of spiritual care needs among terminal cancer patients and Thai palliative caregivers further show that terminal care involves emotional, relational, and spiritual concerns, including the desire for peace, forgiveness, meaning, and preparation for death (Sukcharoen, Sakunpong, and Sripa 2020; Wisesrith, Sukcharoen, and Sripinkaew 2021; Pokpalagon, Chaiviboontham, and Phinitkhajorndech 2024).

Fear of death is one of the most direct spiritual needs of terminal cancer patients. When patients realize that recovery is no longer likely, death becomes immediate rather than abstract. Fear may arise from uncertainty about the dying process, fear of bodily symptoms, fear of

separation from loved ones, or fear of what follows death. From a Buddhist perspective, fear of death is closely connected with attachment to the body and to the sense of self. However, in the experience of terminal patients, fear is not merely a doctrinal misunderstanding. It is a deeply human response to vulnerability. Spiritual care, therefore, needs to offer more than instruction. It needs to provide a framework through which death may be faced with greater clarity and less resistance.

Anxiety and emotional unrest are closely related to fear of death, but not identical with it. A patient may accept the idea of death in general and still experience distress when symptoms intensify, family problems arise, or the future becomes uncertain. Anxiety may appear as restlessness, sadness, agitation, irritability, or inability to settle the mind. This need calls for practical forms of spiritual support because emotional unrest is often experienced in both the body and mind. Buddhist practices such as chanting, recollection, and meditation are relevant because they provide repeated methods for focusing attention and calming the mind. In this sense, emotional unrest is not only a psychological state but also a spiritual problem, because the unsettled mind may be unable to prepare for death peacefully.

Attachment and the inability to let go form another important spiritual need. Terminal patients may remain attached to the body, family, property, unfinished responsibilities, former identity, or hope for recovery. Some forms of attachment are intertwined with love and responsibility, especially concern for family members. However, when attachment becomes clinging, it intensifies suffering. Buddhist teachings on impermanence and non-self become important because they help patients understand that bodily decline, separation, and change are not personal failures but part of conditioned existence. The challenge is not to deny love, but to soften clinging and support a more peaceful relationship to what cannot be controlled.

Unresolved guilt and the need for reconciliation also emerge strongly near the end of life. Terminal illness often leads patients to review the past. Regret, moral burden, difficult relationships, and unfinished words may become more urgent as time becomes limited. Patients may wish to be forgiven, to forgive others, or to release emotional burdens before death. This need cannot be met solely through physical care. It requires moral reflection, emotional expression, symbolic release, and sometimes family participation. Buddhist spiritual care is relevant here because it offers a way to acknowledge the burden without being trapped by it. It also allows the final stage of life to become a period of reconciliation rather than only decline.

Concern for family members is another central spiritual need. Terminal patients may worry about parents, children, spouses, financial responsibilities, or the emotional suffering of those left behind. Such concerns show that spiritual distress is relational. A patient's ability to die peacefully may depend partly on whether family members are prepared, supported, and able to accept the situation. This need shows why community and family participation are not secondary aspects of spiritual care. They are part of the conditions through which patients may gradually release fear and anxiety.

The need for peace and a meaningful final stage of life gathers these concerns into a broader spiritual aim. Terminal patients often need more than symptom relief. They need to feel that the final stage of life still has value. Peace may arise through acceptance, reconciliation, chanting, meditation, family support, and confidence in Buddhist teachings. Meaning may arise when illness is understood as a field for reflection, release, merit, gratitude, and preparation. This final need is therefore not separate from the other five. It is the wider horizon toward which Buddhist spiritual care is directed. These six spiritual needs provide the basis for examining how Wat Kham Pramong responds, as outlined in the DSC Triangle Model. They also prevent the article from treating Buddhist practices as isolated therapeutic techniques. Each practice is examined in relation to a particular burden experienced by terminal patients, and each burden is examined in relation to the broader question of how Buddhist teachings, embodied cultivation, and communal support can work together at the end of life.

