ASIANA INSTITUTE

Buddhist Chaplaincy Curriculum — Academic / Continuing Education Edition

Crossing the Threshold

Integrating the Pali Canon and Near-Death Experience Research in End-of-Life Chaplaincy

A Five-Session Curriculum with Literature Review, Session Plans, and Paritta Texts

> *Just as a candle, before it goes out, flares up; even so the faculty of life, reaching the end, flares up at the final moment.* — *adapted from the commentarial tradition on the Buddha's last hours*

About This Curriculum

This edition expands the original Asiana Institute orientation essay into a full continuing-education curriculum suitable for chaplaincy formation, supervisory review, and accreditation documentation. It is organized in three parts: a literature review establishing the textual and empirical foundations of the training; five ninety-minute sessions, each with stated objectives, a timed agenda, content notes, experiential practice, and discussion questions; and appendices containing paritta texts and further reading.

Total contact time across the five sessions is approximately seven and a half hours, suitable for inclusion as a continuing-education module. Institute administrators should map the objectives below onto the specific competency domains required by their accrediting body, since standards and terminology vary across professional chaplaincy organizations and jurisdictions; this curriculum does not claim certification by, or formal alignment with, any single external accreditor.

Audience: chaplains, chaplain residents, and hospice or palliative-care spiritual-care staff with a working knowledge of basic chaplaincy skills (active listening, family systems, grief literacy). Prior exposure to Buddhist studies is helpful but not required; Session 1 introduces the necessary canonical background.

Learning Objectives

By the end of this curriculum, participants will be able to:

1. Describe the Pali Canon's treatment of death, the aggregates, and the continuity of consciousness, with reference to primary sources.
2. Summarize the major empirical findings of near-death experience (NDE) and end-of-life dream and vision (ELDV) research, including methodology and points of ongoing scientific debate.
3. Identify points of resonance and difference between early Buddhist teaching and NDE/ELDV research.

4. Correctly pronounce and appropriately apply three parittas traditionally used for the sick and dying.
5. Apply a structured bedside protocol integrating presence, chanting, and family companioning.
6. Recognize signs of distress versus comfort in patient-reported end-of-life experiences and respond without pathologizing them.
7. Practice self-care and peer-consultation strategies appropriate to sustained end-of-life ministry.

Theoretical Foundations: A Literature Review

A. Death and the Continuity of Consciousness in the Pali Canon

The Pali Canon's approach to death is anchored in two interlocking ideas: the analysis of the person into five aggregates (pañcakkhandha — form, feeling, perception, volitional formations, and consciousness), and the practice of maraṇasati, mindfulness of death, which the Buddha commends in the Aṅguttara Nikāya as a practice that *"gains a footing in the Deathless"* (AN 6.19; trans. Thanissaro Bhikkhu, 1997). In two paired discourses (AN 6.19–20), the Buddha presses his monastics to practice maraṇasati with increasing urgency, down to the span of a single in-breath, framing the contemplation of mortality not as morbid but as the engine of diligence (appamāda).

The most extensive canonical account of a death — the Buddha's own — appears in the Mahāparinibbāna Sutta (DN 16; trans. Walshe, 1995), which narrates the final months, illness, and passing of the Buddha in close physical and psychological detail. The text depicts a dying process attended to consciously: the Buddha names his location, manages his pain, instructs his community, and is described as moving through successive levels of meditative absorption (jhāna) in his final hours. For chaplaincy purposes, the sutta offers a model less of doctrine than of disposition — attentive, communal, unhurried.

Buddhist psychology locates continuity between lives in consciousness, glossed in places as a "stream" (viññāṇa-sota) carried forward by volitional formations, or karma (Bodhi, 2005). Scholars caution against treating this as a simple transfer of a fixed self — the canon is explicit that no unchanging soul migrates — but the texts are equally explicit that some continuity of process persists. This is a doctrinally subtle point, and chaplains should resist flattening it into either strict annihilation or unchanged personal survival; both readings are contested within Buddhist scholarship itself, and institute faculty are encouraged to consult a qualified Buddhist studies advisor when teaching this material in depth.

