

"True Regard"
Shifting to the Patient's Standpoint of Suffering in a Buddhist Hospital

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Introduction to the Kosei Vihara

Kosei Hospital, affiliated with the lay Buddhist denomination Rissho Koseikai, established its "Supporting Friends" (*fuyu*) Center, which includes a palliative care and *vihara* ward, in April 2004. As of April 2008, there were 3,468 beds for palliative care in Japan with 331 in the city of Tokyo, which has a population of almost 13 million people. Kosei Hospital has a total of 363 beds, which means if we converted our entire hospital to specialize in palliative care and hospice we would roughly match the number in the entire city of Tokyo. This highlights the serious lack of palliative care and hospice facilities in Japan at this critical situation of our aging population. Out of Kosei hospital's total of 363 beds, we have twelve private rooms with single beds in our Palliative Care and Vihara Ward.[1] Each private room also has a sofa bed that families often use for overnight stays. In one case, we had a female patient whose husband would commute back and forth from his job to her room at the Vihara. The Vihara also has a multi purpose room for social events for patients and families, training sessions for staff, and a Buddha image for religious services.[2]

The Vihara Ward is a place for those who desire to ease both the mental and physical pain caused by cancer. Treatment is decided in consultation with the patients and their families. We offer to palliate symptoms to the greatest extent possible but do not offer life-prolonging treatment. The Vihara Ward will neither speed up nor delay death. There is the possibility of using substitute or folk remedies within the Vihara's capacities. In general, our focus is to: 1) get rid of the side effects of patients' previous

[1] Moichiro Hayashi, "Five Years of the Palliative Care Vihara Ward: Making a Place to Journey Together with Patients" (kanwa-kea bihara byoto-no go-nen-kan: kanja-san-to tomo-ni ayumu genba-zukuri), in *Religion and End of Life Medicine (shukyo-to shumatsu iryo),* ed. Chuo Academic Research Institute (Tokyo: Kosei Shuppan, 2009), 24.
[2] Hayashi. "Five Years," 38-39.

treatments, 2) relieve their pain using morphine, and 3) support their appetite.[3] The Kosei Vihara uses an extensive team care system of doctors, medical social workers, nutritionists, pharmacists, office staff, religious professionals, and other specialists as well as volunteers to support the patient and family.

The process for admittance to the ward begins upon receiving a formal request from a patient or family. The head of the nursing staff and a medical social worker (MSW) will inquire about the patient's condition and wishes while at the same time explaining about the Vihara ward to them and their family. There is no charge for this initial consultation. Afterwards, the Admissions Examination Committee conducts an external examination and decides on admission based on the following provisions: 1) the Vihara only accepts cancer patients, due to national insurance regulations, with malignant tumors who no longer wish to receive active treatment; 2) the Vihara only accepts patients who wish to receive an explanation of the actual name and condition of their illness as well as make an acknowledgement of having received such an explanation after entrance to the Vihara; 3) We have no regulations to accept or bar patients based on their religious affiliation or general religiosity.

Once a patient is admitted, there are no special limitations to their needs and requests, outside of our concern for the utmost safety of other patients and not imposing on them and their families. With the mutual consent of the patient and their family, there can be visitation at any time. Families may also spend the night at the Vihara. There is the possibility for patients to go out on visits, stay out overnight, and be released entirely from the ward. Pets may be brought into the patient's room, and ways to accommodate a patient's lifestyle, like drinking alcohol, can be considered.