## Formation of the DSC Triangle Model

The six spiritual needs discussed above provide the problem basis for examining Wat Kham Pramong's Buddhist response to terminal cancer patients. Building on the analytical procedures described in the previous section, the DSC Triangle Model was developed by comparing and synthesizing the findings generated from scriptural analysis, narrative review, participant observation, care-team interviews, and patient interviews. This comparison examined the recurring relationships among the meanings used to interpret illness and death, the practices through which those meanings were embodied, and the relationships that sustained spiritual care.

The comparison across sources revealed three recurring functions. Scriptural analysis and care-team interviews showed that Buddhist teachings provided an interpretive framework for understanding illness, suffering, attachment, bodily decline, and death. Participant observation and interview materials showed that these meanings were translated into lived spiritual cultivation through chanting, meditation, *Buddho* recollection, mindfulness of death, symbolic release, and final-stage spiritual support. Observation and interviews also showed that these teachings and practices were sustained through family participation, peer relationships, caregiver guidance, volunteer monastic support, and the shared environment of temple life.

These three recurring functions provided the basis for the three dimensions of the DSC Triangle Model. The function of interpreting illness, suffering, and death was conceptualized as Doctrine. The function of translating Buddhist meanings into embodied practice was conceptualized as the Spiritual Pillar. The function of sustaining meaning and practice through relationships and shared daily life was conceptualized as Community.

The three dimensions were therefore not selected simply because they are common Buddhist or social categories. They were retained because they organized the material at different but connected levels of care: Doctrine gave illness and death interpretive meaning; Spiritual Pillar translated that meaning into repeated forms of practice; and Community sustained both meaning and practice through relationships and shared daily life. This explains why the model is presented as a triangle rather than as a list of separate components. The evidence showed that the three dimensions worked reciprocally: doctrine shaped practice, practice made doctrine experientially available, and community supported patients in sustaining both within the temple's care environment.

The Doctrine dimension was derived from the doctrinal foundation examined in the study. The analysis of Buddhist teachings identified impermanence (*aniccam*), suffering (*dukkham*), and non-self (*anattā*) as central interpretive principles through which illness, death, and attachment are understood at Wat Kham Pramong. These teachings are not peripheral ideas. They provide the meaning and interpretive direction that frame terminal illness. Death is not understood only as personal defeat or medical failure, but as part of a natural process of conditioned existence. Attachment and emotional burden are also interpreted within a wider Buddhist worldview. For this reason, Doctrine is the first dimension of the model, providing the underlying framework for understanding the patient's suffering. The doctrinal foundation also supports the other dimensions, as spiritual practices and communal support derive their Buddhist orientation from this meaning structure.

Participant observation further showed that this doctrinal framework was repeatedly communicated through the content of the temple's daily chanting. The morning recitation included the *Dhammacakkappavattana Sutta*, whose exposition of the Four Noble Truths places aging, illness, and death within the broader reality of suffering and identifies craving and clinging as conditions that intensify distress (SN 56.11; Bodhi 2000, 1843–47). Within the temple's care context, this teaching provided a recurring interpretive framework through which physical decline

and approaching death could be understood as part of the shared human condition rather than solely as personal failure or medical defeat.

Other verses used in daily chanting reinforced related themes. The *Kamma Gāthā* drew attention to the inevitability of aging, illness, and death and encouraged reflection on personal action and responsibility, without presenting illness as mere punishment (AN 5.57; Bodhi 2012). The locally composed verse “Letting Go of the Body,” although not drawn directly from the *Tipiṭaka*, expressed impermanence, bodily dissolution, mindfulness of death, and the loosening of attachment in language accessible within the Thai Theravāda setting. These recitations show that Doctrine at Wat Kham Pramong was not confined to abstract instruction. Buddhist interpretations of suffering, bodily change, attachment, and death were repeatedly conveyed through the liturgical content that patients encountered in everyday temple life.

