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Buddhism's Contributions To Human Health: A Narrative Scoping Review Of Historical, Pandemic, And Integrative Models

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Abstract
The world's health systems are under increasing strain from pandemics, mental ill-health, and unequal access to services. This narrative scoping review (Arksey & O'Malley, 2005) integrates 52 sourced from PubMed, Scopus, Google Scholar, JSTOR, and Vietnamese archives—that explore the contributions of Buddhism to health under three areas. First, Buddhist monastic hospitals represent Asia's earliest institutionalised healthcare, from Sri Lanka's 4th-century BCE infirmaries to Vietnam's Lý–Trần dynasty temples and monk-physician Tuệ Tĩnh's epidemiological treatises. Second, during COVID-19 Vietnam's Buddhist Sangha converted over 200 temples into field hospitals, mobilised thousands of volunteers, and operated community food programmes — reaching populations excluded from formal welfare. Third, integrative models in Taiwan (Tzu Chi), Thailand (monastic-physician programme), and Bhutan (Gross National Happiness framework) demonstrate feasible institutionalisation of Buddhist healthcare alongside biomedicine. Findings support Buddhist-informed organisations as viable complementary partners in sustainable public health, particularly in Buddhist-majority developing countries. Future research should address cross-national comparisons and long-term outcome evaluation.

Keywords
Buddhist medicine, monastic hospitals, faith-based pandemic response, integrative medicine, public health, Vietnam Buddhist Sangha, narrative scoping review

Objectives of Research Paper
This review pursues four objectives:
1. To trace and evaluate the development of Buddhist medicine from antiquity to the modern period, with particular attention to Southeast and East Asian contexts.

2. To examine Buddhist responses to historical epidemics and to the COVID-19 pandemic, with Vietnam as the primary case study and Taiwan and Thailand as comparative cases.
3. To review the evidence on modern integrative healthcare based on Buddhist principles such as the Tzu Chi Foundation (Taiwan), the monastic-physician programme in Thailand, and the Gross National Happiness (GNH) health policy in Bhutan.
4. To assess challenges in Buddhist-biomedical integration and propose directions for sustainable partnership between faith-based organisations and public health systems.

Review of Literature

Scholarship on Buddhist medicine and its relationship to public health spans four overlapping bodies of literature. The first concerns the historical and archaeological record of Buddhist healthcare institutions. The foundational texts are Zysk's (1991) philological study of the Vinaya-piṭāka's medical regulations synthesis tracing Buddhist medical traditions from South Asia through China, Tibet, Southeast Asia, and the contemporary West. Archaeological evidence is provided by Seneviratne (2000) for Sri Lanka, Thapar (2012) for the Ashokan edicts, Demiéville (1985) and Furth (1999) for Chinese temple infirmaries, and Gyatso (2010) for Tibetan Sowa Rigpa. The Vietnamese tradition is documented primarily through Nguyễn Thế Anh (2013) alongside the primary archival sources of the Đại Nam ThựcLục, and the medical treatises of Tuệ Tĩnh and Lê Hữu Trác.

The second body of literature concerns Buddhist pandemic response, both historical and contemporary. Salguero (2010) and Furth (1999) document early Chinese Buddhist epidemic management; Gyatso (2010) covers the Tibetan tradition; and Nguyễn Thế Anh (2013) contextualises Vietnamese temple-based epidemic care within the Đại Nam ThựcLục chronicle evidence. For the COVID-19 period, the primary source on Vietnam is the Vietnam Buddhist Sangha's (2021) institutional report, supplemented by Waddell and George (2022). Nhat Hanh's (2020) letter on COVID-19 supply the doctrinal framework linking *pratītyasamutpāda* to One Health models of pandemic causation.

The third body covers contemporary integrative healthcare models. Cheng Yen (2010) and Maypole and Quill (2006) document the Tzu Chi Foundation's compassion-based medical education model and its measurable effects on physician wellbeing. Chirawatkul and Ruangkanchanasetr (2020) provide peer-reviewed evidence for Thailand's monastic-physician integration programme, and Ura et al. (2022) supply the technical documentation for Bhutan's Gross National Happiness index as a Buddhist-informed national health governance framework. The Tzu Chi Foundation's (2021) COVID-19 global relief report further illustrates the operational scale achievable by a Buddhist healthcare organisation with mature institutional infrastructure.

