Challenges of Caring for the Aging and Dying: Lessons from Japan

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A Terminal Society

Why should a reader care about terminal care in Japan? First, no country in the world has ever been as old or as crowded as Japan is today. As of 2011, more than 30% of Japanese are over the age of sixty; in another decade, more than 30% of Japanese are expected to be over age seventy. Seventy years is the average lifespan of the human species, but before long, a third of Japan's population will exceed that average lifespan. Furthermore, in the next forty to fifty years, roughly eighty million Japanese people will die due to natural causes. Never in the history of humankind have 127 million people, the present population of Japan, lived in such a small land area, nor have so many people ever died in such a short time with so few people to care for them.

Lowering Japan's population from 127 million to a sustainable 40 million is not only a good thing; it is inescapable. Japan today can feed only a third of its people on its present land resources. It can provide only a tenth of its own energy and electricity. Barring unforeseeable miracles of food production and sustainable energy in the immediate future, it will be impossible for Japan to support its present population of 127 million people for another century. The choice is only whether Japan will do it by planned population reduction, or as North Korea is now doing, by famine.

Post-industrial countries will likely follow Japan in this aging pattern, especially the OECD, South Korea, and China, with its one-child policy. So the eyes of the world are watching Japan's experiment in aging. If Japan can manage aging and dying successfully, it will prove a model for the rest of the world. However, if the Japanese government poorly handles its elderly population problems, it will lose credibility with foreign cultures as well as with its own people. In this sense, Japan's management of its elder care and medicine is a critical issue, both internationally as well as domestically.

Medicalization of Japan

A second major issue of relevance to the rest of the world is that Japan is the most medicalized society on earth. For example:

- While having enough doctors and nurses for a high level of medical care, Japan hospitalizes its patients an average of five times longer than America.
- Japanese visit doctors thrice as often as British and New Zealanders who share a comparable socialized medical system.
- Japanese spend thrice as long as the average European does sitting in doctors' anterooms, waiting for diagnoses and prescriptions.
- Japan prescribes an average of four to five times more medicine per patient than do other industrialized countries with comparable medical systems.

Ironically, the Japanese tendency to overmedicate is contradicted by a reluctance to prescribe palliative analgesics—particularly opioids, like morphine—even at the end of life. The combination of outdated bureaucratic legislation, lack of transparency, failure to document and prioritize patients' wishes, and economic incentives to prolong life, frustrate a nationwide advance in palliative medicine.

Surveys document that most Japanese elderly do not want to have their lives artificially and mechanically prolonged. They want to know when further treatment is futile, so they can prepare themselves for a dignified departure. Yet the medical system wants to hospitalize them, and if they weaken in the hospital, to medicate them; if the medications fail, then to intubate them; and when all else fails, to sustain them on mechanical life support systems. Since the medical system reimburses doctors for services rather than for results, it is to their advantage to make patients dependent upon them. Many doctors' primary motivations have shifted from cure to profit or experimentation, which necessitates keeping patients for extended periods. Further, many Japanese hospitals have already bought so much expensive diagnostic machinery that even now there is not enough money to support them. Swollen by the policies and tax monies of the Ministry of Health and the Japan Medical Association, the Japanese medical system has overridden the mandate of the people.

Economic Meltdown

This leads us to a third major problem: financing the medical system. In order to support a heavily socialized medical welfare system, the average income tax base in northern European countries like Denmark, Sweden, Finland, and France constitutes roughly 50% of their GDPs, while Japan's is about 23% of GDP. Their income and value-added sales taxes total anywhere from 50 to 70% of personal income, while Japan's is less than 25%. (While Japan's tax on industries has been high, average personal tax is low, about 18% income tax and 5% sales tax.) In other words, more than half of European economic activity is absorbed by taxes, largely in order to support their medical welfare systems. Yet even in tax-burdened Scandinavia, there are still complaints that patients would rather die at home. Japan is trying to provide far more medicine and hospital beds on far less tax money, which is simply impossible and largely accounts for Japan's staggering national debt.

Scandinavian studies suggest that Japan has only two options: to raise its own taxes to roughly 70%—or to reduce its medical costs to one-third of present levels. There are many ways of doing the latter, but the Japan Medical Association and the Japanese pharmaceutical industry stridently lobby against cutting medical expenditures. Already, the bankrupt Minister of the Treasury is at loggerheads with the Ministry of Health, which is demanding funds on behalf of the Japan Medical Association. At some point, Japan has no choice but to reduce medical expenses—preferably sooner rather than later.

