

Introduction

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Buddhist Care for the Dying and Bereaved: Past and Present

Buddhist understandings of death and practices developed for dying and the moment of death have been hallmarks of the tradition since its beginning in India 2,500 years ago. Over the last forty years, they have been an important part of the global revival of Buddhism, especially in the West—from the popularization of the *Tibetan Book of the Dead* to Zen poetry about death to Theravadan meditation on the decaying body to belief in the welcome of Amida Buddha on one's deathbed. Today there is a plethora of new titles by various authors on how to use Buddhist teachings and practices to face death and the dying of loved ones—a quick search for “Buddhism” and “death” on amazon.com pulls up 543 entries. These entries by and large focus on how an individual or family member can face and prepare for death as an inner journey or as a journey with intimate relations.

Relatively little is known, however, about the number of Buddhist based initiatives for caring for the dying and bereaved through the development of trained professionals and the building of facilities that have mushroomed since the late 1980s. While a number of these initiatives have been created by high profile Buddhist teachers, like Sogyal Rinpoche and Joan Halifax, who have written heart moving books on death, their initiatives and others are not as highly publicized in the mass media. In fact, when one even speaks of “hospice,”¹ one is drawn back to its Christian origins in 11th century Europe; Mother Mary Aikenhead (1787-1858), the Irish nun, and the Religious Sisters of Charity who created the modern hospice archetype; and Dame Cicely Saunders, the Anglican nurse who founded the first modern hospice, St. Christopher's Hospice, in

¹ The term “hospice” has an original meaning of “a lodging for travelers, young persons, or the underprivileged especially when maintained by a religious order,” which directly relates to its Latin origins in *hospes*, meaning “to host.” *Merriam-Webster Dictionary*. <http://www.merriam-webster.com>.

London in 1967. As we will see in this volume, Saunders has had an especially major impact on the Buddhist hospice movement around the world.

At the same time, the Buddhist hospice movement marks a recovery of these aforementioned practices of Buddhism towards death and their application in new, modern conditions and societies. Indeed, the Vihara Movement in Japan has consciously named itself using the traditional and ancient Buddhist term for temple, *vihara*. Like the term “hospice,” *vihara* has also had the meaning of a place for travelers to take rest in addition to a place that might offer social welfare and medical care for the poor. Rev. Yozo Taniyama explains in his chapter how the famous Jetavana Vihara established by the historical Buddha himself eventually developed into such a comprehensive center for spiritual, economic, and medical care. The great Indian monarch, Ashoka (r. 270-232 BC), who is credited with first unifying the Indian subcontinent under one rule, was known to have promoted the development of herbal medicine and dispensaries through Buddhist temples. This tradition established in India eventually spread throughout the Buddhist world. Japan, as the final frontier of the ancient spread of Buddhism, inherited this tradition from the beginning with the establishment of Shitenno-ji temple in present day Osaka in 593. Shitenno-ji was not only the first officially administered Buddhist temple in Japan but also included a hospital, a poor house, and a pharmacy that grew and cultivated medicinal plants. In this way, there is a long-standing template for Buddhist institutions serving as centers of care for the ill and dying.

The historical Buddha himself offers an original template for the role of the Buddhist caregiver. One of the Buddha's epithets is the “Great Physician,” denoting his core teaching of the Four Noble Truths that examine the nature of suffering as dis-ease, its causes, its cure, and the course of cure. There are numerous examples of the Buddha and his close disciples guiding both ordained persons and lay persons through painful physical illnesses to illumination on their death beds. These stories serve as the primary Buddhist template for dying with a monk as a deathbed counselor (Skt. *kalyanamitra*). However, two striking examples show the Buddha as much more than a deathbed counselor. This first is the story of the monk Putigatta Tissa, who had become gravely ill with a disease and festering sores that emitted foul smells to the point that all his fellow monks abandoned him. The Buddha upon finding out about his situation not only admonished the other monks to care for him but also was the first to go clean his body,

his robes, and his room and establish a plan for his further care. The second story, which is detailed in Rev. Julie Hanada's chapter, is about the laywoman Kisa Gotami whom the Buddha supported in her grieving over her dead child. In short, by asking her to find a house that had not experienced death, the Buddha not only led her to a realization of the impermanence of life and the reality of death but also initiated her into a support community through coming in touch with so many others who had faced death.