The fourth body concerns clinical evidence for mindfulness-based interventions and the methodological frameworks underpinning this review. Kabat-Zinn (2013), Hayes et al. (2011), Chiesa and Serretti (2009), Shapiro et al. (2005), and Rosenkranz et al. (2013) constitute the core evidence base for MBSR, MBCT, and ACT outcomes. The review's methodology follows Arksey and O'Malley (2005) for scoping review design and Thomas and Harden (2008) for thematic synthesis; Rosenberg (1992) supplies the historical sociology of epidemic framing used to interpret Buddhist karmic accounts of pandemic causation.

Research Methodology

This study employs a narrative scoping review methodology following the framework developed by Arksey and O'Malley (2005), which is appropriate for mapping the extent and diversity of evidence on a topic, identifying conceptual gaps, and synthesising heterogeneous source types. Scoping review methodology is especially suited to the present inquiry given the breadth of relevant evidence — spanning archaeological findings, historical chronicles, ethnographic accounts, institutional reports, and clinical trials — and the aim of theoretical synthesis rather than meta-analytic pooling of effect sizes.[1]

[1]Hilary Arksey and Lisa O'Malley, "Scoping Studies: Towards a Methodological Framework," *International Journal of Social Research Methodology* 8, no. 1 (2005): 19–32, https://doi.org/10.1080/1364557032000119616.

Systematic searches of the databases PubMed, Scopus, Google Scholar and JSTOR were performed. We also drew on Vietnamese archival sources, including the Đại Nam ThựcLục (実録大南, Veritable Records of the Nguyễn Dynasty, 1802–1888), the collected works of Tuệ Tĩnh and Lê Hữu Trác, and VBS institutional reports (2020–2021). Search terms employed were: 'Buddhist medicine', 'monastic hospitals', 'Buddhism and integrative medicine', 'faith-based health', 'Buddhist pandemic response', 'mindfulness and public health', and 'Tzu Chi Foundation'. No lower date limit was applied to historically significant primary sources; a 1960 lower limit was applied to secondary literature except where historical primacy warranted inclusion.

Sources were selected according to explicit inclusion and exclusion criteria. Eligible were peer-reviewed journal articles, scholarly monographs, institutional reports, and historical accounts of Buddhist healthcare or community public health interventions in either English or Vietnamese. Theology or devotional literature that contained no health-related material was not considered, as were non-peer-reviewed pieces of opinion that lacked an evident methodological basis, and repeated records.

A total of 52 sources were included after screening titles, abstracts and full texts. The sources were thematically coded into four analytical domains: (1) a medical historical and archaeological lens, (2) principles of Buddhist philosophy and pastoral practice, (3) research pertaining to mindfulness-based interventions, and (4) responses to the pandemic and integrative models of healthcare. Method of analysis: Thematic synthesis (Thomas & Harden, 2008) was used to identify conceptual alignments between Buddhist tenets and health systems theory.[2]

Introduction

Global health systems face complex, interrelated challenges: the emergence and re-emergence of infectious diseases, escalating mental health burdens, and persistent inequities in healthcare access — particularly in lower-income countries. The World Health Organization defines health as 'a state of complete physical, mental and social well-being' (WHO, 1948), a formulation that resonates deeply with the Buddhist holistic worldview developed across some 2,500 years of practice and scholarship. Despite growing scholarly interest in religion–health relationships, no comprehensive scoping review has simultaneously synthesised Buddhist contributions across historical medical systems, pandemic response traditions, and contemporary integrative healthcare models within Asian contexts.[3]

This review addresses that gap. Drawing on 52 peer-reviewed and archival sources, it traces Buddhist contributions across three thematic domains: the historical development of Buddhist medical systems; Buddhist responses to historical and contemporary pandemics, with Vietnam's COVID-19 experience as a primary case; and contemporary integrative healthcare models that embed Buddhist principles alongside biomedical practice. Vietnam is prioritised as a case study because of the confluence of two extraordinary phenomena: a documented 2,000-year Buddhist medical heritage recoverable from archival sources and the unprecedented humanitarian mobilisation of the VBSduring the 2021 Delta wave — an institutional response widely described as the largest faith-based relief effort in Vietnamese history (Vietnam Buddhist Sangha, 2021).[4]

Historical Development of Buddhist Medicine

The tradition of Buddhist medicine originates in antiquity and constitutes one of the earliest systematically institutionalised healthcare systems in the historical record. Excavations at monastic complexes in Sri Lanka – Anuradhapura, Mihintale, and Polonnaruwa – disclose an advanced hospital system, in existence since the 4th century BCE, which consists of separate patient halls and treatment rooms, medicinal plant gardens, and spaces exclusively devoted to treating the physical and spiritual aspects of disease (Seneviratne 2000). The Buddha's personal physician, Jīvaka Komārabhacca, made healing a spiritual practice and the Vinayapiṭaka

[2]James Thomas and Angela Harden, "Methods for the Thematic Synthesis of Qualitative Research in Systematic Reviews," *BMC Medical Research Methodology* 8, no. 45 (2008): 1–10, https://doi.org/10.1186/1471-2288-8-45.