The most practical and acceptable starting-points for reducing medical expenditures are to begin by cutting counterproductive services, such as over-long hospital stays, and eliminating services that patients themselves least desire. Evidence-based medicine (EBM) already provides ample data that short hospital stays are preferable to long ones for a majority of physical conditions. Surveys of which medicines are being discarded rather than properly ingested can serve as one basis for reduced reimbursement for prescription of medicines that are not likely to be effectively used. Advanced directives, designated decision-makers, Physician Orders for Life-Sustaining Treatment (POLST) forms, and living wills, that allow patients and their representatives to express their desires, should be the basis for reduced artificial life-extension for those who do not desire it. Significantly, most terminal patients themselves express more interest in quality of life than quantity of life—a fact brought

out in the research by the Interdisciplinary Center for Palliative Medicine (IZP) at Munich University Hospital, detailed in the chapter on Germany.

A Buddhist Reflection

The situation described above epitomizes the Buddhist analysis of the human condition. Humans always want more than we have. Japanese medicalization shows that this is not only true of possessions like cars and cell phones but also true of health. We always want to be healthier than we are. Yet patients' desires perpetually exceed however much medicine and health care a system can provide. The only proper solution to this psychological tendency is to adjust our desires to sustainable levels. No population is ever as healthy as it would ideally like to be. Aging, sickness, and death are part of the human condition. The Buddhist prescription is to adjust our desires to reality.

The demographics discussed above will force Japanese to abandon their overreliance on medicine, because there are not enough caretakers, doctors, beds, nor money to enable eighty million patients to die in highly mechanized hospital settings—even if that were desirable. A growing percentage of Japanese elders will die at home—as had always been the case prior to the bubble economy of the 1980's. Home care will entail a less medical approach but a greater need to confront the elephant in the room that people have been trying to ignore—the reality of death. Japan can face this situation with tremendous social and political resistance, outraged at the idea of cutting medicare; or it can appreciate how other systems can complement and provide alternatives to this uncontrolled medical system. The Ministry of Health and Labor has already recognized this and is encouraging people to spend their last days at home, which is what most Japanese people have been saying they want.

The Denial of Death and the Effects of the Fear of Death

Almost all Japanese, especially those hospitalized for slow processes like cancer and diabetes, know when they are dying. Typically, this is less from any clear discussion with their doctors or health care providers than from the following kind of dialogue:

> "Please Doc, level with me. I've been lying here for months already. My hair is falling out. I've lost all my appetite. I know I'm weakening. Is it cancer? Is there something in my brain? What's happening to me?"

The doctor's subsequent pause is unnaturally short or long. With ill-concealed discomfiture, the doctor puts up a strong front: “No, no, no. Don’t talk like that. You'll be out of here before you know it. Pick up your spirits. We’re working on it. You’ve still got a way to go.”

From the overly solicitous response of the obviously nervous doctor, the patient learns two lessons: The first is “Yes, I’m dying. My hunch was right.” The second is: “The doctor does not want to talk about it; dying is not a subject for conversation in this hospital ward.”

The patient gets the same kind of response when he asks the same questions of his family who have already been informed that he is dying. They jump in with overreactive protests or furtive glances around the room like, “Who is going to respond to this, please?” This tells the patient, “Yes, my suspicions are correct; and no, we cannot talk about this.”

In English, we distinguish “truth telling” from “informed consent.” “Informed consent” means asking patients about their desires to receive medical procedures to cure their conditions. In terminal cases, however, the issue becomes less “informed consent” of how to cure them, than “truth telling” about the end of life. Research on “truth telling” in Japan shows that doctors and families do not want to tell the patient the truth. Nurses often want to communicate more fully with their patients, but are intimidated by the doctors not to do so.

The common fear that “truth telling” will depress patients is not totally groundless. Anyone suddenly informed that they had only two months left to live would be shocked and confused. However, the issue is not *whether* to tell the truth; it is *how* to tell the truth. Doctors have not been trained how to tell the truth about dying, because the taboo of silence over death and dying pervades Japanese medical education. As Rev. Tomatsu’s chapter details, the six to nine years of medical education in Japan cover diagnosis, operations, treatment, and medical cures. Doctors are taught neither to communicate bad news nor to deal with patients' inevitable facts of death. These communication skills need more training, preferably during medical school, or at least in workshops after medical school. However, there is precious little room in the Japanese medical system for retraining or continuing education units.