Cancer is an awful disease, but it is also wonderful in that after receiving a terminal prognosis there is usually time to attend to matters with one's leftover time. On average, a patient will stay for one month in the ward, though our policy is to admit patients who have a prognosis of six months or less to live. In the first stage of this time, the patient has to re-evaluate who they are and decide how they will spend this time. In the next stage, they have to make a decision on where they want to be, either with home hospice care or here at the Vihara. In the final stage, life is lived slowly and final conversations with loved ones take place. About 70% of our patients experience their

[3] Hayashi. "Five Years," 49-51.

final moments surrounded by their families. However, we also feel strongly that *vihara* and hospice are not just for helping patients die but also for helping families with the grieving that comes afterwards.[4]

Palliating Physical Pain and Confronting Spiritual Pain

In general, health is defined by the medical studies field and is, thus, based on a scientific perspective. The World Health Organization (WHO) has defined health as:

> Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity.[5]

Recently, there are also people who have made definitions in which health is not just about being blessed with mental well-being but also spiritual well-being. If we regard health not so much as a field of medicine but rather as an art or a problem of the heart and mind, then perhaps the conventional understanding of "health" might not reflect what health really is. In Japanese, we use the term "complete health" (*kenzen*) when speaking of a healthy person.

In this way, when we consider the condition of the patients who enter the Kosei Vihara, we have those who cannot walk and even those who cannot speak. However, these people are able demonstrate their intentions. They may not be able to live beyond one month, but if you remove their pain, they can spend this time freely on their own. They might fear death, but these kinds of people are in a much healthier situation than compared to those in the everyday world who have physical health but are stressed, have anxiety, and think every morning that they want to die. While trying to fight their illness, our patients are not filled with anger or malice toward other people and can say thanks toward the people who are close to them. In this way, can we call them sick people? I think the phrase "sick people" does not fully describe them. If you can call this state of positive intentionality "healthy, " then you can say they are healthy. I think that is what the WHO definition of health is trying to say. In this case, even though they

[4] Hayashi. "Five Years," 77.

[5] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, June 19-22, 1946; signed on July 22, 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on April 7, 1948.

are looking death right in the eye, it is quite irrelevant to their overall health condition. What is more important is the manner in which these people can continue to live.

It is quite easy to remove physical pain by using morphine, contrary to what people would think. We have only been running our palliative care unit since 2004, yet we have enough practice to remove the physical pain of patients 99% of the time. The pain can be removed unless a mistake is made in preparing the treatment. The more intense problems we face are the mental ones, especially regarding problems between families. We are really unable to solve these matters. No matter how much anesthetic we use, we cannot remove this pain. When this kind of pain appears, we cannot remove it from the specified place, because it comes from words. The more you remove the physical pain, the more their daily life settles down. However, their spiritual pain may not go away and may actually increase. Therefore, when a patient knows that their family is there to support, it really helps them to calm down. When I say this kind of thing, people ask me, "Is it good or bad to remove pain? Is it then better to have some physical pain?" Of course, it is better not to have physical pain. If a patient is enduring serious physical pain, they will want to die quickly and will not have any free time to think about spiritual pain. It does not make sense to call such a physical situation a kind of spiritual pain.

However, even if a patient is physically falling apart, they may be able to say to their family that it is all right to go home, because they are mentally and emotionally fine. I think it is important if the patient can face their family and make this point, "I'm OK. It's OK for you to go home now." This happens more often than you would think. In one such case, there was a patient who said such a thing while he was breathing in great distress. Why did he say, "I'm OK"? Everyone in the family could clearly understand that it had become impossible for him recover. Yet the family was able to share the same thinking with him, because they understood he was departing this world. Although there was little time left, each of them had come close to this patient. Because of this kind of family, it is certain that this patient could say, "There is nothing to worry about; it's OK." There was only this thought in the end. Because the family relationship was fulfilled, he was "OK."

This is something that Rev. Yoshiharu Tomatsu, whose writing also appears in this volume, has talked with me about. In coming to face death, the patient who has a connection with their family, the doctor, or a nurse, can die peacefully. Even if they do

not have family on hand at the time of death and are alone in bed staring up at the ceiling, they are not lonely at the time of death. Rev. Tomatsu said that for our own sense, we probably think that if no family is there at the moment of death, then it is a pity. In reality, however, the person who dies understands their own death from conversations with their family. By coming to such an understanding, there is no such sense of loneliness. If there is a patient who has come close to and had real communication with a caregiver, then even when directly facing death that person can have peace of mind. Humans after all will live their lives, and then they must die.