B. Canonical Texts for Illness and Dying: The Paritta Tradition

Alongside its philosophical literature, the canon and its commentaries preserve a practical tradition of texts recited at the bedside of the sick and dying, known as paritta (protection). The commentator Buddhaghosa and the Milindapañha together list nine core parittas, including the Ratana Sutta, Mettā Sutta, and Bojjhaṅga Sutta. The Saṃyutta Nikāya records the recitation of the seven factors of enlightenment (bojjhaṅga) at the bedside of gravely ill senior monastics, with recovery reported in each case (SN 46.14–16; Bodhi, 2000). A separate discourse, the Girimānanda Sutta, recounts the Buddha

instructing Ven. Ānanda to recite ten perceptions to the gravely ill monk Girimānanda, after which, the text reports, *"his illness died down on the spot"* (AN 10.60; trans. Sujato, SuttaCentral).

The Theravāda scholar Lily de Silva, in a widely cited essay on Buddhist pastoral care, notes that inviting a monastic to chant protective suttas at the bedside of the dying is a long-standing custom, intended to help the patient meet death with developed faith and composure (de Silva, 1986). De Silva also observes that the efficacy attributed to these chants is traditionally linked to accurate, attentive recitation and to the listener's confidence in the Triple Gem — a reminder that pronunciation and pacing matter, not merely content. This essay is recommended foundational reading for chaplains adapting these texts (see Appendix B).

C. The Empirical Study of Near-Death Experience

Modern interest in near-death experience (NDE) research begins largely with psychiatrist Raymond Moody's Life After Life (1975), which collected first-person accounts and popularized the term. The field gained empirical traction through psychiatrist Bruce Greyson's 1983 NDE Scale, a sixteen-item instrument assessing cognitive, affective, paranormal, and transcendental features, which remains the standard research tool for identifying and comparing NDEs (Greyson, 1983). Greyson directs the Division of Perceptual Studies at the University of Virginia.

The best-known prospective clinical study is Dutch cardiologist Pim van Lommel and colleagues' 2001 investigation of 344 consecutive cardiac arrest survivors across ten hospitals, published in The Lancet. Roughly eighteen percent of survivors reported some memory of the period of unconsciousness, and the authors found no significant correlation between NDE occurrence and the duration of cardiac arrest, medication use, or fear of death prior to the arrest — a finding they argued was difficult to reconcile with purely physiological explanations (van Lommel et al., 2001). The same year, UK-based physician Sam Parnia and colleagues published a parallel prospective study with comparable incidence findings (Parnia et al., 2001). Parnia subsequently led the multi-center AWARE and AWARE-II studies, which combined survivor interviews with real-time EEG and cerebral-oxygenation monitoring during resuscitation; AWARE-II, published in Resuscitation in 2023, documented brain activity associated with thought and memory in some patients during cardiopulmonary resuscitation, alongside lucid recalled experiences of death (Parnia et al., 2014, 2023).

Researchers continue to disagree about underlying mechanism. Van Lommel has proposed a "nonlocal consciousness" hypothesis, arguing that current neuroscience does not fully account for lucid, structured experience reported during periods of greatly reduced or absent measurable brain activity (van Lommel, 2013). Other researchers favor neurophysiological explanations involving surges of electrical activity, hypoxia, or the effects of resuscitation drugs. The Handbook of Near-Death Experiences, an academic survey edited by Holden, Greyson, and James (2009), documents this range of interpretive positions without resolving it. Chaplains should hold this debate with epistemic humility: the consistency of the experiential pattern across studies is well established; its ultimate explanation is not, and this curriculum does not require participants to adopt any single explanatory theory.

D. End-of-Life Experiences in Hospice and Palliative Populations

A related but distinct line of research examines what hospice clinicians term end-of-life dreams and visions (ELDVs), or end-of-life experiences (ELEs) — vivid, often comforting experiences of deceased loved ones, travel, or preparation reported by actively dying patients rather than resuscitated survivors. The most extensive contemporary study, led by hospice physician Christopher Kerr and colleagues at Hospice & Palliative Care Buffalo, longitudinally interviewed sixty-six hospice inpatients and found that a large majority experienced at least one ELDV, with comforting content increasing in frequency as death approached (Kerr et al., 2014). Kerr's subsequent book, Death Is But a Dream (2020), and a related qualitative study (Nosek et al., 2015) describe ELDVs as most commonly featuring deceased relatives, preparation for travel, and a marked easing of the fear of dying. This work echoes earlier hospice-nursing literature, notably Callanan and Kelley's Final Gifts (1992), which first popularized the idea that dying patients communicate meaningfully through symbolic and visionary language caregivers can learn to recognize and honor.