The percentage of people in Japan who consciously prepare for death is

extremely low. It is this denial of death that obfuscates and frustrates the natural dying process. As recently as sixty years ago, shortly after World War II, international Fear of Death surveys ranked the Japanese among the least death-fearing people in the world. Within the forty years between 1960 and 2000, among the dozens of countries surveyed, Japan became the most death-fearing country in the world. Fear is an indication of ignorance. For example, when we fear an interview, a contract negotiation, or a doctor's appointment, we are afraid because we don't know what will happen. If we know what is going to happen, then we can mentally prepare for it. It may seem difficult, challenging, even attractive, but we are no longer afraid of it.

This forty year turnaround indicates that Japanese have changed from a people that understood death—and the Pure Land—to a people that no longer understand death, much less the hereafter. The reference to the Pure Land is advised, because most Japanese are Pure Land Buddhists of one sect or another. Even those who do not call themselves Pure Land Buddhists know of Amida Buddha and the Pure Land, a better place where they can meet their ancestors after death. This knowledge was taken for granted until the 1960's.

Over the following forty years, a culture of silence made death unspeakable. Nothing kills as effectively as deliberately ignoring something. The anthropologist Clifford Geertz noted that in parts of Indonesian and Malay society, community punishment involves not exile nor death, but ostracism by the entire society, where no one looks at, speaks to, nor acknowledges the existence of the outcast. Frequently, such outcasts go insane, commit suicide, or go off to die alone in the jungle. If we ignore and ostracize death throughout education, adult professional life, eventual aging and illness, then death too becomes a black box—something we no longer understand. In turn, dying patients find that people no longer know how to speak to them, doubling the misery of their physical dying process through the psychology of estrangement.

In traditional societies like Japan, one qualification for "coming of age" was having watched and cared for elders in the process of death—typically grandparents, great aunts or uncles. When people lived in large families and died at the age of fifty or sixty, by the time young people were fifteen years old, they had watched one or more of their family die. They had helped in feeding, washing, and caring for them in that process.

Today, very few teenagers live under the same roofs as their great-

grandparents, the generation that is facing death. Even the Japanese who do live in extended families tend to hospitalize their elders as they approach death. So death is hidden from the public eye, and the youth have no chance to watch their elders pass away under their care, much less in their arms. This is what makes death fearful. Observed directly, death can be sad, heart-wrenching, sometimes peaceful or even uplifting, but not fearful. Like a child being born into the world, or like first love, death is a rare and precious event, a special sacred moment, a rite of passage. Rites of passage formed an integral part of traditional culture, as Philippe Aries (1914-1984), the influential writer on childhood and dying, recognized fifty years ago. Fifty years ago, extended families were still common in Japan. However, due to extended life spans, nuclear families, and hospitalization of the infirm, young people in the process of growing up no longer care for dying people. The whole subject area of death has been excluded from their worldview. The resulting ignorance brings fear and further repression; a cycle of silence, fear, and avoidance.

Today, many Japanese youth display a fundamental inability to maintain intimate relationships. Electronic technology enables a lifestyle superficially connected with many people. However, when relationships become more complex, uncomfortable, difficult, or threatening, Japanese youth suddenly break off contact, like turning off their TV. They seem to lack the emotional strength to work through issues to develop more meaningful and intimate relationships. Many young people in Japan are obsessed with *jiga-sagashi* or "trying to find themselves." However long they stare at their navels, trying to find themselves, they will never find meaning unless they step *beyond* themselves, into larger contexts, as members of families, contributors to larger projects, or club members aiming at a higher purpose. Meanings only emerge in relationships, so a self without relationships cannot find meaning.

In terms of terminal care, this lack of intimacy in contemporary Japan can make the practice of truth-telling harmful, if dying patients retain no close relationships either with friends, family, or caregivers, with whom to work out the issues of their final days. The structure of a good death as taught in progressive hospice care cannot proceed from the act of truth telling alone; it requires intimate relationships.