If you work in medicine in general and especially in dealing with the final moments of dying people, I think it really becomes a very common way of speaking about the situation. I do not think terminal patients are *necessarily* lonely. The important thing is the promise that is made between a patient and their family or caregiver. For example, when a patient says it is OK for his family to go home, they still need to make a promise to come back, such as the next morning at 9:00. At all costs, they then must come the next morning at 9:00. If they cannot come the next morning at 9:00, then it is OK to promise to come the next day. As we observe patients and families, there are families that only come once a week to visit but are still firmly bonding. On the other hand, there are those families that come quite often but go home quickly. In this case, I will say to the patient, "Your son came to visit today. When is he coming next time?", but the patient says he does not know. He wonders whether his son will come the next day or not, and then suddenly he becomes anxious. Therefore, I always say to families to please be punctual in your routine. If you do not keep your promises, in the end the patient will become lonely and will increasingly complain of pain.

Dealing with Spiritual Care in a Secular Environment

In the WHO's definition of palliative care, there is the addition of a spiritual element:

> Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical,

psychosocial, and spiritual.[6]

The problem for most Japanese, however, is that they cannot understand why the term "spiritual" should be added to the definition of health. In general, it is said that religion provides an answer for people about what to do in difficult times. When I see Christian patients, they almost always have an icon, a statue of Mary, or a cross. In this way, I can understand how Christians do little things. I think this is quite different from typical Japanese Buddhists. On the other hand, the patients at the Kosei Vihara who are Rissho Kosei-kai members tend to be more openly religious, such as having sutras and a rosary at their bedside. There was once a patient who was a member of Tenri-kyo, a Shinto based new religious denomination, but he was not as overt in showing his faith. In general, we stay out of these matters, because we feel they are personal.

The Kosei Vihara is the first hospice in Japan owned by a Buddhist denomination. The Vihara Ward at Nagaoka Nishi Hospital in Niigata is well known for having Buddhist priests on call, especially ones from the Jodo Shin Pure Land denomination. However, it does not belong to this or any other religious group. It is a standard medical institution. In this way, almost all of the people who come here ask about our relationship to religion. They do not know that we actually do not allow religious professionals open access to enter this place. It is not that we reject them but that the patients simply do not request for them. When we established this Vihara, we listened to the Vihara priests and the thinking of people who visited us from Nagaoka Nishi Hospital. We also thought we needed chaplains on call 24 hours a day, 365 days a year, and we were able to create such a system with everyone's cooperation. However, after a year or two had passed, we found that there was no demand from anyone to talk with them.

Certain requests, though, did come out little by little. For example, a volunteer might be pushing a wheelchair when a patient would say to them, "Excuse me but … can I say something?" The volunteer would eventually say during their conversation, "You seem to have some spiritual pain. I know someone who you can talk with about this." Then the patient would ask, "What is he like?", and the volunteer would reply, "The person on that photo there that says 'mental counselor' will listen to you."

[6] http://www.who.int/cancer/palliative/definition/en/

However, Japanese still dislike having their own self seen through by mental counselors. Many of them do not express this directly, but those that do say, "Oh, I don't want that." That means they are happy just talking with the usual volunteers.

The problem with bringing up religious or spiritual topics is that if people do not accept these topics when they are healthy, then when they become sick, there won't be any room to accept them. By that time, they are just struggling to live. After becoming hospitalized is not the time to begin religious dialogue. For example, we had a patient who was the head of his temple parishioner's association (*danka sodai*). Once he was hospitalized, he talked about such matters as his temple undergoing reconstruction and so on. We thought that he was somewhat interested in religious conversations and that it would be nice to have someone for him to do that with. Thus, for the first time at Kosei Hospital, we called in a mental counselor. However, the conversations became too difficult for the patient. He complained that he was tired and had had enough already, so we stopped. For this person, rather than talking about such inner matters, talking about something more concrete, like taking a pilgrimage to the one hundred famous Buddhist temples in Japan, would probably have been best. For a patient staying in the hospital, talking about "What does it mean to live?" can get complicated.