The Spiritual Pillar was derived from the observed practices at Wat Kham Pramong. Daily chanting, mindfulness meditation on death, *Buddho* recollection, the herbal medicine and guilt-letter ceremony, and final-day spiritual support repeatedly showed a common function: they translated doctrinal understanding into lived spiritual cultivation. These practices do not merely symbolize Buddhist belief. They provide repeated forms through which patients hear, recite, imagine, breathe, remember, and bodily participate in Buddhist meanings. Chanting gives sound and rhythm to doctrinal reflection. Mindfulness meditation on death brings mortality into direct awareness. *Buddho* recollection gives the mind a simple and stable object when longer chanting becomes too difficult. The guilt-letter ceremony gives symbolic form to inner burden and release. These examples show why the dimension is called the Spiritual Pillar rather than the Ritual Pillar. Its significance lies not only in ritual form, but in embodied cultivation that patients can repeatedly encounter within the rhythm of temple life.

Participant observation added operational clarity to this dimension without changing its analytical role. Morning chanting was usually held around 7:00–8:00 a.m., with seasonal adjustment, while evening chanting was usually held around 7:00 p.m. Both took place in the chanting room and were followed by approximately fifteen minutes of meditation, then the distribution of herbal medicine. Patients, family members, and staff participated together. Those with sufficient strength sat near the Buddha image, physically weaker patients sat on chairs, and patients unable to come to the chanting room could listen through the temple loudspeaker from their rooms. Those with enough energy followed the chanting book, while weaker patients listened quietly. The whole routine usually lasted about forty-five minutes. These details are important because they show that chanting and meditation were not occasional symbolic additions, but repeated practices built into the temple’s daily care schedule.

Other practices show how the Spiritual Pillar was adapted to bodily limitation and emotional burden. On Buddha Days, death contemplation was guided by the medical care-team leader or the abbot of Wat Kham Pramong; patients were led to contemplate the process of dying and to imagine a peaceful world after death. Patients could sit if able, lie down if physically weak, or follow the guidance through the loudspeaker from their rooms. In the herbal medicine and guilt-letter ceremony, patients usually prepared their letters in advance, while family members often burned the letters on behalf of physically weak patients. The patient could remain seated nearby, allowing participation even when direct handling of fire was not suitable. Care-team explanations presented the act as a symbolic release of hidden guilt, regret, or unresolved emotional burden. Care-team informants also described final-day spiritual support, in which staff and family members may chant the *Ratana Sutta* and guide the patient to recollect wholesome deeds or *Buddho* according to the patient’s level of consciousness.

The Community dimension was derived from perspectives on the temple care setting and temple-based interviews. Buddhist spiritual care at Wat Kham Pramong is not carried out by isolated individuals alone. It is sustained by a relational environment that includes volunteer monastic guidance, medical and lay caregivers, family participation, patient community, and the

shared environment of temple life. This dimension goes beyond general social support because Buddhist meanings and practices shape daily relationships. Caregivers, family members, patients, and volunteer monastic guides participate in an environment in which illness and death are confronted within a shared spiritual field.

Participant observation showed that the community appeared in ordinary daily life rather than only in formal religious activities. Patients and accompanying family members ate, rested, slept, and stayed together, so family care and temple life were intertwined. Patients spoke with one another before and after chanting and during ordinary free time. Family members exchanged practical advice about diet, herbal medicine preparation, temple living arrangements, and daily care; some went outside the temple together to buy food and daily necessities, while others helped staff cut herbal medicine or assist with temple tasks. The community also included informal activities such as evening walks, watching the sunset, walking meditation under bamboo trees, music, singing, tai chi, painting, shared meals during Theravāda Buddhist festivals, and contact with the temple's dogs as a form of pet therapy. These scenes show how Community functioned as a lived environment rather than an abstract category.

The model is a triangle rather than a simple list because the three dimensions depend on one another. Doctrine provides meaning and interpretive direction. The Spiritual Pillar provides embodied cultivation through which doctrinal meaning becomes lived practice. Community provides the sustaining environment in which doctrine and practice are supported across time. Doctrine without spiritual practice would remain abstract. Spiritual practice without doctrinal meaning would lose depth and orientation. Neither would be sustained in the same way without a compassionate communal environment. The triangular form is therefore important because the evidence shows a reciprocal relationship: doctrine shapes practice, practice makes doctrine experientially available, and community sustains both through daily care and shared presence. The following section turns from model formation to patient narratives and observed outcome patterns.