The Role of Buddhism in Facing Aging, Sickness, and Death

The great 20th century scholar of religions, Mircea Eliade, said that humans are not

only *homo sapiens* but *homo religiousus*. In other words, a fundamental part of our nature is connected to the invisible, to the spiritual, to powers in the universe that we can only experience through synchronicity, dreams, and spiritual experiences. Eliade said that if organized religion is suppressed by government or society, it will emerge in countless less organized forms, such as fortune telling, because some part of our being needs connectedness with the invisible spiritual universe. [1]

Some twenty years ago, when Taiwan was just beginning to socialize its medical system, Taiwanese colleagues of mine in medical psychology surveyed about one thousand homes in rural Taiwan between Kaohsiung and Chiayi and one thousand homes in the highly industrialized Taipei area. One question asked respondents whether they would choose traditional Chinese medicine, western medicine, or religious healing to treat an illness. In the countryside, about 40% chose each.[2] In Taipei, where the government was already subsidizing clinics using western medicine, the choice of western medicine rose from 40% to 80%, while the choice of nonsubsidized Chinese medicine dropped from 40% to 20%. Researchers had hypothesized that the more educated and wealthy urban Taipei people would rely less on religious healing than those in the countryside. In fact, the number of urban Taiwanese who said they would visit temples doubled from 40% to 80%.

Surprised by this finding, they sent graduate students to interview why more urban people relied on religion. The following story repeatedly emerged: When a person went to the hospital, she waited for two hours. Then in three to five minutes, the doctor looked at her tongue, checked her pulse, and wrote a prescription. Doctors did not ask about patients' lifestyles nor listen to their concerns. They neither counseled patients about how to avoid recurrences, nor listen to the problems that the patients faced. Respondents said that their daily problems and maladies were inextricably intertwined, but their doctors only looked at symptoms and gave them something to cover the symptoms.

However, Taipei respondents reported that if they went up the back hill to an old temple and spoke to an old bearded monk, he would listen patiently and quietly for an hour or two as they poured out their hearts and dilated on life's problems. The monk's

[1] One fascinating aspect of Japan is how they broadcast astrological fortunes in the newspapers, on the trains, and even right after the weather reports.
[2] People's choice of more than one method brought the total to 120%.

brief sage advice at the end of their visit helped such parishioners regain faith and courage to persevere. When they left the temple, such clients gladly left offerings for the monks, unconnected to the national health insurance system.

Traditional Chinese medicine not only diagnoses the patient's tongue, fingernails, and pulses, but also allows time for the doctor to get to know the patient. As modern medicine becomes increasingly routinized, such spiritual interaction occurs less and less frequently. Feeling the need for this kind of interaction, Taipei respondents visited local Buddhist or Taoist temples where priests would listen patiently and give them a quotation from the *Tao Te Ching* or a Buddhist sutra, that would serve as a *koan* to contemplate until their next meeting.

In the time of the Buddha, Buddhist monks used local pharmacopeia to heal people physically as well as spiritually. Japanese Buddhist monks followed that tradition in the 6th and 7th centuries when Buddhism first came to Shitennó-ji Temple in Osaka. Arguably, it was the superiority of Buddhist medicine and hygiene that forced the anti-Buddhist Mononobe clan to grudgingly acknowledge the value of Buddhism in the 7th century. In Japan, traditional rural doctors were typically priests as well. Like Yamamoto's Doctor Red Beard, they counseled in the process of caring for the families they visited. They served as healers, not only after patients died, but also for the patients' families while patients were still facing sickness or old age.

By the 17th century, the words "monk" and "doctor" had become almost synonymous, because the only people with the time and education to read Chinese medical texts were Buddhist priests. These priests served not only to send off departing souls but also to purvey pharmaceutical, psychiatric, and acupuncture care for their parishioners. While providing physical care, Buddhist priests interacted with their patients on a personal and even philosophical level, helping them to understand that aging, sickness, and death are natural stages of the human condition. Instead of fighting death as if it could be overcome, Buddhists learned to accept reality for what it was. They visited homes not only to chant sutras after a death, but to counsel their patients before their deaths, and to comfort the bereaved families thereafter.

Sadly, most Japanese people have lost this closeness to their temples. This is partly because temples were manipulated by the Tokugawa government and disbanded by the Meiji government. When General MacArthur arrived, he blackened out all discussion of Shinto. For over a century, the Japanese were taught that Buddhists were

disreputable and subsequently that Shinto was false and dangerous. In the post-war period, education has emphasized the physical sciences at the expense of human cultivation, and mass media have been outspokenly anti-religious. Over the past century and a half, authorities have repeatedly told the Japanese that religion is not a suitable source for spiritual consultation.