There are occasionally traditional Buddhist priests among the patients who have entered Kosei Hospital. One time we had a patient who was a Soto Zen priest and the father of my senior colleague's wife. He was really an authentic monk, so when he arrived, I wondered what kind of things he would do in this situation. However, it ended up not mattering that he was a priest. He did not chant sutras in the morning or do any such overt religious practice. I guess that he could have been chanting in his mind, but he did nothing that was obvious. We often say to the families of patients that even a doctor is not treated as a doctor when he becomes a patient here. If there is a patient who is a medical professional, we do not want him to ask other family members medical questions. We are the medical professionals. Therefore, it is our job to speak about what we know and not the role of the family. In the same way, I think that for us to talk about religion with a patient just because he/she is a religious professional is not appropriate. Even though he/she is a priest, it does not make a difference once they become patients. We treat them just as one of the patients.

When the founder of Rissho Kosei-kai, Rev. Nikkyo Niwano (1906-1999), entered the hospital here during his final days, I do not know whether he was reciting

the sutras or doing anything overtly religious. At that time, though, one of the staff asked him what about the purpose of the daily morning service and sutra chanting, saying, "What should we pray for and why?" He answered, "It is like brushing one's teeth everyday. If you don't do it, then the mind does not become clear, and you cannot proceed with your daily living." I think this expression sums up the point that it is not about thinking about what one should do externally, but rather internalizing it as a part of one's own body. In reality, a person who is a religious leader never dies like "a religious leader." I think that each person dies in their own way.

At the same time, I have increasingly come to believe that it is important to be open about the religious base of our hospital and to know the religion of our patients. Here at Kosei Hospital, there is a questionnaire that nurses must give patients when they first arrive. One of the questions at the end asks, "What's your religion?" There was one nurse who said, "Dr. Hayashi, we have to ask people about their religion, but it's hard to do so." Then I asked her, "Why?" The nurse replied, "It shouldn't matter what religion the patient is."; but I said, "That's not true." For example, if a patient is Muslim, there is a chance that this person will want to pray five times a day in the direction of Mecca. They may also have particular requests about food or something else. This kind of person may not come to our hospital, but if they do, we have to think about what to do about such things. The reason why we ask about religion is not because we are a religious hospital. Although we have a principal religious image in the Buddha, we are not focused on emphasizing our religiosity. However, I want us to be careful about respecting the religion of the patient. Therefore, we ask them in order to respect their religion.

I have asked a number of Buddhist priests whether it is all right to speak this way to patients. Even they quickly retorted, "Doctor Hayashi, it is strange to ask what religion they have." They have also said, "This question is strange. Everyone is free concerning religion." If I refuse to back down on this matter, they say, "Well yes that's true, but I dare say isn't it all right not to ask?" I think that is strange, maybe it is because I'm not a priest. For Japanese, it seems religion is not made very clear in order to be safe. Perhaps that is also what Buddhist monks think should be done. However, I feel we must know how to respect each other's religions.

Religion is nothing more than the entrance into the truth of all things. For Japanese, we have received explanations on this matter by such great teachers as Rev.

Niwano, Nichiren—the 13th century reformer, and Saicho—founder of the Tendai denomination in Japan. Yet every religion is leading us to the very thing that Rev. Niwano said is "true regard" (*shinkan*). This is the essence or spirit of the universe. We are nothing more than interpreters of this essence, so in a way, any religion is good enough. That is why for me it is not strange to ask about religion.