E. Points of Convergence

Placed side by side, the Pali Canon's account of the dying mind and the pattern documented in NDE and ELDV research illuminate one another without collapsing into each other. The table below is a teaching aid, not a claim of equivalence.

Pali Canon	NDE / ELDV Research	Representative Sources
Maraṇasati — death as a threshold for diligent practice, not mere ending (AN 6.19–6.20)	A sense of crossing a boundary or threshold rather than ceasing to exist	Moody (1975); Greyson (1983)
Viññāṇa-sota, the stream of consciousness said to continue beyond bodily dissolution (Bodhi, 2005)	Reports of awareness persisting, and at times sharpening, as bodily function declines	van Lommel et al. (2001); van Lommel (2013)
Devas, ancestors, and the Buddha himself appear in the canon as guiding figures at moments of crisis	Encounters with deceased relatives or luminous guiding presences	Kerr et al. (2014); Holden et al. (2009)
Mettā — boundless, unconditional loving-kindness as a cultivated, sublime abiding (Sn 1.8)	An overwhelming, unconditional love often described as the dominant and lasting impression	Greyson (1983); Moody (1975)
Right View arising from clear seeing of one's karma and conduct	A panoramic “life review” experienced with clarity and minimal self-judgment	Greyson (1983); Holden et al. (2009)
Paritta chanting for the gravely ill, e.g., the Bojjhaṅga and Girimānanda Suttas (SN 46.14–16; AN 10.60)	Reported reduction in fear and distress associated with the dying process itself	de Silva (1986); Kerr (2020)

F. A Note on Interpretive Pluralism

This curriculum places Buddhist doctrine and NDE/ELDV research side by side without asserting that one validates the other. The Pali Canon offers a coherent soteriological framework developed over millennia of contemplative practice; NDE and ELDV research offers a younger, still-maturing empirical literature whose findings are robust at the level of pattern but contested at the level of mechanism. Chaplains trained in this curriculum are asked to recognize both bodies of knowledge, draw on each where it serves the patient and family in front of them, and avoid overstating either tradition's claims as settled fact.

Session Plans

Each session below is designed for ninety minutes with a single facilitator and a cohort of six to fourteen participants. Facilitators should adapt timing to group size and prior familiarity with the material.

Session 1 — Foundations of Maraṇasati and the Buddhist Map of Dying

Session Objectives

- Define maraṇasati and locate it within the Pali Canon (AN 6.19–20).
- Outline the five aggregates and the concept of viññāṇa-sota.
- Summarize the structure and pastoral significance of the Mahāparinibbāna Sutta (DN 16).
- Practice a guided maraṇasati reflection appropriate for personal formation.

Agenda

Time	Segment	Format
0:00–0:15	Opening centering practice (silent sitting, bell)	Experiential
0:15–0:40	Lecture: the five aggregates and maraṇasati (AN 6.19–20)	Didactic
0:40–1:00	Text study: the Buddha's final days (DN 16)	Guided reading + discussion
1:00–1:20	Guided maraṇasati reflection	Experiential
1:20–1:30	Closing circle and journaling prompt	Reflection

Content Notes

Open by introducing the five aggregates (pañcakkhandha) as the canon's working analysis of a person, then turn to AN 6.19–20, in which the Buddha questions his monastics about how seriously they practice mindfulness of death and presses them toward practicing it with the urgency of a single breath. Facilitators should emphasize that maraṇasati is taught as a tool for living attentively, not as a morbid preoccupation. Close the didactic portion with a guided reading of selected passages from the Mahāparinibbāna Sutta (DN 16), drawing out the Buddha's composure, his attention to his community, and his movement through meditative absorption in his final hours.

Experiential Practice: Guided Maraṇasati Reflection (20 minutes)

Facilitator leads participants through a seated reflection adapted from AN 6.19–20: beginning with the reflection "my life is not guaranteed beyond this breath," participants are invited to notice what arises — fear, urgency, calm, resistance — without suppressing it, then to ask what remains undone in their own lives that this awareness clarifies. Close with three minutes of mettā directed toward oneself.