Since Buddhists were oppressed in the Meiji period—and indeed some did violate their vows and lost the respect of their parishioners—it will be a long and winding road to regain their prior social status. However, Buddhist priests are beginning to realize that they have important roles to play in this society. Today, a small but growing number of priests in Japan are visiting hospitals and lending ears to the concerns of dying people. Doctors who also happen to be ordained are "coming out" openly as Buddhist priests, to provide Buddhist counseling as well as *materia medica* for their clients. The Buddhist hospice movement in Japan, called the Vihara Movement, and the concern of priests to counsel, are as welcome as they are overdue. As Revs. Taniyama, Sengoku, and Dr. Hayashi relate in this volume, Buddhist *viharas* (hospices) in Niigata, Kyoto, and Tokyo are beginning to provide alternative venues for the dying. At the same time, western scholars are rediscovering the wisdom of Japanese Buddhism in dealing with death and dying. This introduction complements that scholarship with insights that may help or heal people facing the care or departure of a loved one.

Japanese Buddhism's Special Skill in Grief Care and "Continuing Bonds"

Medicine may be able to combat sickness, but medicine is virtually powerless in the face of aging and death. No industry can reverse aging or avoid death. A small but growing number of Japanese doctors are beginning to realize that aging and death are beyond their provenance. The shocking reality of aging, sickness, and death were what catapulted Gautama Siddhartha into his quest for enlightenment; the teachings of Buddhism begin not from myth, fable, nor faith, but from the suffering of aging, sickness, and death. So Buddhists have recognized and contemplated aging and death since the time of Buddha.

Caring for the aged and dying has been a concern of Japanese Buddhists for 1,500 years. From the 9th to the 19th century, Japanese priests kept records of the

deathbeds of their most famous monks and parishioners.[3] This Buddhist tradition is not merely of historical interest; it holds tremendous resources for helping people to age and die gracefully, peacefully, honorably, in some cases even beautifully. In Japan, however, roughly 90% of the nearly 200 hospices in Japan are Christian-based, while only 2% are avowedly Buddhist; this contrasts with roughly 90% of the Japanese people who desire to have Buddhist type funeral rites and less than 2% who say they want Christian care at the end of life. Not surprisingly, Christian hospices emphasize salvation by faith, Biblical mythology, and even a spirit of celebration. Collared chaplains visit with Bibles or hymnals, while crosses adorn the halls, and muzak hymns pour from ceiling speakers. The Buddhist approach to death and dying is less celebratory and faith based. Buddhist *viharas* I have visited are more solemnly accepting of suffering, proffering hope without vivacity, endurance without celebration.

At the same time, the fact that people around the world attest to being met by a compassionate figure of light at their deathbeds is something that can unite different faiths in contemplating death. Compassionate figures of light have been documented in medical journals like *The Lancet* by Pim van Lommel, in the *Journal of Resuscitation* by Sam Parnia,[4] and by many other medical doctors. Western physicians from Carl Jung and Elisabeth Kubler-Ross to Raymond Moody Jr. and Larry Dossey publicly acknowledge that meeting a compassionate light at the time of death is central to the dying experience. In fact, so many western patients reported this experience that Western doctors had to coin the phrase "figure of light" simply to refer to this phenomenon. However, Chinese, Korean, and Japanese Buddhists had already recorded and named this experience for two thousand years. The figure of light is called Amida Buddha, which in Sanskrit means "Buddha of infinite light and life," and the coming of this light at the time of death is called the *raigo* experience. I have seen patients staring at a wall or a window with extreme joy in the last moments of their lives, so eagerly that I too looked at the wall to see what they were experiencing—but could only see the wall. Seeing the face of a dying patient who a moment before had been pallid or wrenched in

[3] This became an indispensable resource for my book *Breaking the Circle: Death and the Afterlife in Buddhism* (Carbondale: SIU Press, 1992). For more on this topic see, *Death and the Afterlife in Japanese Buddhism*. Edited by Jacqueline I. Stone and Mariko Namba Walter (Honolulu: University of Hawaii Press, 2008).

[4] Pim van Lommel et al., "Near-Death Experience in Survivors of Cardiac Arrest," *The Lancet* 358, (2001): 2039; Sam Parnia et al., "Near Death Experiences, Cognitive Functioning, and Psychological Outcomes of Surviving Cardiac Arrest," *Resuscitation* 74, (2001): 215-221.

pain suddenly glowing in anticipation was a very persuasive experience for me.