The Role of Buddhism for Medical Professionals

As someone who has been the head of a hospital owned by a religious group, I have been asked the difficult question of whether we have a different mission than other hospitals. The Kosei Hospital holds as its founding principal one verse from Chapter 25 of the *Lotus Sutra* called The All-Sidedness of the Bodhisattva Regarder of the Cries of the World. This verse speaks about the five different ways that the bodhisattva regards the world and the suffering of sentient beings, the first being "true regard" (真観 *shinkan*). Rev. Niwano offered this verse on the founding of this hospital, explaining that "true regard" is to perceive the form and the situation of the suffering of humans in this world as well as to discern the true nature of suffering.[7] After receiving this message from him, I made the vow that this hospital should have doctors who work with the aim to not only treat the illness of the physical body but to diagnose and heal the illness of the spirit body. I have also developed a feeling for the importance of coming into contact with patients moment by moment by being present with them, deeply listening to their feelings, and deeply perceiving them.[8]

From this basis, if I were to say what is unique about this hospital, it would be the general atmosphere. Every year when I greet all the new staff, I do not have any great insight into them. However, when I hear them speak, I can immediately recognize if they are Rissho Kosei-kai followers. When other doctors come here, they always say the nurses are kind and laid back in a good way. They are not as strict and tense as nurses from most other university hospitals. Our nurses are honest and have had a laid back rhythm ever since they were Kosei students. I think this is a good point of our hospital. A person who, like myself, has spent time here since their residency would never feel uncomfortable when another staff speaks about the founder of Rissho Kosei-kai, Rev.

[7] For more on this teaching, see Nikkyo Niwano, *Buddhism for Today: A Modern Interpretation of the Threefold Lotus Sutra* (Tokyo: Kosei Publishing Co., 1976).
[8] Hayashi. "Five Years," 61.

Nikkyo Niwano. That person might even take a look at the Buddhist sutras or learn something from the others.

This reminds me of one case with a family who were shown the Vihara and also our statue of Shakyamuni Buddha. They remarked, "Yep, this place is run by a religious group. Let's go somewhere else." According to the people who gave the tour, their reaction was probably because they thought we would thrust our beliefs upon them. The young people at Nagaoka Nishi Hospital have said that the Shakyamuni Buddha image, which the Vihara Association bought in Southeast Asia, is important. It has become a centerpiece there. Nevertheless, people who go there still ask, "Is this place religious?" If you go to St. Luke's International Hospital in Tokyo, people do not ask if the place is religious. Of course they know it is. This is the kind of thing that happens in Japan. In this way, we are carrying on somewhat single handedly, but we have to have a system in which at least the people who work at our hospital can feel proud about what they do. People on the inside of our hospital have to carry on with nursing while also thinking in the traditional, gentle Buddhist manner.

However, the feeling of a doctor who has come here from a university hospital is indeed totally different. For most doctors here, it is impossible to have such a sense, because they were not raised as followers of our denomination. In this situation, it is difficult for them to understand terms like "true regard." For example, at first we would not show young doctors applying as clinical interns who come for a study tour the 7th floor where the Buddha hall and altar are located. At that time, the Vihara still had not been established on that floor either. If we had shown them that floor, they probably would have had some uncomfortable feeling, since it is rare to have religious facilities in Japanese hospitals. However, over time I have begun to develop a different feeling about this. Now, I make sure to show the interns the Buddha Hall on the 7th floor. Every year there are at most two new interns, and when they get the tour, none of them say they feel uncomfortable and just leave. When we visit the Buddha and look at the statue, I ask them, "Do you notice anything particular in the Buddha statue?" They mostly say they do not know. I tell them that when patients look at the statue, they often do not say that the face is tender or the gaze is kind. Rather, they say that the hands are tender. Undoubtedly, this indicates their sense of pain in the body, and their desire to caressed to make the pain go away.

Then I ask these young interns what is the meaning of treatment in terms of how

much does a doctor listen and become familiar with a patient's point of view? While I myself have sometimes not fully done so, the point I want them to see is the more you know, the more you may understand. When a patient says they don't like some treatment but don't explain how they dislike it, if you cannot persuade them that there is enough personal benefit in the treatment, you best not do it. You have to say to them, "Since you don't want to do it, then we won't do it." Patients often tell us, "I'm fine with the treatment. I'm fine with the surgery. In any case, I'll be asleep. But one month after the surgery, will I have returned to normal?" That is from the viewpoint of the patient. We talk all the time about surgery, but afterwards the patient wants to return to their way of life. In the end, only a few doctors are able to develop such a mind-heart towards patients needs.