Discussion Questions

1. What is the difference between maraṇasati and morbid rumination about death? Where is that line, and how would you describe it to a new chaplain?
2. What did you notice in your own body or mind during the guided reflection?
3. How does the composure modeled in the Mahāparinibbāna Sutta compare to deaths you have witnessed in your own practice?

Reading assignment before Session 2: Holden, Greyson, & James (2009), Chapter 1, and van Lommel et al. (2001) (abstract and discussion sections).

Session 2 — The Science of Near-Death Experience and Consciousness Studies

Session Objectives

- Summarize key findings from Greyson (1983), van Lommel et al. (2001), and Parnia et al. (2001, 2014, 2023).
- Distinguish NDE research (resuscitated survivors) from ELDV research (actively dying hospice patients).
- Practice responding to a family's question about a loved one's reported vision without over- or under-interpreting it.

Agenda

Time	Segment	Format
0:00–0:10	Check-in from Session 1 reflections	Discussion
0:10–0:40	Lecture: the empirical NDE literature and the mechanism debate	Didactic
0:40–1:00	Lecture: ELDV research in hospice populations (Kerr et al., 2014)	Didactic
1:00–1:25	Small-group case vignette discussion	Applied / small group
1:25–1:30	Large-group synthesis	Discussion

Content Notes

Walk participants through Greyson's NDE Scale as a measurement tool before turning to van Lommel et al. (2001) and Parnia et al. (2001, 2014, 2023), highlighting study design (prospective, consecutive patients), key findings, and the limits of what each study can and cannot establish. Present the mechanism debate — van Lommel's nonlocal consciousness hypothesis versus neurophysiological explanations —

evenhandedly, then shift to Kerr et al. (2014) and the ELDV literature, underscoring that ELDV research concerns actively dying patients rather than resuscitated survivors, a distinction chaplains should keep clear when speaking with clinical staff.

Case Vignette (composite, for training purposes only)

"Mrs. A, age 78, is an inpatient hospice patient with end-stage heart failure. For the past several nights she has reported her late husband 'visiting' and sitting at the foot of her bed. She is not frightened by this; she says it brings her comfort. Her daughter, however, is alarmed and asks the nurse whether her mother is 'losing her mind.' The nurse pages the chaplain."

Discussion Questions

1. How would you respond to the daughter's question, drawing on the ELDV literature without overstating certainty about its meaning?
2. What language would you avoid using with Mrs. A's family, and why?
3. Where does your own theological or philosophical position create a temptation to over-interpret an experience like this one?

Session 3 — Parittas for the Sick and Dying: Chanting Practicum

Session Objectives

- Correctly pronounce and chant the Karaṇīya Mettā Sutta, an excerpt of the Bojjhaṅga Paritta, and an excerpt of the Ratana Sutta.
- Understand the traditional pastoral function of each text (de Silva, 1986; Encyclopedia of Buddhism, 2024).
- Apply paritta chanting sensitively across religious backgrounds, including with non-Buddhist patients and families.

Agenda

Time	Segment	Format
0:00–0:15	Background: the paritta tradition and its pastoral use	Didactic
0:15–0:55	Guided chanting practicum (three parittas)	Experiential / call-and-response
0:55–1:15	Cross-religious sensitivity discussion and role-play	Applied
1:15–1:30	Closing chant and debrief	Experiential

Background

Recap from the literature review: paritta ("protection") texts have been chanted at the bedside of the sick and dying since the earliest period of the tradition, with the Bojjhaṅga and Ratana Suttas among the most prominent (SN 46.14–16; Sn 2.1; de Silva, 1986). De Silva notes that traditional practice emphasizes accurate, attentive recitation; facilitators should treat correct pronunciation and unhurried pacing as part of the pastoral offering itself, not a technicality.

The renderings below are introductory teaching texts prepared for this curriculum. Before using any paritta liturgically at a bedside, chaplains should learn pronunciation from a qualified teacher or a verified recording and cross-check the text against a published chanting book such as Piyadassi Thera's The Book of Protection (see Appendix B).

1. Karaṇīya Mettā Sutta (Sn 1.8) — the Discourse on Loving-Kindness

Traditional use: general bedside comfort; a blessing for the patient and the family present.