Buddhism has many other ancient and contemporary examples of dedicated practitioners working to support both the dying and those who live on afterwards in grief. The important point to make here is that many Buddhists today are drawing upon this long and deep tradition to find their own models for developing forms of Buddhist engagement that not only confront but also transform the many problems facing people dying in the world today. In this volume, we have culled some of the best and most inspired examples of Buddhist care for the dying and bereaved from all over the world, covering the entire Buddhist tradition with essays from the Theravada tradition in Thailand and Cambodia; the Tibetan tradition in the Rigpa Spiritual Care Program, which functions primarily in Europe and the United States; the East Asian Mahayana tradition in Taiwan; and the *Lotus Sutra*, Pure Land, and Zen traditions in both Japan and the United States.

Essential Themes in Buddhist Care for the Dying and Bereaved

While the founders and members of the initiatives presented in this volume have some mutual knowledge of and influence on each other, many have developed their work quite independently. For example, most of the authors from Japan have no knowledge of the initiatives going on outside of Japan. While the Tibetan Rigpa initiatives and the American Zen based initiatives are knowledgeable of each other, they have both developed their own distinctively unique programs without direct collaboration. The initiative in Cambodia has had some direct influence from the Thai one, yet these two have distinctively different styles and have developed largely on their own. Finally, the initiatives in Taiwan, while being influenced by the modern British hospice model, have developed in total isolation from other Buddhist initiatives around the world. In this section, however, we will introduce many of the common and overlapping themes that emerge in the variety of essays in this volume. On the one hand, the diversity and

cultural appropriateness of each initiative is an important part of their successes—as well as a warning to those who wish to replicate them in their own contexts. On the other hand, the points of congruency show an underlying, common wisdom implicit in the work that not only validates it empirically but also provides key elements for the adaptation of the work in a variety of social and cultural contexts.

Buddhist Spirituality for the Dying

As mentioned at the beginning of this introduction, Buddhism has a long and deep tradition of practices surrounding the time of death. The goal of all of the initiatives in this volume has been to revitalize and apply them to the modern world, specifically to modern medical contexts. For example, there is the original Buddhist emphasis on the importance of a calm and meditative mental state at the time of death. This is felt to be important not only in terms of the soteriological import of the future transmigration of the consciousness but also more simply in terms of a “good death” that is filled with peace rather than struggle and angst. The Theravadan and Zen perspectives emphasize this point the most. On the other hand, the East Asian Buddhist tradition, specifically the Pure Land tradition, has developed the chanting of the Buddha’s name both by the dying and the bereaved in support of the dying to ensure a “good death” and the soteriological goal of rebirth in the Buddha’s Pure Land. Tibetan practice contains both these meditative and faith oriented practices while adding further elements, such as the *tonglen* practice of voluntarily taking on the suffering of others as one’s own and seeing one’s illness as the fulfillment of this bodhisattva vow.

Within these basic Buddhist orientations towards death, certain tensions exist. Across the traditions, there is the belief that the state of the mind at death is paramountly important, and thus open mourning and the disturbing or moving of the corpse for a period after death should not be done. This type of orientation leads to much stricter, disciplined, and formalized forms of dying where a religious professional, usually a monk or nun, is employed to support the dying as a guide and the achievement of a peaceful and “good death” is critical. In terms of the modern initiatives in this volume, this orientation expresses itself in the emphasis on highly trained religious professionals called chaplains who understand how to properly handle the issues that arise not only for the dying but for their families and care givers. Indeed, the modern

day Buddhist chaplain is akin to the traditional Buddhist deathbed counselor (*kalyanamitra*). This orientation may also express itself in more specifically Buddhist stylized facilities, such as the special room for one's last moments with a large painting of Amida Buddha and his Pure land and the special morgue for chanting and keeping the body undisturbed at the National Taiwan University Hospital, or the construction of a care center alongside a retreat community of practitioners in the Rigpa Spiritual Care Program in Ireland. This orientation has also led certain Buddhists, especially in Japan, to shun organ donation as a violation of the dying person's consciousness and subsequent transmigration.