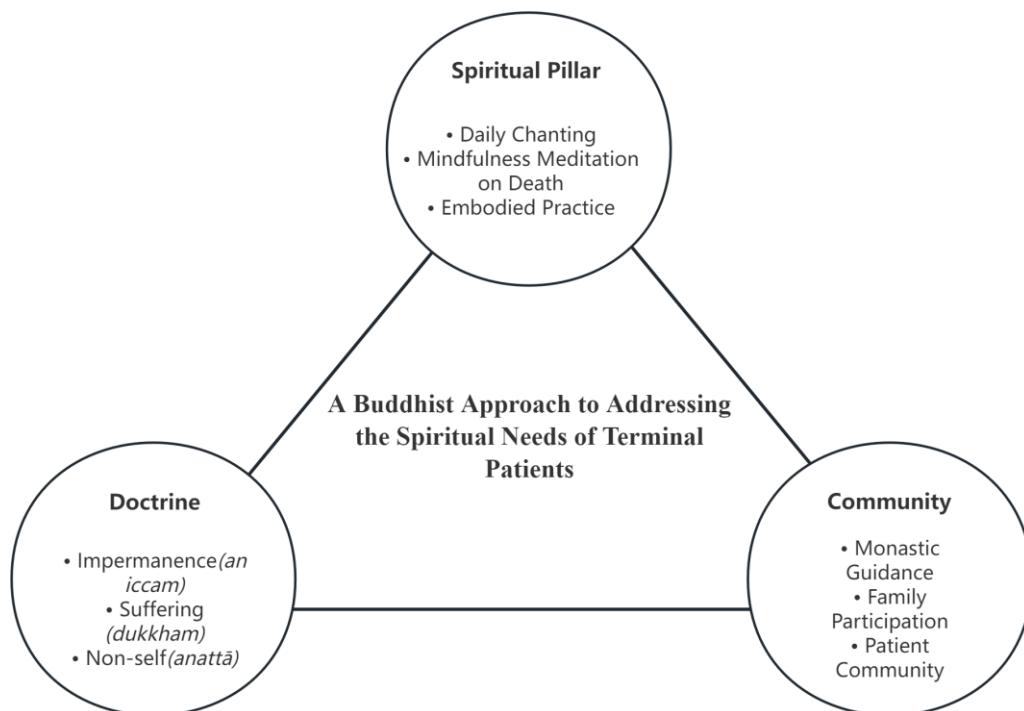


**Figure 1.** The DSC Triangle Model of Buddhist Palliative Care at Wat Kham Pramong

## Patient Narratives and Observed Outcomes

Having explained the formation of the DSC Triangle Model, this section examines how the model appears in patient narratives, care-team explanations, and observed outcomes. The assessment of impact here is qualitative rather than statistical. It does not measure patients against fixed numerical criteria, nor does it claim that all patients experienced the same result. Instead, it examines how Buddhist meanings, embodied practices, and community life appeared in patients' experiences while also noting variation and limitations.

**Table 1.** Qualitative Matrix of Spiritual Needs, Buddhist Responses, and Observed Outcomes in the DSC Triangle Model

| Spiritual Need                                   | Main DSC Dimension           | Buddhist Response                                                                                   | Observed Outcome                                          | Variation / Limitation                                                                                                |
|--------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| Fear of death                                    | Doctrine / Spiritual Pillar  | Impermanence, non-self, mindfulness meditation on death, daily chanting                             | Greater acceptance of death and reduced resistance        | Change was stronger among patients with greater psychological readiness or prior religious familiarity.               |
| Anxiety and emotional unrest                     | Spiritual Pillar             | Chanting, meditation, ritual participation, temple atmosphere                                       | Increased calmness and inner stability                    | Relief was not always continuous and could weaken when physical symptoms intensified.                                 |
| Attachment and the inability to let go           | Doctrine / Spiritual Pillar  | Teachings on impermanence and non-self, <i>Buddho</i> recollection, and embodied spiritual practice | Greater willingness to let go and reduced mental struggle | Response varied according to psychological readiness and the ability to participate in practice.                      |
| Unresolved guilt and the need for reconciliation | Spiritual Pillar / Community | Guilt-letter ceremony, chanting, supportive presence, family participation                          | Emotional relief and reduced inner burden                 | Response varied according to psychological readiness and the ability to participate in the temple's care environment. |