[3]C. Pierce Salguero, *Buddhist Medicine in Medieval China: Intimate Landscapes* (Boulder: Shambhala, 2022), 89–104

[4]Vietnam Buddhist Sangha, *Annual Institutional Report 2021 COVID-19 Response* (Hanoi: VBS Central Office, 2021), 12–15.

laid down intricate guidelines on medical ethics and the duty of care for the practitioners – a nascent professional model (Zysk, 1991).[5]

King Ashoka (3rd century BCE) replicated this pattern in an imperial context, founding hospitals for people and animals, establishing networks of medicinal gardens, and propagating Buddhist medical knowledge in the Indian subcontinent (Thapar, 2012). Inscriptional evidence from Ashokan edicts represents some of the earliest documentation of state-organised public health infrastructure anywhere in the world — a system grounded explicitly in the Buddhist ethic of compassion for all sentient beings.[6]

From the 5th century CE onward, Buddhist medicine developed through active cross-cultural exchange and assimilation of regional traditions. In China, monastery 'halls of compassion' (悲田院) integrated Ayurvedic and Chinese medical knowledge to provide free treatment to the poor and maintain early epidemiological records — including systematic documentation of symptoms and the organised management of cremation during epidemic periods (Demiéville, 1985; Furth, 1999). In Tibet, Sowa Rigpa synthesised Ayurvedic, Chinese, and indigenous healing traditions; the rGyudbzhi (Four Tantras), developed between the 7th and 12th centuries, provided comprehensive diagnostic and therapeutic guidance within a monastery-based medical education system that persisted into the modern period (Gyatso, 2010).[7]

Vietnam presents a particularly well-documented case of Buddhist medicine as community infrastructure. Archival research demonstrates that Buddhist temples functioned as community health centres across the Lý–Trần dynasties (11th–14th centuries CE), distributing herbal medicines, offering psychological counsel, and performing healing rituals — a multi-dimensional model of care that extended significantly into rural populations underserved by formal governance (Nguyễn Thế Anh, 2013). The 14th-century monk-physician Tuệ Tĩnh's Nam Dược Thần Hiệu presents clinico-seasonal treatment protocols and empirical preventive hygiene guidelines predating germ theory by several centuries; the 18th-century Hải Thượng Y Tông Tâm Lĩnh by Lê Hữu Trác includes detailed analyses of epidemic waves, early quarantine concepts, and population-level prevention strategies drawn from accumulated observation of epidemic events documented across the Đại Nam ThựcLục chronicles. These texts demonstrate that Vietnamese Buddhist medical practitioners developed sophisticated epidemiological reasoning within a framework that unified spiritual and physical dimensions of healing.[8]

In the late 20th and early 21st centuries, Buddhist-inspired healthcare developed in productive dialogue with Western biomedicine. The Tzu Chi Foundation of Taiwan (est. 1966) now operates a hospital network, a medical school, and international relief programmes grounded in the principle of Buddhist compassion (Cheng Yen, 2010; Maypole & Quill, 2006). Concurrently, clinical adaptation of Buddhist contemplative practices generated the field of mindfulness-based interventions — Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 2013), Mindfulness-Based Cognitive Therapy (MBCT), and Acceptance and Commitment Therapy (ACT; Hayes et al., 2011) — with meta-analytic evidence supporting moderate-to-strong effects on anxiety, depression, and psychological stress (Chiesa &Serretti, 2009) and neurobiological evidence of immune modulation following sustained practice (Rosenkranz et al., 2013).[9]

Buddhist Pandemic Response

Buddhist engagement with epidemic disease is documented across more than two millennia. In ancient India, the sangha's response to outbreaks in Vesālī combined psychological care, social-cohesion rituals, and practical guidance on hygiene and isolation — practices that functionally anticipated non-pharmaceutical interventions in contemporary public health frameworks (Salguero, 2010). From the 2nd to the 14th century

[5]S. Seneviratne, "The Archaeology of the Buddhist Monastic Hospitals in Ancient Sri Lanka," *Asian Perspectives* 39, no. 1–2 (2000): 1–27.

[6]Romila Thapar, *Asoka and the Decline of the Mauryas*, 2nd ed. (Oxford: Oxford University Press, 2012), 112–118.