I think by going back to our Buddhist origins one more time, we can support the salvation of the mind/heart of our patients by entering into their daily lives and those of their families. If we, who have come to work in medicine, do not look at it from the patient's viewpoint, we have undoubtedly entered the issue "with our shoes on"—that is, we've been selfish and rude. The common people cannot accept this from us. This is the experience I have had since starting here five years ago. There is certainly no textbook at present in Japanese about hospice wards like our Vihara unit. In textbooks, this kind of space is not taught.

The Future Role of Traditional Japanese Buddhism in Spiritual Care

Buddhism was introduced to Japan in the 6th century and gradually entered into the lives of all Japanese. However, for various reasons, it has become distant over the last sixty years, and now everyone speaks of how Buddhism is no longer a part of daily life. In the past in Japan, when one was suffering, one first went to talk with someone. My grandfather was a village doctor, and people came to consult with him about anything. In his generation, the wisest people in the village were the school teacher or the doctor. However, even in those days, there were also people who would go to see the Buddhist priest. Nowadays, the social community, which includes the family, has become dispersed. There are no bonds. There are no traditional hospitals. Even memorial services are now not being done, especially by the young generation. The old system of delivering mental and spiritual care has collapsed, or we can at least say that the people who performed such roles has decreased. In short, the fertile ground for the culture that

supports the traditional Japanese system is collapsing at its foundations.

Nowadays, in a family if a son becomes out of control, there is no support coming from the temple. So who will help resolve this matter? Are Buddhist priests or organizations making an effort to help this situation? Religion, which originally bore a central role in this matter, does absolutely nothing now. The center of every denomination has withdrawn from such work. There are simply focusing on maintaining their own organizations. Rev. Tomatsu and others have talked about the problem of "Funeral Buddhism," in which priests and temples seem only concerned with making their living off of people after they have died.

Contrary to Japan, Buddhist monks in Southeast Asia must go out every single day to beg for alms. In those countries, Buddhism is internalized through such daily living. In this way, if a monk asks a common person, "What's the matter?", they will probably answer straight away. However, in Japan, if one day a priest suddenly appears and asks, "What's the matter?", the response will be something more like, "If you are asking about the funeral, we have prepared for that." If Japanese priests suddenly start coming to hospitals to visit patients, the patients may naturally respond, "What does he want? Money for a posthumous name (*kaimyo*) and other things?" If when he arrives, the patient's condition is not good, they might say, "Why does the priest come today? I'm still alive damn it!" In this way, Buddhist priests must first show the people how Buddhism can have meaning in the midst of everyday life.

It has come to a point that all patients including those with cancer have developed not only "needs" but also "wants" for spiritual care from medical institutions that deal with total pain. Doctors as well as all nurses are also increasingly understanding this sensibility. At *viharas*, more than at usual hospitals, there will be more such people, and that is the reason they get such a high evaluation. In this way, I think the demand for hospitals with *vihara* facilities will tend to increase from now. Citizen volunteer groups have also emerged, and there are now groups like bereaved family support associations. However, it is certain that these groups are not enough to meet the demands. In this way, when one thinks about Japanese religious culture as a whole, we should ask, "Can it respond to the 'wants' of the people, especially those who are ill?" If the present situation continues, I think there will not be any such demands made of them even fifty to one hundred years from now. Rev. Tomatsu and others have said that this is something that they have to confront. He said to me, "Dr. Hayashi, it will take hundreds

of years, but we are already moving in that direction." Rev. Tomatsu and others like Inoue Vimala of Koyasan University affiliated with the Shingon denomination are certainly in a rush to get there. I think that there are Buddhists who really want to enter this field, but are priests really going to be able to become clinicians?