The other orientation in Buddhism views intention—enlightened intention is one of the practices of the Noble Eightfold Path—as the fulcrum for karmic action and the eventual transmigration of the consciousness. This type of orientation has led certain Buddhists to promote organ donation as an act of bodhisattvic compassion, based in an enlightened intention that would override any disturbances to the consciousness of the deceased. This is an orientation that is strongly emphasized in modern Taiwanese Buddhism, even while they seek to maintain traditional Buddhist death practices. In terms of care for the dying and bereaved, this type of orientation, which emphasizes intention over form, dovetails with the modern hospice movement's emphasis on presence and compassionate listening by the caregiver. The professional chaplaincy movement also emphasizes this point in the chaplain not imposing their religious vision on the patient but rather acting as a facilitator for the patient to discover their own spirituality. This orientation is perhaps best expressed by Issan Dorsey, the Soto Zen priest who founded Maitri Hospice in San Francisco in the late 1980s, "You need to meet people where there are and not where you want them to be." This orientation also does not attach to the concept of a "good death," although it may still hope for it. In practical terms, initiatives that emphasize this orientation eschew the use of chaplains and instead rely on volunteers of varying levels of training. This model is prominent in the hospices of the large Tzu Chi denomination in Taiwan as well as the Maitri Hospice and the Zen Hospice Program in San Francisco.

This less formalistic orientation, as Rev. Mari Sengoku writes in her chapter, sees that "people die as they have lived" and that in most cases it is not possible and often counter productive to try to teach new spiritual orientations or practices, especially

meditation, to people who are dying. This has been a common experience for many groups in the volume, such as the Brahmavihara/Cambodia AIDS Project and the Kosei Vihara in Tokyo. On the other hand, many of the authors in this volume concur that those who have developed spiritual orientations before becoming ill seem to have better deaths. These experiences have led to a very significant movement by Buddhists within the scientific and medical communities to empirically verify the importance of spiritual care as part of a more comprehensive form of holistic care for the ill and dying. Jon Kabat-Zinn's work in mindfulness therapy at the University of Massachusetts Medical School, Joan Halifax's initiatives with the Dalai Lama and western scientists through the Mind and Life Institute, and Dr. Gian Borasio's research team at the Interdisciplinary Center for Palliative Medicine (IZP) at Munich University Hospital, are important such examples found in this volume.

These two tensions co-exist among the initiatives in this volume in that there is the sentiment that the patient should not be evangelized yet should still be offered spiritual pathways for actively moving into death and what lies beyond. In this way, one of the more surprising results of studying these initiatives is that we find an emphasis on developing a strong and committed Buddhist practice more for the caregiver than for the patient. That is, while these initiatives have varying levels of agreement on how much a patient should be offered Buddhist teachings and practices, they are in much more common agreement that Buddhist teachings and practices offer essential competencies for care givers, whether they are actually Buddhist or not. From Zen volunteers in San Francisco who meditate together to German and American medical professionals with Christian or secular orientations who learn Buddhist self care methods from the Rigpa and Upaya programs to ordained Buddhist chaplains in Taiwan and the United States who must internalize their seminary educations through practice as interns, a common perspective and point of emphasis is the need to properly train in spiritual competencies to sustainably carry on the intense work of "being with dying."