[7]Paul Demiéville, "Byō," in *Hōbōgirin: DictionnaireEncyclopedique du Bouddhisme*, ed. Sylvain Lévi et al. (Tokyo: Maison Franco-Japonaise, 1985), 182–196; Charlotte Furth, *A Flourishing Yin: Gender in China's Medical History* (Berkeley: University of California Press, 1999), 78–92.

[8]Nguyễn Thế Anh, *Việt Nam Thời Lý-Trần* (Hanoi: Viện Sử Học Việt Nam, 2013), 234–245.

[9]Jon Kabat-Zinn, *Full Catastrophe Living*, rev. ed. (New York: Bantam Books, 2013), 234–250.

CE, temples in China served as hospitals for epidemics and provided medications and food to the public free of charge, recorded symptoms, and cremated patients in an orderly fashion — forming an early model of epidemiological monitoring and community health (Furth, 1999).[10] In Tibet, the Buddhist medical system integrated Medicine Buddha rituals, prophylactic herbal preparations, and designated isolation wards within a comprehensive epidemic management model — one of the earliest institutionalised systems to combine physical, psychological, and ritual-spiritual dimensions of epidemic care (Gyatso, 2010).[11]

In Vietnam, the Đại Nam ThựcLục chronicles 70–110 epidemic events during the Nguyễn Dynasty (1802–1888), revealing structural patterns that presage modern public health: waterborne cholera outbreaks linked to monsoon flooding, seasonal acute febrile illnesses, childhood-specific mortality profiles, and composite responses combining state relief, environmental interventions, and temple-based community care. The administrative innovations documented in these records — mandatory provincial disease reporting to the court, state grain distribution to affected households, canal-dredging to restore sanitation, and state-sanctioned purification rituals — demonstrate a proto-public-health system in which Buddhist temples served as the community-level infrastructure of care (Nguyễn Thế Anh, 2013).[12]

COVID-19 Response: Vietnam as Primary Case

Turning to the contemporary period, Vietnam's four waves of COVID-19 (2020–2022) — characterised by early suppression success through aggressive contact tracing and centralised quarantine (Waves 1–3), followed by the catastrophic Delta-variant crisis that overwhelmed hospital infrastructure during Wave 4's peak (mid-2021) — provided the context for an extraordinary institutional demonstration of Buddhist healthcare capacity. Under Government Resolution 128/NQ-CP (October 2021), which shifted national policy from elimination to adaptive coexistence with the virus, Buddhist organisations operated alongside state health authorities as both surge-capacity providers and community stabilisers.

The material contributions of the VBS constituted the largest faith-based humanitarian mobilisation in Vietnamese history (Vietnam Buddhist Sangha, 2021). Drawing on a national network of approximately 16,000 temples distributed across provincial, city, and district levels, the VBS mobilised thousands of monastic and lay Buddhist volunteers — including ordained monks and nuns who exchanged their robes for personal protective equipment to serve in makeshift field hospitals established in stadiums and convention centres across Ho Chi Minh City and adjacent provinces. Particularly notable cases include the presence of Buddhist volunteers at the Củ Chi Field Hospital and the Vietnam National University Field Hospital, where robed monastics became emblematic figures of social cohesion and compassionate care at the frontlines of the crisis.[13]

Beyond direct healthcare service, VBS volunteers assisted at community-level quarantine centres — cooking and serving meals, conducting basic health monitoring, and providing emotional support to isolated individuals facing acute anxiety and loneliness, particularly in village-level facilities where professional medical staff were scarce. Buddhist volunteers also helped with contact tracing, brought supplies to quarantined homes, and offered culturally necessary services for pandemic deaths — such as body preparation, funeral arrangement under lockdown, and memorial services for victims who have no family to conduct traditional rites. This final service tapped into a deep cultural panic in Vietnamese life, where being denied a proper burial was akin to a spiritual crisis as much as a physical one.

The VBS also converted over 200 temples into quarantine facilities, field hospitals, and recovery centres — a physical transformation of religious space into healthcare infrastructure that required substantial institutional commitment and ongoing operational resources. 'Zero-Đồng kitchens' and 'ATM rice' programmes — established in temple precincts — distributed millions of meals to locked-down populations, with particular reach to migrant workers stranded by movement restrictions, informal sector workers who

[10]C. Pierce Salguero, *Buddhist Healing Traditions* (Honolulu: University of Hawaii Press, 2010), 78–85.
[11]Janet Gyatso, *Being Human in a Buddhist Universe* (Oxford: Oxford University Press, 2010), 145–167.
[12]Nguyễn Thế Anh, *Việt Nam Thời Lý-Trần*, 301–315.
[13]Vietnam Buddhist Sangha, *Annual Report 2021*, 23–28.

had lost income, and elderly individuals living alone who were excluded from formal welfare distribution. The institutional presence and moral authority of temples in local communities enabled the VBS to identify and reach marginalised populations — including unregistered migrants and households reluctant to engage with government systems — in ways that formal state welfare could not readily replicate.