In this situation, I really dislike the use of the term "needs." I first heard this term about twenty years ago. We always speak about necessity, but necessity is different from what is being requested by the patient. Needs and wants are different. In the Kosei Vihara, we thought we *needed* a mental counselor. However, the reality has been that from the patient's standpoint, they do not have such demands or "wants." At regular Christian hospitals in Japan, chaplains will be there on the days assigned by their residency, but if they are summoned somewhere else, a substitute will show up. At Yodogawa Christian Hospital and St. John's Hospital, they try their best in such situations to fulfill the demands of various people. However, at other hospitals that are doing an incomplete job, it has become more of a situation in which they say, "If you need anything, just give us a call." I think this is not something to be satisfied with, because normal people do not know how to ask for what they want. They do not know the proper way to ask. Therefore, we have had to figure out how to handle this situation. It is not good that a patient's demands become a justification for any kind of need. However, it is all about the patient's point of view in the end. I have specialized in pre-natal care and now in hospice care. However, I still do not have the answers regarding life and death, so I have to continue to work to understand the patient's own point of view.

I also have reservations about the terms "spiritual pain" and "grief care," which many people in Japan now talk about. I feel like they do not know what they are talking about, because Japanese Buddhism, with its wakes and funeral ceremonies and so forth, is all about grief care. As Carl Becker points out in his chapter, we Japanese have been doing it already for centuries. Every single year, Japanese make a large fire at the summer Obon festival to welcome back for a few days the spirits of dead ancestors and relatives. As long as we treasure these traditions, then specialized grief care programs should not be needed. The reason this has become an issue today and that people say we need "grief care" is because we are not taking care of these traditions.

Here at the Kosei Vihara, we still do not have a bereaved family support group. I continue to wonder what that means, because in the public documents provided by the

government on the establishment of hospices, it is written that bereaved family support groups and grief care are necessary services. In this situation, we must again return to the real demands of the patients. I think we have to create a system that enables us to take action immediately. However, we cannot just present Buddhism in a rather direct and artificial way. We should move towards thinking in a more natural manner. I do not know how many years this will really take, perhaps 100 or even 200 to 300 years. However, in the process, we can steadily borrow from all standpoints, such as, of course, celebrating traditional Japanese New Years, putting up a Christmas tree, singing Pure Land hymns, and celebrating the Flower Festival that is Buddha's Birthday (*hanamatsuri*). When we do such things, there will be the elderly who say, "This brings back memories," but the young may not understand. Grandchildren may really not understand. However, all we can do is to try our best by properly carrying out such traditional style grief care.

I would not say this is a small endeavor. However, the first generation of patient families have passed through here now, and the second generation is starting to come back. There was a person who thought this is a good place to come to die, because his older brother died here. There were other people who thought that since their own grandmother or father died here, they also want to come here. There was a person who thought that, "Since my aunty came here, why not my uncle too?" Up to now, three such people have come back. For us, those people are three very major achievements. If you ask us about the level of care at Kosei Hospital, we can definitely say that over a period of three years, we have had three family members of three people who died in the Vihara come back here to die. Of the five hundred people who have been here, there are only three, but those three are very profound.

I think that from now other people will also want to return when they have such an experience. I do not really know to what extent people will return. It depends on how much energy we put into the process. Therefore, it undoubtedly depends on how we cultivate the second generation. Hospice is about getting intimate with patients. It is the ultimate form in that everything from catching a cold to having a pain somewhere to cystitis to tonsillitis involves palliative care. That is the palliation we must do. Doctors have so many ideas about palliative care, but it is not such a difficult matter. The basic thing is making the patient the center of things.

The main text, except where noted in footnotes, comes from an interview conducted January 14th, 2009 from 1:00-3:00 at the office of the Director of Kosei General Hospital by the following staff of the Rissho Koseikai magazine Dharma World*: Kazumasa Osaka (Editor), Katsuyuki Kikuchi (Editorial Staff), Toru Nakagawa (Senior Staff Writer).*