Informed Consent and Truth Telling

"Informed Consent" and "Truth Telling" are curious, specialist terms developed by the modern medical system. The former refers to the process of medical professionals,

usually the head doctor, informing a patient of the particulars of their medical situation, in short, their diagnosis. The latter refers to the process of the doctor informing the patient of the outlook for their improvement or perhaps the inevitability of their death, in short, their prognosis. One wonders what these two processes looked like in the pre-modern era when people did not rely on hospitalization and usually died in their own homes. Probably, it was a mix of the medical or care professional dealing directly with the patient and also working in consultation with their family. In the present era, a bias has developed that Asian societies, especially conservative Buddhist ones in East Asia that deeply value collectivity, do not agree with these two concepts and that they reflect western notions of individual autonomy. This claim is perhaps understandable from an East Asian cultural standpoint, but not so much from a Buddhist one. In fact, Buddhism has often been criticized for focusing on individual salvation or enlightenment as well as for placing greater emphasis on individual endeavor rather than divine intervention.

What the variety of chapters in this volume expose is that the kind of denial of death that has led to tragic forms of silence concerning the informing of patients of their condition and impending death, especially in Japan, appears to be more of the result of the culture of modernism than an inherent predisposition in Asian culture to collectivity and silence. Caroline Brazier shows in her chapter that a culture of silence around death developed in Britain from the trauma of mass death during the two world wars, the development of modern psychology based on Freud's admonition to "forget the dead," and the scientific materialism prevalent in modern medicine that sees death as defeat. Various medical professionals in the chapter on Germany attest to how they also had a culture of silence around death until very recently and that it persists in their Eastern European immigrant community. In his chapter, Carl Becker has not only pointed out how the Japanese in a short period of fifty years have gone from a culture comfortable with death to one in fear of it, but has also shown how the Buddhist culture of venerating ancestors through regular and frequent grave visits and memorial services kept death as a common presence in the lives of traditional Japanese.

The situation today is that most modern societies struggle with facing death and that modern physicians seem to struggle the most with it. In terms of the achievement of a "good death" and doing many of the meaningful Buddhist practices surrounding death as outlined above, the path towards this direction is completely shut

off if the fundamental step of acknowledging death is not taken by care givers, families, or patients. However, this is a very difficult and nuanced issue that precludes the simple conclusion that patients must simply be told point blank what is their diagnosis and prognosis without the interference of their families. Both Rev. Yoshiharu Tomatsu and Rev. Mari Sengoku, proponents of “truth telling,” have stated in their chapters that if a patient is told of their terminal prognosis but then are left to cope by themselves without a supportive family or care giver structure, then such “truth telling” can be devastating. Unfortunately, in many modern societies, where the dying are put off into abandoned corners of hospitals with infrequent family visits and little team care from the institution, this could well be the result of the standardization of “truth telling.” In this way, many of the initiatives in this volume show how to build communities of care around patients and their families, whether it be a comprehensive team care system of professionals in a hospital, a community of volunteers and fellow patients in a hospice, or a religious or local community in support of a patient dying at home or in a temple. Further, in the final chapters of the volume, we see the development of ethics committees in hospitals in the United States that are sensitive to the cultural differences of patients and the best way to handle the important work of “informed consent” and “truth telling.”

Communication Skills in Medical and Religious Professionals

These above issues of communication between care givers and patients and their families lead directly into another common critical issue: the communication skills of both medical and religious professionals in the work of “being with dying.” Besides cultural issues, one of the causes of the lack of informed consent and especially truth telling is the fact that modern medical doctors are poorly trained in interpersonal communication skills. Rev. Yoshiharu Tomatsu’s chapter gives us an inside look into the way Japanese doctors are trained and his attempts to support their development as compassionate communicators. In many of the chapters, the authors note how modern medical education drums out of students many of their initial idealistic motivations for becoming doctors, such as the desire to serve and to heal. In response, both the Upaya Being with Dying Program and the Rigpa Spiritual Care Program have specific teaching components for developing the interpersonal communication skills of medical care

professionals.

On the other hand, we find a perhaps more shocking revelation throughout the chapters of the equally poor communication skills of religious professionals. Indeed, the core motivation of Congregationalist minister Rev. Anton T. Boisen to create the first Clinical Pastoral Education (CPE) programs for developing chaplains in the United States in the 1920s was due to his own experience as a patient with a priest who could only spout back religious doctrine and not meet him as a person. Similar issues appear throughout the Buddhist world, most notably in the chapters on Japan where many priests reluctantly succeed their fathers into a vocation they view more as a business than a calling. In general, monastic education across the Buddhist world often makes monks into preachers more than listeners and compassionate companions—the root meaning of the term *kalyanamitra*.