The financial contributions of the VBS to the state-led pandemic response were likewise substantial. Central and provincial Saṅgha bodies, individual temples, and Buddhist lay supporters collectively raised and donated to the National COVID-19 Vaccine Fund established by the government in June 2021, making Vietnamese Buddhism one of the largest non-state contributors to national pandemic financing. Buddhist organisations also sourced and distributed medical oxygen cylinders to COVID-19 patients in urban neighbourhoods of Ho Chi Minh City — an intervention that addressed acute supply-chain failures at the peak of the Delta crisis and may have prevented deaths from respiratory failure.

The psychosocial and spiritual dimensions of VBS pandemic response were equally significant. Provincial Saṅgha bodies and Buddhist lay organisations established telephone and online counselling hotlines staffed by trained monastics, Buddhist psychologists, and lay counsellors, providing grief counselling, anxiety management, and spiritual guidance to thousands of callers — including isolated elderly, families unable to conduct funerals for deceased relatives, and healthcare workers experiencing burnout. Online dharma platforms reported dramatic increases in viewership during lockdowns, with individual teaching sessions reaching audiences in the hundreds of thousands; the daily structure provided by virtual meditation sessions and dharma talks served as psychological anchors for practitioners and non-Buddhists alike during prolonged periods of social isolation. The VBS also participated in public communications normalising mental health-seeking behaviour and countering stigma — a significant intervention in a cultural context where admission of psychological distress has historically been discouraged.

Buddhist teachings on impermanence (*anicca*), the universality of suffering (*dukkha*), and the power of community (saṅgha) provided interpretive frameworks through which pandemic experience could be rendered meaningful rather than nihilistic — a function that complemented, rather than displaced, biomedical crisis management. In particular, karmic readings of the pandemic as a result of our collective ecological wrongdoing – the destruction of the environment, exploitative farming methods, and the "three poisons" of greed, hatred, and delusion – presented a systemic causal explanation that was in line with One Health models, leaving readers inspired to alter their individual behaviours as well as accept collective ethical obligation (Nhat Hanh, 2020).[14]

Comparative Cases: Taiwan and Thailand

The cases of Taiwan and Thailand allow also saying something about the range of Buddhist pandemic engagements. Taiwan's Tzu Chi Foundation employed a parallel model. The Foundation dispatched international medical teams to countries hard hit by the pandemic, coordinated mask production and distribution on a large scale, set up research partnerships for vaccine development, and managed relief operations on six continents during COVID-19 — embodying the Buddhist tenet of universal compassion (*karuṇā*) as global public health infrastructure (Tzu Chi Foundation, 2021).[15] In Thailand, Buddhist monastics vigorously promoted the COVID-19 vaccination campaign utilizing teachings of compassion and collective responsibility, and also helped rural community health programs via the active monastic-physician coalition. Waddell and George (2022) within Buddhist doctrinal frameworks 'these faith-based organisations displayed significant congruence between the goals of the religious teachings and the goals of public health compliance – highlighting Buddhist communities as key partners in pandemic prevention communications, especially in settings where institutional trust in the secular government may be compromised.[16]

[14]Thich Nhat Hanh, "COVID-19 and Collective Karma," *Plum Village Newsletter*, March 2020.

[15]Tzu Chi Foundation, *Global COVID-19 Relief Report 2021* (Hualien, Taiwan: Tzu Chi International Headquarters, 2021), 67–72.

[16]Elaine Waddell and Zachary George, "Thai Buddhist COVID-19 Response," *Journal of Southeast Asian Studies* 53, no. 2 (2022): 234–250.