> *Karaṇīyamatthakusalena yantasantaṁ padaṁ abhisamecca,*
> *Sakko ujū ca suhujū ca, suvaco cassa mudu anatimānī.*
> One skilled in the good, who seeks the state of peace, should be capable, upright, truly upright, easy to correct, gentle, and without conceit.

> *Mātā yathā niyaṁ puttaṁ, āyusā ekaputtamanurakkhe,*
> *Evampi sabbabhūtesu, mānasaṁ bhāvaye aparimāṇaṁ.*
> Just as a mother would protect her only child with her own life, so should one cultivate a boundless heart toward all living beings.

> *Mettañca sabbalokasmiṁ, mānasaṁ bhāvaye aparimāṇaṁ,*
> *Uddhaṁ adho ca tiriyañca, asambādhaṁ averamasapattaṁ.*
> Let one cultivate boundless loving-kindness toward the whole world — above, below, and across — unobstructed, free of hatred and ill will.

> *Tiṭṭhaṁ caraṁ nisinno vā, sayāno vā yāvatassa vigatamiddho,*
> *Etaṁ satiṁ adhiṭṭheyya, brahmametaṁ vihāramidhamāhu.*
> Standing, walking, sitting, or lying down, as long as one is free from drowsiness, one should sustain this mindfulness — this, it is said, is the sublime abiding here.

(The complete sutta runs to ten verses; the full Pali and a published English translation should be sourced from Appendix B before formal liturgical use.)

2. Bojjhaṅga Paritta (excerpt) — the Seven Factors of Awakening

Traditional use: at the bedside of a patient in physical distress, pain, or agitation; associated in the canon with the relief of serious illness (SN 46.14–16).

> *Bojjhaṅgo satisaṅkhāto, dhammānaṁ vicayo tathā,*
> *Vīriyaṁ pītipassaddhi-bojjhaṅgā ca tathāpare,*
> *Samādhupekkhabojjhaṅgā, sattete sabbadassinā*
> *Muninā sammadakkhātā, bhāvitā bahulīkatā*
> *Saṁvattanti abhiññāya, nibbānāya ca bodhiyā,*
> *Etena saccavajjena, sotthi te hotu sabbadā.*
> Mindfulness as a factor of awakening, and likewise investigation of phenomena, energy, rapture, and tranquility as factors of awakening, and also concentration and equanimity as factors of awakening — these seven, taught completely by the All-Seeing Sage, when developed and made much of, lead to direct knowledge, to liberation, and to awakening. By the speaking of this truth, may you be well at all times.

3. Ratana Sutta (Sn 2.1, opening verse) — the Discourse on the Jewels

Traditional use: protection and blessing during transition; historically associated with relief from epidemic illness and calamity.

> *Yānīdha bhūtāni samāgatāni, bhummāni vā yāni va antalikkhe,*
> *Sabbeva bhūtā sumanā bhavantu, athopi sakkacca suṇantu bhāsitaṁ.*
> *Tasmā hi bhūtā nisāmetha sabbe, mettaṁ karotha mānusiyā pajāya,*
> *Divā ca ratto ca haranti ye baliṁ, tasmā hi ne rakkhatha appamattā.*
>
> Whatever beings are gathered here, whether of the earth or of the sky, may all beings be glad at heart, and may they listen carefully to what is said. Therefore, all you beings, give attention: show loving-kindness to the human community, who by day and night bring offerings; therefore protect them, and do not be negligent.

Most verses of the Ratana Sutta close with the refrain *Etena saccena suvatthi hotu* — "By this truth, may there be well-being" — which can be chanted alone as a brief blessing when time at the bedside is short.

Practicum Instructions

- Facilitator chants one line at a time; participants repeat (call-and-response) until comfortable, then chant together.
- Practice slow, soft, even pacing — bedside chanting should never be rushed.
- A small bell or singing bowl may mark the opening and close of a bedside chant; this is a cultural convention, not a doctrinal requirement.
- With non-Buddhist patients and families, offer rather than impose chanting ("I know a traditional chant for ease and protection — would it be alright if I offered it quietly?"), and be prepared to translate or simply hum the melody without words if requested.