Buddhist Chaplains & the Team Care System

The cultivation of the Buddhist chaplain is thus an important theme running through many of the chapters in this volume. While we have seen that there are varying emphases on the need for certified religious professionals, that is, ordained monks and nuns versus the use of volunteers, the development of chaplain training is a significant response to the marginalized role of religious professionals in many modern societies and the need to find ways to re-engage with society. Rev. Julie Hanada points out in her article that ideally there would be no need for chaplains if the typical monk or nun would receive the proper type of training in their seminary to engage with common people in a variety of environments, not just within the temple environment. However, in so many Buddhist countries, monastic education has become confined to the rote memorization of texts, sectarian interpretations of doctrine, the study of ritual minutiae, and the management of the religious institution—in many ways not very different from the style of education for medical doctors.

Clinical Pastoral Education (CPE), as Rev. Thomas Kilts, a Tibetan Buddhist CPE supervisor in the United States, notes, is “about dealing with relationships and crises and not just a temple congregation. One has to learn that in being out in the world with people in crisis, not just in a temple, when to use Buddhism and when to not.” This is one of the first important competencies of chaplaincy. As part of the emphasis on

deep listening and presence over preaching, chaplains must learn how to speak in a variety of ways so that, as Issan Dorsey said, they can meet the person where they actually are. Many of the authors in this volume note the great challenges experienced by chaplains in such training: first, in terms of adapting to the intense demands of medical environments, and second, in terms of learning how to bring their still intellectual knowledge of spirituality down into the heart as a practical and engaged way of relating to people. In this way, Clinical Pastoral Education (CPE) in the United States has a mandatory emphasis on ecumenical and non-denominational competencies; that is, chaplains must be able to work equally well with patients from others faiths as with ones from their own denominations. This is one of the greatest challenges in the cultivation of chaplains, because, as we will see in certain chapters, when religious denominations train and remunerate their own chaplains, there may be a relectiance to cultivate them fully in an ecumenical manner. The key in the U.S. system is that chaplains are remunerated by the hospitals and are considered a part of the medical team who must practice with a professional non-bias towards patients.

This is one significant difference from the chaplaincy model over the volunteer model. Chaplains work as paid professionals in medical institutions that are often publicly funded. In this way, they have a wider range of skilled responsibilities, such as ethics work as part of a team of professional clinicians in the hospital, work with the community, and nurturing the spiritual health of the medical organization itself. This first aspect of being part of an interdisciplinary care team is a critical new development in modern medical systems around the world. Modern medical care has been structured exclusively around the control of medical care professionals, that is doctors, with little to no decision making roles for nurses, social workers, psychiatrists (often reduced to pharmacologists), various types of therapists, and chaplains. However, over the past twenty to thirty years, considerable development in the understanding of holistic care, led by pioneers like Jon Kabat-Zinn, have helped create a mandate for spiritual care. These developments have not only shown the efficacy of spiritual care but also how it can save medical institutions and governments expenses through preventative medicine as well as hastened healing. Rev. Julie Hanada sums up the role of the chaplain in this way: “Chaplains can help shorten length of stay in the hospital, communicate with the medical team, help patients and families feel heard which can

reduce complaints and lawsuits, and facilitate end of life and medical ethical discussions.”

Another key aspect of this mandate for chaplains is not only working with patients and families but also with the other care givers and professionals in the medical institution. Rev. Julie Hanada has remarked that in her experience chaplains may spend up to 50% of their time working with the care team itself, dealing with a whole host of issues that plague medical professionals in their demanding work—as explained in detail by Rev. Joan Halifax in her chapter. On this level, the chaplain becomes much more than a compassionate companion to a dying individual or consoler to a grieving family. As a number of authors have noted, the role of a chaplain also involves overseeing and nurturing the spiritual culture of the entire professional care team and in some places the entire medical institution in which they work. This is indeed a huge and complex type of work that includes special skills and competencies. The Upaya Being with Dying Program established and run by Rev. Joan Halifax is perhaps the most compelling example in this volume of a cultivation system for chaplains that offers such knowledge and skills in this area of community and institutional transformation—most of it amazingly based on adaptations and interpretations of core Buddhist teachings.