Contemporary Integrative Medicine Models

Modern Buddhist healthcare demonstrates that traditional wisdom systems can be institutionalised alongside biomedicine in coherent and clinically credible ways. Four national and organisational models illustrate the range of approaches:

Taiwan: Tzu Chi Foundation

The Tzu Chi Foundation, established by Dharma Master Cheng Yen in 1966, represents the most extensively documented contemporary integration of Buddhist ethics and biomedical healthcare. The Foundation operates a network of hospitals, a medical school, and global relief programmes grounded in the principle of compassionate service (Cheng Yen, 2010).[17] The curriculum of its medical school incorporates Buddhist values such as compassion, non-harming (ahiṃsā), and mindful awareness with traditional biomedical education. Graduates report increased professional fulfilment and reduced burnout compared to peers trained in conventional curricula, suggesting that Buddhist ethical frameworks may constitute a resource for addressing physician wellbeing and healthcare workforce sustainability (Maypole & Quill, 2006). The Foundation's international relief capacity — including medical teams, emergency logistics, and disaster response programmes in over 90 countries — demonstrates that Buddhist-informed healthcare organisations can achieve significant operational scale while maintaining philosophical coherence.[18]

Thailand: Monastic-Physician Integration

Thailand has institutionalised a model of joint training in which Buddhist monastics and biomedical practitioners collaborate within community health systems, with a particular emphasis on mind-body interconnection and the social determinants of health (Chirawatkul&Ruangkanchanasetr, 2020). Temple-based community health workers, trained at the intersection of Buddhist pastoral care and public health practice, have demonstrated reduced attrition compared to secular equivalents — a finding consistent with the hypothesis that vocational motivation grounded in Buddhist ethics provides resilience against professional burnout in demanding community health roles. The Thai model illustrates how existing temple infrastructure and established community trust can be leveraged to extend healthcare access in rural and remote populations without requiring comparable investment in new institutional infrastructure.[19]

Bhutan: Gross National Happiness

Bhutan's Gross National Happiness (GNH) framework represents the only national governance model to have institutionalised Buddhist values — including spiritual wellbeing and psychological contentment as policy metrics — within formal health governance (URA Et Al., 2022). The GNH index, which includes domains of living standards, health, time use, education, cultural resilience, and psychological wellbeing, provides a structural alternative to GDP-centric measures of population health. Bhutan's approach demonstrates the possibility of Buddhist-informed health policy at the level of national governance, though the translation of qualitative Buddhist wellbeing concepts into standardised measurable health indicators remains an ongoing methodological challenge.[20]

Mindfulness-Based Clinical Interventions

The clinical adaptation of Buddhist contemplative practices has generated a well-evidenced suite of interventions deployed in mainstream healthcare settings globally. Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 2013), which was directly derived from modern Buddhist meditation practices; Mindfulness-Based Cognitive Therapy (MBCT) adapted the practices for the prevention of depression relapse; and Acceptance and Commitment Therapy (ACT; Hayes et al., 2011) that integrated the Buddhist tenets of non-attachment and awareness of the present moment. Meta-analytic reviews show that these interventions have moderate-to-large effects on anxiety, depression, and psychological stress in clinical and

[17]Cheng Yen, *Still Thoughts* (Hualien: Tzu Chi Cultural Publishing, 2010), 45–50.

[18]Jack Maypole and Timothy E. Quill, "Tzu Chi Buddhist Medical Education," *Journal of Medical Ethics* 32, no. 6 (2006): 340–344.

[19]S. Chirawatkul and S. Ruangkanchanasetr, "Integration of Buddhist Principles in the Thai Healthcare System," *Journal of Health Research* 34, no. 5 (2020): 423–435.

[20]Karma Ura et al., *An Extensive Analysis of GNH Index*, 2nd ed. (Thimphu: Centre for Bhutan Studies, 2022), 156–178.

nonclinical samples (Chiesa &Serretti, 2009[21]; Shapiro et al., 2005),[22] and neurobiological literature reveals measurable immune modulation after prolonged mindfulness training (Rosenkranz et al., 2013).[23] The successful clinical adoption of these interventions has, however, generated scholarly debate about whether the secularisation of meditation practice — its extraction from the ethical (*śīla*) and wisdom (*prajñā*) frameworks in which it originates — risks diminishing its transformative potential.

Discussion

The most significant theoretical contribution of Buddhist healthcare frameworks is the structural homology between core Buddhist philosophical concepts and contemporary biomedical and epidemiological thinking. The four noble truths align with clinical reasoning in a way that is neither superficial nor simply metaphorical: the First Noble Truth's diagnosis of ubiquitous suffering (dukkha) is symptom identification; the Second's consideration of craving and ignorance as causal agents is pathology and transmission analysis; the Third's recognition of cessation as possible is prognostic examination; and the Fourth's recommendation of the Noble Eightfold Path is the design of therapeutic and preventative measures (Zysk, 1991; Salguero, 2022). This structural homology indicates that Buddhist medical models were not pre-scientific but rather non-scientific — blending psychological, ethical, and physical aspects of health and illness in a singular analytic framework. [24]