| Spiritual Need                                      | Main DSC Dimension                      | Buddhist Response                                                                                                           | Observed Outcome                                              | Variation / Limitation                                                                                                                                |
|-----------------------------------------------------|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| Concern for family members                          | Community / Doctrine                    | Patient and family member community, shared care, Buddhist reflection on attachment and acceptance                          | Reduced loneliness and partial easing of relational distress  | Response varied according to psychological readiness, prior religious engagement, and the ability to participate in the care environment.             |
| Need for peace and a meaningful final stage of life | Doctrine / Spiritual Pillar / Community | Final-day spiritual support, <i>Ratana Sutta</i> chanting, <i>Buddho</i> recollection, calm presence, preparation for death | Greater inner peace and a more meaningful final stage of life | Outcome varied according to disease progression, physical suffering, psychological readiness, and the ability to participate in the care environment. |

The matrix should be read as a qualitative thematic map rather than a scoring instrument. It shows how the DSC Triangle Model addresses spiritual needs through one or more dimensions and how patient narratives, care-team explanations, and observations indicate corresponding changes. The following discussion presents three integrated observed-outcome pathways: facing death and calming emotional unrest, letting go and releasing unresolved burden, and relational support for a meaningful final stage of life.

The first pathway concerns facing death and calming emotional unrest. Patient 1 described fear not as a doctrinal idea but as the lived intensity of pain: “The nervous pain at that time was the ultimate pain. I could not resist it.” The same patient explained that the most important task became “to find a way to die peacefully,” and connected this preparation with chanting, meditation, and *Buddho* recollection. He later described a clear change in his relationship to death: “The thing that changed is that I now have zero fear of death itself. Instead, I think about how to die a good death.” In his words, when a patient is very sick and weak, “even practicing chanting can be too difficult,” so “the most important thing is to keep one big word in mind at every moment”: “*Buddho*.” This narrative shows why the Spiritual Pillar must remain practical and simple enough for bodily weakness. It also shows that fear of death was often mixed with fear of suffering, pain, and loss of control.

Care-team explanations support this interpretation. Care-team Informant 1 explained that Buddhism helps patients approach death as a natural process. At the same time, the temple community allows patients to see that they are not alone in suffering or facing death. Care-team Informant 4 described the Four Noble Truths as a “roadmap” for distinguishing physical pain from mental suffering and for helping patients see the root of distress in expectation, resistance, or clinging. This distinction is important because medical treatment may reduce bodily pain. At the same time, Buddhist guidance addresses the additional mental suffering that arises from fear, anger, denial, or the wish that reality were otherwise. In this sense, Buddhist care does not operate

only by preaching doctrine. It works through therapeutic conversation, deep listening, and repeated practices that bring the patient back to the present moment.

Care-team materials also clarify why the guidance had to remain concrete rather than abstract. Care-team Informant 2 identified meditation and chanting as “the most consistently effective” practices in meeting patients’ spiritual needs. Care-team Informant 3 described a short death-contemplation meditation in which patients are invited to close their eyes, imagine the dying process, and stay with the breath through the recollection of *Buddho*. This simple form of practice was important because some patients could not sustain complex doctrinal reflection when pain or weakness intensified. The same practical logic appeared in daily care. When patients could not chant, they could listen; when they could not sit, they could lie down; when they could not come to the practice space, they could still follow the guidance from their rooms. These adjustments show that the Spiritual Pillar operated through graded participation rather than through a single ideal form of practice.

Field observation further showed that the significance of daily chanting and meditation lay not only in their regularity, but also in their adaptability to patients whose bodies were weakening. Patients who could not chant aloud could listen, and those unable to attend in person could hear chanting or guidance through the temple loudspeaker from their rooms. Even listening could therefore become a form of participation when physical strength declined. This observed adjustment helps explain why *Buddho* recollection and chanting are not merely formal rituals, but graded practices that can be adapted to the patient’s changing bodily condition.