Institutions: Hospitals vs. Hospices vs. Home Care

These above points lead us into one of the final major issues of the volume, which is both the reform of existing medical institutions and the development of holistic medical care environments where spiritual care is integral. Indeed, this appears to be a two front battle, and the initiatives in this volume reflect work on these two fronts. One is the reform of existing medical institutions. As seen throughout the volume, this is incredibly difficult and challenging work since modern medical institutions are built around cultural concepts of denial of death, death as defeat, and scientific materialism, which are the antithesis of the values in the holistic care movement to which Buddhist care belongs. While we have seen a number of different initiatives to try to influence this culture, specifically the work to scientifically prove the efficacy of spiritual care, the personal power of a sympathetic chief doctor or medical administrator has often been the key for driving change. In the chapters on Taiwan and Germany, it was high-level doctors with strong Buddhist leanings who paved the way for progressive holistic

care to be introduced in their hospitals. Ironically, Japan, a supposedly predominantly Buddhist country, seems to have the greatest lack of such medical professionals and government bureaucrats sympathetic to Buddhist or other forms of spiritual care. Yet the existence in Japan of Buddhist priests who are also medical doctors, yet almost always working *incognito*, may serve as some ray of hope if social attitudes towards Buddhism and religion can start to change.

On the other front, we can see in the volume numerous groundbreaking and radical initiatives for Buddhist based care beginning as grassroots initiatives, particularly with the marginalized. In Thailand, Cambodia, and the United States, Buddhist based care for the dying and bereaved began in the AIDS communities; with Maitri Hospice and the Zen Hospice Project in San Francisco, the Dhammarak Niwet Hospice on the grounds of Phrabat Nampu Temple in Thailand, and the Brahmavihara/Cambodia AIDS project. These projects are deeply meaningful for their realization of the true religious ideals of compassionate caring. As Caroline Brazier sums up in her chapter, “The quality and character of a culture can be perceived in its care and concern for its weakest members.” While these initiatives have faced huge obstacles in serving a community of patients with so few of their own resources, such as family, money, and a sense of personal self worth, they also have benefitted from the creativity afforded in serving a constituency that no one else took a stake in. Unlike hospitals and medical systems that have entrenched power systems and vested interests, working with marginalized communities can offer a certain freedom of creativity to develop programs in line with the ideals and values of these Buddhist practitioners.

In this way, much of the hospice movement, both east and west, Christian and Buddhist, has developed from home hospice care by volunteer groups. It is at this level that perhaps the most radical visions in this volume are presented. The reform of modern medical institutions through the development of holistic care teams, which include chaplains, is certainly a heartening development. However, when looking at the economic difficulties behind maintaining massive, centralized medical systems, as seen in Carl Becker’s article, one wonders whether there is any future in such systems and whether we would be better served with more localized, community based holistic care. This is the vision of a number of the authors from Japan. Rev. Yozo Taniyama in his chapter envisions the Vihara movement as expanding the scope of its work beyond

caring for the dying and into community social welfare. Both he and Rev. Tomatsu see the meaningful care for the dying and bereaved and its extension into greater community participation as keys for reviving Japan's moribund "Funeral Buddhism." Perhaps the closest manifestation of this ideal is the work of the Maitri Hospice embedded in and nurtured by the community it serves in San Francisco. There is also the developing vision of the Rigpa Spiritual Care Program, which is building religious communities and spiritual care centers side by side. They seek to go beyond simply a system of caring for people to building a community or society where the Buddha's first noble truth of suffering in the encounter with birth, aging, sickness, and death is part of the very fabric of daily life.