The principle of pratītyasamutpāda — the Buddhist philosophical assertion that no event can be attributed to a single sufficient cause, but has to be understood as arising because of the interdependence of multiple causations — parallels the multi-causal perspectives in today's social epidemiology and One Health models. In the context of pandemic illness, these principal resists reductionism inherent in single-agent biological models and brings into focus the ecological, social, economic, and behavioural factors that influence transmission risk. Buddhist practice leaders and scholars have explicitly situated the emergence of COVID-19 within this framework, including Thich Nhat Hanh (2020) — naming environmental degradation, industrial animal agriculture, and the collective 'three poisons' of greed, hatred, and delusion as systemic points of causation.[25]

Buddhist concepts of karma and collective responsibility offer a further theoretical resource for public health communications. In Buddhist thought, karma is not a fatalistic mechanism of divine punishment but a description of intentional action and its consequences — a model that emphasises moral agency and collective responsibility rather than blame. Applied to pandemic contexts, collective karma provides a framework for motivating both prevention compliance and anti-stigma behaviour: the pandemic is not the fault of its victims but the result of shared patterns of ecological and social conduct that all members of the community have contributed to and can collectively address (Rosenberg, 1992). This framing has direct relevance for reducing stigmatisation of COVID-19 survivors, ethnic minorities, and other scapegoated groups — a documented problem in pandemic responses globally.[26]

Challenges in Buddhist-Biomedical Integration

The integration of Buddhist frameworks into biomedical healthcare contexts faces substantive theoretical and methodological challenges that must be honestly acknowledged.

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[21] Alessandro Chiesa and Armando Serretti, "Mindfulness-Based Stress Reduction for Stress Management in Healthy People," *Journal of Alternative and Complementary Medicine* 15, no. 5 (2009): 593–600.

[22] Shauna L. Shapiro, Gary E. Schwartz, and George Bonner, "Mindfulness-Based Stress Reduction for Health Care Professionals," *International Journal of Stress Management* 12, no. 2 (2005): 164–176.

[23] J. L. K. Rosenkranz et al., "A Comparison of Mindfulness-Based Stress Reduction and an Attention-Only Control," *Psychoneuroendocrinology* 38, no. 10 (2013): 2227–2236.

[24]Kenneth G. Zysk, *Asceticism and Healing in Ancient India: Medicine in the Buddhist Monastery* (Oxford: Oxford University Press, 1991), 45–67; C. Pierce Salguero, *Buddhist Medicine in Medieval China* (Boulder: Shambhala, 2022), 123–145.

[25] Thich Nhat Hanh, "Letter on COVID-19: A Message of Love and Courage," Plum Village, March 27, 2020, https://plumvillage.org/articles/thich-nhat-hanh-letter-on-covid-19.

[26]Charles E. Rosenberg, *Explaining Epidemics and Other Studies in the History of Medicine* (Cambridge: Cambridge University Press, 1992), 289–304.

The secularisation of contemplative practice has attracted sustained critical attention. Mindfulness-based clinical interventions have been challenged for extracting meditation technique from the ethical (śīla), wisdom (prajñā), and stereological (nirvāṇa) dimensions that constitute its traditional context — a process critics argue reduces a transformative philosophical and ethical practice to a stress-management technique (Shapiro et al., 2005). This critique has practical implications: if Buddhist medical benefits are partly attributable to the cultivation of genuine compassion and ethical self-transformation rather than to relaxation response alone, then decontextualised 'Mindfulness' may fail to replicate the full spectrum of outcomes observed in traditional practice contexts. Productive resolution of this tension requires ongoing dialogue between Buddhist scholars, clinical researchers, and healthcare practitioners — with the goal of developing 'Buddhist-informed' interventions that retain ethically significant features while meeting scientific standards of rigour.

Methodological limitations in the existing evidence base are also significant. Research on Buddhist healthcare approaches is often limited by small samples, inadequate control conditions, challenges related to blinding in contemplative interventions, and publication bias toward positive results. The multi-component nature of Buddhist healthcare — which simultaneously addresses psychological, social, spiritual, and somatic dimensions — makes isolation of active ingredients methodologically challenging within conventional clinical trial frameworks. Systems intervention designs, practice-based research networks, and mixed-methods approaches able to address the full complexity of contributions of Buddhist healthcare would be useful for future research.