Discussion Questions

1. Which of the three texts felt most natural to you, and which will require the most practice?
2. How would you adapt your offer of chanting for a patient or family from a different faith tradition?
3. What is lost, and what is gained, by using a brief refrain (e.g., the Ratana Sutta refrain) instead of a full sutta when time is short?

Session 4 — Bedside Protocols and Companioning the Dying and Their Families

Session Objectives

- Apply the five-step bedside protocol: grounded presence, chanting as container, listening for transition language, naming impermanence gently, and holding silence.
- Practice plain-language family communication about ELDVs and NDE-related phenomena.
- Complete a triad role-play of a bedside visit, including a chanting offering and a family conversation.

Agenda

Time	Segment	Format
0:00–0:20	Lecture: the five-step bedside protocol	Didactic
0:20–0:40	Family communication: language that reassures without diagnosing	Didactic + examples
0:40–1:15	Triad role-play (chaplain / patient / family member)	Applied / small group
1:15–1:30	Debrief and large-group discussion	Discussion

The Bedside Protocol

- **Grounded presence first.** Before any words are offered, the chaplain settles their own breath and mind, embodying the equanimity they hope to extend; the dying are often acutely sensitive to the emotional state of those around them.
- **Chanting as a container.** Paritta chanting offers rhythm and continuity that can settle an agitated mind without requiring the listener to track meaning word for word (see Session 3).
- **Listening for transition language.** When a patient speaks of travel, of being met, of seeing departed family, or of light, the chaplain receives this without correction or over-interpretation, affirming that such experiences are common and meaningful (Kerr et al., 2014).
- **Naming impermanence gently.** Where appropriate, the chaplain may offer the Buddha's own framing — that the aggregates dissolve while some continuity of process is described as carrying forward — as a resource for those who find comfort in it, remaining sensitive to each family's own beliefs.
- **Holding silence.** Much of this work happens without speech at all. A hand held, a steady presence, unhurried time communicate what doctrine alone cannot.

Family Communication: General Guidance

- Reassure without diagnosing: describe ELDVs as common and well-documented in the hospice literature rather than offering a clinical or psychiatric label.
- Invite direct address: encourage family members to speak aloud to their dying relative, and to deceased relatives the patient mentions, since hearing is understood to persist later than other senses.
- Offer, don't impose: chanting, prayer, or scripture should be offered as an option, never assumed.
- Normalize ambivalence: some families find these experiences comforting and others find them disorienting; both responses are appropriate and deserve a non-judgmental hearing.

Role-Play Exercise (35 minutes)

In triads, assign roles of chaplain, dying patient, and family member. Using the composite scenario from Session 2 (Mrs. A) or a scenario of the group's own design, the chaplain conducts a five-to-seven-minute bedside visit incorporating at least one element of the protocol and one offered (not imposed) chant excerpt. Rotate roles so each participant plays the chaplain once.

Discussion Questions

1. What was hardest to hold simultaneously — your own presence, the patient's experience, and the family's anxiety?
2. Where did the language you used slip into reassurance that overstated certainty?
3. What would you do differently at the next bedside?

Session 5 — Integration, Case Consultation, and Chaplain Self-Care

Session Objectives

- Apply the full integrated framework to two composite case studies in small-group consultation.
- Identify signs of compassion fatigue and secondary traumatic stress in oneself and peers.
- Draft a personal self-care and supervision plan.
- Participate in a closing ritual appropriate for cohort completion.

Agenda

Time	Segment	Format
0:00–0:10	Centering practice	Experiential
0:10–0:45	Small-group case consultation (two composite cases)	Applied / small group
0:45–1:05	Self-care and secondary traumatic stress discussion	Didactic + discussion
1:05–1:20	Personal self-care plan (individual writing)	Reflection
1:20–1:30	Closing mettā chant and cohort ritual	Experiential

Composite Case Studies (for training purposes only)

Case 1. A 16-year-old patient with a terminal diagnosis describes a recurring dream of a grandmother she never met, who tells her “not to be afraid.” Her parents, who do not practice any religion, ask the chaplain whether this means something is “wrong” with their daughter.

Case 2. A 60-year-old patient who survived a cardiac arrest a decade earlier and had what he calls a “death experience” at that time is now actively dying of an unrelated illness. He is calm, says he is “not afraid of what's next,” and asks the chaplain to chant with him rather than talk.