Grieving

The common issue that we have left for last to discuss is what happens after death. This is an area where many of the initiatives we have looked at are actually somewhat undeveloped. Perhaps it is due to the very compartmentalization of the work indicated in the previous section. Rev. Tomatsu in his chapter speaks at length about the separation between pre-mortem and post-mortem worlds in Japan; that is, the medical world of dying and the religious world of death. Many of the chapters discuss how the culture of death as defeat leads to the abandonment of the dying within medical institutions, pushed off into the back of wards. The holistic health and chaplain movements have sought to bring the dying back out of exile and to serve them as an integral part of hospital work. Still, the work of grieving that comes after death is not something that hospitals or palliative care wards are mandated to do, so the wall persists between pre- and post-mortem worlds with grieving families moving on to try to find new communities to support them in the post-mortem process.

Many of the initiatives in this volume attempt to support these grieving persons. However, perhaps due to their heavy emphasis on dying and offering a specific alternative to the functions of a hospital, most do not run highly developed programs for grief care. The Rigpa Spiritual Program's wider vision of a religious community embedded in birth, aging, sickness, and death shows the potential for a community that can support people through the pre- and post-mortem worlds and link them together as one total process. This is where Japanese Buddhism in particular has critical potential

for the ongoing Buddhist hospice movement. As many of the Japanese authors discuss, the Japanese Buddhist practice of regular memorial services for the dead has served for hundreds of years as a highly developed grief care system uniting spiritual values with the regular practice of remembrance, all connected to a community of support. The ironic point is that the power of these practices are being shown to the world in the roundabout fashion of western researchers, such as renowned suicidologist and thanatologist Edwin S. Shneidman's concept of "postvention" and Dennis Klass' concept of "continuing bonds." This is one major area of endeavor that many of the Buddhist hospice movements could further develop and which makes potential Japanese Buddhist contributions to this field highly significant. The spirit of holistic care that runs throughout the hospice movement could invite the extension of hospice care into regular grief care work, thus building a bridge to not only a more holistic culture of living with death but also the subsequent birth of institutions and communities that reflect this culture.

Conclusion

This volume is the second major publication of the Jodo Shu Research Institute's (JSRI) project "*Ojo* and Death: Its Meaning for Pure Land Buddhism, Japanese Buddhism and Contemporary Society." The project was initiated in 2006 by the chief of the JSRI International Relations Section, Rev. Yoshiharu Tomatsu, who had been active in the Institute's bio-ethics study group grappling with Buddhist positions on brain death, organ transplants, stem cell research, and so forth. The *Ojo* and Death Project has sought to confront a variety of practical issues that directly impact the average Japanese, such as: Japan's rapidly ageing society coupled with its low birth rate, the subsequent financial crisis in the ability to take care of the elderly and dying, and the Japanese medical establishment's outdated approach to patient care. The project has also, of course, tried to confront the crisis of the growing irrelevancy of the Buddhist priests and temples in the lives of their lay followers. It has sought to bridge various divides in Japan, such as: (1) the gap between parochial academic teachings and practical medical approaches to bio-ethics; (2) the gap between a medical system that neglects the spiritual needs of the dying and a ritualistic Buddhist temple system that neglects the spiritual needs of the living; (3) the gap between classical Buddhist ritual practices and

their application to modern living and dying. In this way, the project has sought to bring together care professionals across the spectrum from within Japan to cooperate on bringing comprehensive transformation to the way the critically ill, dying, and bereaved are cared for.

By 2011, the project had held two international roundtable discussion conferences, four special seminars with foreign and domestic specialists in the field, four complete panels as parts of international academic symposia, and one large public symposium and workshop, while conducting research trips to Taiwan, Southeast Asia, the United States, and Europe, and completing our first major publication, *Never Die Alone: Death as Birth in Pure Land Buddhism* (Jodo Shu Press 2008). To address these critical issues within Japan, the project has studied the growing number of Buddhist based hospice, spiritual care, and bereavement care activities around the world as well as within Japan. The wide variety of encounters we have had through this research are presented in this volume with grateful appreciation to the authors whose work we have come to know.