The second pathway concerns letting go and releasing unresolved burden. Patient 2 explained that being treated at Wat Kham Pramong helped him learn to let go of property, money, and even the body: “Even my body must be returned to nature.” The same patient reflected that family concern had once made death more difficult, but he later came to understand that “everyone has their own karma” and that he could not bear everyone’s karma for them. He also explained that he tried to do each moment well because “in the next five minutes, we might die.” He summarized his changed attitude in striking terms: “Thank you for having cancer.” This does not mean that cancer itself was presented as good. Rather, the narrative shows how illness could be reinterpreted as an opportunity for preparation, generosity, release, and a different way of relating to the remaining time.

Patient 3 described the temple’s approach as “using Dharma to treat the heart while using herbs to treat the physical body.” This statement is useful because it does not separate physical care from spiritual care. It suggests that, in the patient experience, Buddhist care was not merely an additional religious activity alongside treatment. It was part of a broader way of reorienting the mind toward illness, the body, and death. Within the Buddhist interpretive framework, letting go does not mean emotional indifference. It means learning to relate to illness, family concern, regret, and bodily decline without being completely overwhelmed by them.

The guilt-letter ceremony helps explain how this pathway becomes embodied rather than merely doctrinal. Care-team explanations present the letter as a way for patients to express hidden guilt, regret, or emotional burden that may be difficult to disclose directly to others. Observation showed that burning the letter often involved a quiet family presence, with a family member burning it while the patient sat nearby. The scene included gestures of closeness and encouragement, such as embracing, leaning quietly together, or gently patting another patient on the back. These gestures matter analytically because they show that the release of burden was not only a private mental act. It occurred in a ritual and relational setting where family, peers, and staff helped create the conditions for symbolic letting go.

This pathway is also connected with family support. Care-team materials describe the use of affectionate touch, massage, and hugging to help patients and relatives express care that may have been left unsaid. Such practices are not doctrinal teachings in themselves, but they create a relational condition in which reconciliation becomes more possible. For terminal patients,

unresolved burdens often concern not only past actions but also unfinished words with family members. The observed presence of family during the guilt-letter ceremony, together with ordinary gestures of closeness, shows how the Spiritual Pillar and Community dimension overlap in practice: symbolic release is strengthened when it occurs within a supportive relationship.

The third pathway concerns connection and the easing of isolation. Community appeared not only in formal religious activity but also in daily shared life. Patients and family members ate, stayed, and rested together. Patients spoke with one another before and after chanting and during ordinary free time. Family members exchanged practical knowledge about diet, herbal medicine, temple routines, and daily care. Some also joined simple temple tasks, such as helping staff prepare herbal medicine. These scenes do not need to be treated as separate therapeutic techniques. Their significance lies in the way they softened isolation and allowed patients to experience illness within a shared human setting rather than as a purely private burden.

Care-team Informant 1 explained this community function by noting that patients who entered the temple community could see others facing similar suffering and death, helping them realize they were “not alone.” Patient 4 described the temple community as “like a university,” where patients learn the final chapters of life from shared routines, exercise, chanting, and daily conversation. He also observed: “Patients learn from each other. In a normal hospital, cancer patients do not talk to each other... Here, we exercise together in the morning before chanting. We understand each other.” This point is important for the Community dimension. Community does not merely mean that other people are physically present. It means that patients encounter others who understand the same illness condition, and this shared recognition can ease the feeling of facing cancer alone.

Field observation also showed that ordinary shared activities contributed to the emotional atmosphere of care. These activities included patients and family members walking together, talking before and after chanting, joining simple group activities, sharing meals, and spending time in the temple environment. Care-team Informant 3 described such activities as creating “happy energy,” allowing patients to temporarily shift attention from pain to the fact that they were still alive and able to experience moments of joy. This does not replace medical pain control, but it complements it by reducing isolation and emotional fixation on suffering. It also shows why the Community dimension should not be reduced to general social support; it includes shared activities, daily rhythm, ordinary conversation, and the emotional atmosphere of the temple.