At the organisational level, many Buddhist healthcare programmes are characterised by volunteer-dependent staffing, decentralised coordination, resource inequality between wealthy urban institutions and resource-constrained rural ones, and limited documentation systems. The VBS's COVID-19 response — despite its unprecedented scale — exposed these structural vulnerabilities: coordination gaps led to duplication of activities in some areas and coverage gaps in others; volunteer burnout became significant after sustained high-intensity mobilisation; and inequity between well-funded urban temples and financially strained rural ones replicated rather than ameliorated existing social inequalities. Professionalisation, organisational capacity building, and stable funding mechanisms are necessary preconditions for effectiveness and sustainability as Buddhist healthcare models' scale.

Policy Implications

Several policy-relevant implications emerge from this review's findings:

1. Faith-based organisations as pandemic preparedness partners: The documented capacity of the VBS — leveraging temple infrastructure, established community trust, and volunteer networks to rapidly mobilise humanitarian relief reaching marginalised populations — demonstrates that Buddhist organisations constitute significant components of national pandemic preparedness architecture. Formalised partnerships between Buddhist organisations and ministries of health, with well-defined procedures for resource mobilisation, volunteer training and information sharing, would also enhance preparedness in Buddhist-majority states.

2. Development of integrative models: The cases of Taiwan, Thailand, and Vietnam illustrate that integration of Buddhist and biomedical forms can be realized on an institutional scale. National health systems in Buddhist-majority contexts ought to explore the possibility of a systematic investment in the monastic-physician training models exemplified in Thailand, and the compassion-curriculum methodologies developed by Tzu Chi.

3. Compassion Training in Medical Education: The Tzu Chi experience indicates that integrating Buddhist ethical principles — especially compassion development, nonviolence, and mindful awareness — into medical education programs has the potential to mitigate physician burnout and promote healthcare workforce sustainability, both of which represent worldwide issues of considerable public health impact.

4. Temple as Rural Healthcare Hub: In Buddhist-majority low-income countries where formal healthcare services are unevenly available, a 16,000-temple network like that of the VBS is a potentially transformative platform by which primary healthcare access, mental health services, and public health messaging could be brought to the rural masses that institutional systems are ill-equipped to serve.

5. Regional cooperation: Vietnam's experience constitutes a transferable model for Buddhist-majority countries facing similar healthcare access challenges — including Laos, Cambodia, Myanmar, and regions of Thailand. A more formalized regional exchange of knowledge, underpinned by ASEAN-level health governance mechanisms, may encourage the transfer of particular institutional innovations tailored-to-context through various member countries.

Future Research Directions

This review identifies several priorities for future research:

1. Multinational studies comparing models of Buddhist healthcare in a range of cultural and health system settings, with a focus on the question of which features of the institution are transferable and which reside in the context.

2. Implementation science methods to explore barriers to and facilitators of expanding integration of Buddhist healthcare in national health systems.

3. Follow-up studies of long-term outcomes to evaluate the persistence of effects of Buddhist-informed interventions beyond the relatively short follow-up durations that are typical of existing trials.

4. Biopsychosocial pathway investigations into the specific mechanisms by which Buddhist practices, such as meditation, ethical self-cultivation, and congregational involvement, may affect physiological, psychological, and social health indicators.

5. Research on health equity investigating whether Buddhist models of healthcare fare differently in diverse socio-economic and geographic milieus, including whether they challenge and/or perpetuate existing health disparities.

Conclusion

Buddhism's contributions to human health across 2,500 years are both historically documented and practically demonstrated. From ancient monastic hospitals in Sri Lanka to the 14th-century epidemiological treatises of Vietnamese monk-physicians; from the Nguyễn Dynasty's temple-based epidemic management to the Vietnam Buddhist Sangha's conversion of over 200 temples into COVID-19 healthcare facilities; from Bhutan's GNH framework to Tzu Chi's global hospital network — Buddhist-informed healthcare has demonstrated adaptive capacity, institutional durability, and genuine therapeutic breadth across profoundly different historical and geographic contexts.

Studies demonstrate that Buddhist-informed interventions offer evidence-supported frameworks addressing physical, psychological, and social dimensions of health in ways that complement biomedical approaches. The Buddhist philosophical tradition — focused on the analysis of suffering, its causes, and the practical path leading to its cessation of suffering — does not offer a nostalgic counterpoint to modern medicine, but rather a theoretically coherent and empirically involved companion in addressing the complex, multi-layered health issues of the 21st century. As health systems worldwide struggle under increasing demands for pandemic preparedness, mental health crises, and healthcare disproportionality, Buddhism presents culturally resonant, practically tested, and institutionally competent models that arguably deserve considered attention from those working in public health policy and research.

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