- In small groups, discuss: What from the literature review (Sections C and D) is relevant here? What from the bedside protocol (Session 4) applies? What would you say, and what would you deliberately not say?

Self-Care and Secondary Traumatic Stress

Sustained end-of-life ministry carries a cumulative emotional cost. Facilitators should normalize fatigue, intrusive imagery, and grief as expected features of this work rather than signs of unsuitability for it, and should review the institute's own peer-consultation and supervision structures. Participants are encouraged to identify one peer or supervisor with whom they will debrief difficult cases going forward.

Personal Self-Care Plan (15 minutes, individual writing)

Participants write brief responses to: What replenishes me after a difficult bedside visit? Who do I turn to for consultation? What is one boundary I will hold this quarter?

Closing Ritual

Close the curriculum as a cohort by chanting the Karaṇīya Mettā Sutta excerpt from Session 3 together, followed by a moment of silence and an optional sharing of one word each participant carries forward.

Final Reflection (for continuing-education credit)

Participants submit a 750–1000 word reflective paper applying the integrated framework to a real or anonymized case from their own practice, addressing: (1) what from the Pali Canon and what from NDE/ELDV research was relevant to the case; (2) which elements of the bedside protocol were used; (3) what the chaplain would do differently in a similar future case.

Appendix A — Paritta Quick-Reference Card

A condensed reference suitable for printing as a laminated bedside card. Full texts and proper pronunciation should be learned in Session 3 before relying on this card alone.

Text	Key Line	When to Use
Karaṇīya Mettā Sutta (Sn 1.8)	*Mātā yathā niyaṁ puttaṁ, āyusā ekaputtamanurakkhe... ("as a mother protects her only child…")*	General comfort; blessing for patient and family
Bojjhaṅga Paritta (SN 46.14–16)	*Etena saccavajjena, sotthi te hotu sabbadā. ("By this truth, may you be well always.")*	Physical distress, pain, agitation
Ratana Sutta (Sn 2.1)	*Etena saccena suvatthi hotu. ("By this truth, may there be well-being.")*	Protection and blessing during transition; brief offering when time is short

Appendix B — Suggested Further Reading and Source Texts

For full liturgical texts, verified pronunciation, and deeper doctrinal study, consult:

- Piyadassi Thera (Trans.). The Book of Protection (Paritta). Buddhist Publication Society — standard published chanting text with full Pali and English.
- Walshe, M. (Trans.). (1995). The Long Discourses of the Buddha (Dīgha Nikāya). Wisdom Publications — for the Mahāparinibbāna Sutta in full.
- Bodhi, B. (Trans.). (2000, 2012). The Connected Discourses of the Buddha; The Numerical Discourses of the Buddha. Wisdom Publications — for the Bojjhaṅga and Girimānanda Suttas in full.
- Bodhi, B. (2005). In the Buddha's Words: An Anthology of Discourses from the Pali Canon. Wisdom Publications — accessible thematic entry point for chaplains new to the canon.
- SuttaCentral (suttacentral.net) — online libraries of Pali Canon translations, useful for cross-checking texts and audio pronunciation guides.
- Holden, J. M., Greyson, B., & James, D. (Eds.). (2009). The Handbook of Near-Death Experiences. Praeger/ABC-CLIO — the standard academic survey of NDE research.
- Kerr, C. W. (2020). Death Is But a Dream: Finding Hope and Meaning at Life's End. Avery — accessible synthesis of the Hospice Buffalo ELDV research, suitable for sharing with families.
- Callanan, M., & Kelley, P. (1992). Final Gifts. Poseidon Press — foundational hospice-nursing text on symbolic communication near death.

References

Bodhi, B. (Trans.). (2000). The connected discourses of the Buddha: A translation of the Saṃyutta Nikāya. Wisdom Publications.

Bodhi, B. (2005). In the Buddha's words: An anthology of discourses from the Pāli Canon. Wisdom Publications.

Bodhi, B. (Trans.). (2012). The numerical discourses of the Buddha: A translation of the Aṅguttara Nikāya. Wisdom Publications.

Callanan, M., & Kelley, P. (1992). Final gifts: Understanding the special awareness, needs, and communications of the dying. Poseidon Press.

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