The same community dimension also helps explain why the model complements medical palliative care. In a hospital, patients may receive professional symptom control but remain socially isolated or emotionally defined by diagnosis and treatment. At Wat Kham Pramong, shared routines allowed patients and family members to encounter others living with similar uncertainty. The temple environment did not remove disease progression, but it changed the social field in which patients faced illness. This is why Community is treated as one side of the DSC Triangle rather than as a secondary background condition.

Patient variation remains important. Patient 5 described the care at Wat Kham Pramong not as one specific Buddhist ritual but as a holistic natural healing practice: “At Wat Kham Pramong, patient care follows a holistic approach. So it is hard to say which specific activity is the most helpful.” This response suggests that patients may receive support from the temple environment without interpreting every practice in explicitly Buddhist ritual terms. Care-team informants also noted challenges involving patients of other faiths, patients with little religious background, patients with prejudice against monks, patients forced by relatives to come to the temple, and patients whose pain or weakness made formal practice difficult. In some cases, a patient may be unable to repeat *Buddho* or sit in meditation because pain is too intense; Care-team Informant 5 explained that, in other cases, illness and death could be discussed as “facts of life” or “nature’s

law.” These variations show that the DSC Triangle Model should be understood as a flexible framework rather than a fixed sequence of practices that every patient follows in the same way.

The observed outcomes were therefore qualitative and varied rather than uniform. The evidence suggests movement toward acceptance, calmness, release, connection, and meaning among some patients, but not an identical transformation in all patients. The depth and stability of these changes depended on prior religious familiarity, cultural background, disease progression, physical pain, psychological readiness, family support, and ability to participate in the temple’s care environment. The study may also underrepresent patients who were too weak to participate, left the temple after care, did not remain in contact, declined formal interviews, or were unable to complete informed consent because of rapid disease progression. Experiences without completed informed consent were excluded from the empirical data. These limits mean that the DSC Triangle Model should not be read as an automatic mechanism that produces the same result for every patient. Rather, it identifies a recurring pattern in the available patient narratives, care-team explanations, and field observations while acknowledging that other experiences may be less visible in the formal data.

Final-day spiritual support, as described by care-team informants, illustrates how the three dimensions may converge at the threshold of death. When a patient enters the final phase and the family agrees, staff and family members may gather to chant the *Ratana Sutta*, encourage the patient to recollect wholesome deeds, or guide the patient to remember *Buddho* according to the patient’s level of consciousness. Doctrine provides the meaning of a peaceful, final mind; the Spiritual Pillar provides chanting and recollection; and Community provides the shared presence of staff and family members. This example is included as a care team explanation rather than a direct field observation, but it helps illustrate how the care team understands the model at the point of dying.

Taken together, these pathways support a qualitative understanding of the DSC Triangle Model. The model helps explain how Buddhist responses are related to terminal patients’ spiritual needs and observed changes in lived experience, while also showing why these outcomes remain varied and context-dependent. Its value lies not in proving a uniform effect but in explaining how meaning, embodied practice, and relational support are integrated within a single Buddhist palliative care setting.

## Conclusion

This article has developed the DSC Triangle Model from the case study of Wat Kham Pramong and argued that Buddhist spiritual care for terminal cancer patients at the temple is structured through an integrated relationship among Doctrine, Spiritual Pillar, and Community. The model is not a pre-existing framework applied to the case. It is formulated from the convergence of doctrinal analysis, participant observation, care-team explanations, patient narratives, and the temple care setting. Through this model, Buddhist spiritual care at Wat Kham Pramong is understood as a coherent qualitative response to the spiritual distress of terminal cancer patients.

The findings may be summarized in relation to the study’s objectives. First, Wat Kham Pramong responds to the spiritual needs of terminal patients through an integrated care model that combines Buddhist teachings, embodied spiritual practices, and communal support. Second, the Buddhist teachings and practices most relevant to these needs include impermanence (*aniccam*), suffering (*dukkham*), non-self (*anattā*), mindfulness meditation on death (*marañānussati*), *Buddho* recollection, daily chanting, the herbal medicine and guilt-letter ceremony, and final-day spiritual support. Third, patient narratives, care-team explanations, and field observations indicate qualitative patterns of movement from fear, resistance, anxiety, unresolved burden, and isolation toward greater acceptance, inner peace, relational connection, and a more meaningful final stage

of life. These patterns were grounded in patient interview statements, care-team explanations, and observation-based evidence concerning chanting and *Buddho* recollection, flexible participation for physically weak patients, the guilt-letter ceremony, family presence, and community life among patients and families. At the same time, these outcomes vary according to physical condition, disease progression, psychological readiness, religious familiarity, family support, and capacity to participate.

The new body of knowledge offered by this article is the case-derived DSC Triangle Model. Its main contribution lies in showing how doctrinal meaning, embodied spiritual practice, and relational support work together as lived Buddhist spiritual care in a contemporary temple-based palliative setting. Doctrine provides meaning and interpretive direction. The Spiritual Pillar provides embodied cultivation. Community provides the sustaining environment. The model should therefore be read as a case-based analytical framework, not as a universal or prescriptive formula for all Buddhist palliative care settings.

The study also has practical implications. For clinical and secular healthcare workers, the Wat Kham Pramong case suggests that spiritual care should be recognized as part of quality palliative care rather than an optional supplement. Its value lies not only in reproducing temple rituals but also in deep listening, patient-centered conversation, family communication, meaning-making, respect for patient autonomy, and present-moment support. In secular or religiously diverse settings, explicitly Buddhist language may sometimes need to be translated into more broadly accessible terms such as natural process, human suffering, acceptance, emotional release, or compassionate presence. Healthcare settings may draw from this case by developing culturally sensitive spiritual-care assessments, training palliative-care providers in active listening and in working with diverse belief systems, creating space for family presence and quiet reflection, and collaborating carefully with religious or community-based caregivers where appropriate. In this sense, the model complements rather than replaces medical palliative care. Medical care addresses pain and bodily symptoms, whereas spiritual care attends to fear of death, unresolved burden, attachment, family concern, and the search for peace.

At the same time, the model must be applied with caution. The study is based on a single case and a small qualitative sample. It does not claim statistical representativeness, does not include a comparison group, and cannot isolate the specific effects of Buddhist practice from the wider temple environment. It may also underrepresent patients who were too weak to participate, left the temple after care, did not remain in contact, declined formal interviews, or were unable to complete informed consent because of rapid disease progression. These limitations are important because the available narratives may not fully represent patients who did not respond to the temple environment in the same way or whose conditions prevented sustained participation.

Beyond Wat Kham Pramong, the DSC Triangle Model may be useful as an analytical framework for comparison with other Buddhist, community-based, or culturally embedded palliative-care settings. However, it cannot be assumed to apply unchanged across all Buddhist traditions, secular hospitals, or non-Buddhist patients. What may be most transferable is not every external form of the temple's practices. However, the underlying logic of helping terminal patients reinterpret death, cultivate inner calm through embodied spiritual practice, and receive sustained support within a compassionate community. Different Buddhist communities may express these functions through different texts, rituals, and caregiving arrangements, while non-Buddhist or secular settings would require further adaptation. The model's value, therefore, lies not in proving a uniform effect but in explaining how meaning, embodied practice, and relational support are integrated in one Buddhist palliative care setting and how this integration may inform future discussion of spiritually sensitive end-of-life care.

## Ethics Statement

Ethical approval for interviews with terminal cancer patients, who constitute a vulnerable research population, was obtained from the Institutional Review Board of the Hospital of Excellence in Thai Traditional and Complementary Medicine for Cancer at Sakonnakhon, IRB No. 02/2025, with approval granted on May 20, 2025. The terminal patients were informed of the study's purpose and voluntarily provided informed consent before interviews. Interviews with care-team informants were conducted with appropriate institutional permission, and the care-team informants were also informed of the study's purpose and voluntarily agreed to participate. Materials from informal contact or potential participants without complete informed consent were excluded from the empirical findings. Patient materials are presented in a way that protects participants' dignity and avoids claiming representativeness beyond the qualitative case study.

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