Buddhist discussion of the afterlife is not grounded on Maccabean myths of bodily resurrection and apocalyptic judgment. It is grounded on the understanding of the cycle of rebirth that we gain through meditation, and through the countless deathbed visions that report the coming of a salvific figure of light. Like others who have experienced this at death, Pure Land Buddhists believe that there is light at the end of our tunnels. We should walk every step of this tunnel, accepting it for what it is and learning what we can from it. Indeed, there may be commonalities between Christian and Buddhist myths that are worthy of more exploration.

Another important insight of Buddhism is that death seriously affects the bereaved and society as well as the dying person. The Japanese Buddhist tradition of ceremonies following the wake, at one week, three week, and seven week intervals, followed by the first summer Obon celebration and periodic ceremonies thereafter, serve as valuable occasions to address the grief of the bereaved. If these ceremonies fossilize into rituals that no longer attend to the needs of the bereaved community, they lose this important function. However, longitudinal medical research on bereavement is documenting that bereaved people who participate in follow-up counseling sessions escape many of the problems that typically follow the loss of a loved one. Those problems typically include depression, reduced immunity, increased sickness, absenteeism, accidents, even sudden death and suicide attempts. This is a tremendous cost, not only to the people undergoing them, but also to their caretakers and society who lose productivity and have to pay police, ambulances, hospitals, and caretakers to deal with the accidents, illnesses, or suicide attempts.

The Japanese Buddhist tradition of periodically convening bereaved people to reminisce about the deceased and reconsider their understanding of life and death is a brilliant traditional mechanism to avoid these tragic after effects. In pre-modern days, the Japanese labeled recurrent tragedies afflicting the bereaved with the word *tatari*—curses from the other world. If one did not sincerely perform the ceremonies and appreciate the meanings or messages of the deceased, it was believed that the deceased might respond with some curse. Today, we can interpret this curse not as some ghostly revenge, but rather as immune system depression leading to sickness, or lapses in concentration leading to a car accident or to cutting off a fingertip when chopping vegetables. This may be less a curse than our own failure to fully reintegrate after a

period of mourning. Every society in the world has had a period of mourning followed by rituals of reintegration—a re-understanding of the world after which bereaved people no longer are sick or suicidal. Temples effectuated these meaningful and valuable rituals in previous generations.

Another important insight of the East Asian Buddhist tradition concerns our indebtedness to former generations. In 1910, Sigmund Freud counseled widows deeply attached to their deceased husbands. Unable to cure them, Freud pontificated in *Melancholia and Mourning* (first penned in 1915, published in 1917) that the best solution to mourning were to degrade and forget the figure to whom one felt attached. In the wake of World War I, where virtually every family in Europe either lost someone or knew people who lost someone, Post Traumatic Stress Disorder (PTSD) further encouraged Europeans to forget their dead—as Caroline Brazier discusses in her chapter. Hitler used this forgetfulness to his advantage when he extinguished millions of Jews and disabled people. For many tragic reasons in 20th century history, the message to "forget the dead" was imprinted on Europe. Freud's message was echoed by Americans, so geographically mobile that often they could not even remember where they had buried their dead. Freud's admonition to forget the dead was compatible with the American ethos, since Americans had deliberately chosen mobility over attachment.

About twenty years ago, a brilliant psychologist of religion named Dennis Klass, educated at the University of Chicago under Mircea Eliade, visited Tokyo. He watched people talking and listening to their ancestors in front of Buddhist home altars and people reporting to their ancestors at gravesites. Klass concluded that, far from crazy, these were some of the wisest people he had met. When they faced challenges in their lives, they asked their parents or grandparents in their hearts how to deal with them. In quiet meditation, they listened to the voices of their grandparents or parents advising them. Relying on the wisdom of former generations, they dealt with serious problems in their lives without hiring psychiatrists. Their ancestors in their hearts knew better answers than any third party psychiatrist could provide. Dennis Klass returned to the United States, and with Phyllis Silverman and others wrote *Continuing Bonds.* "Continuing Bonds" is the idea that when someone dies, although their body is no longer present, their spirit remains connected to us. We can respect, appreciate, and even learn from them. We can no longer call them on our cell phone, but we can call them on the "cell phone" in our heart. If the cell phone in our heart has its battery

charged—if our mind is receptive—we can get their messages even after their body is no longer with us.

Many readers in Europe and America rejoiced at the Continuing Bonds theory, for although their loved ones were gone, they too could hear their voices and feel their presence. Klass and Silverman depathologized mourning, overturning the Freudian psychology of grief by translating this Japanese Buddhist wisdom to the West: far from pathological, learning from our elders can be psychologically and ethically beneficial.

From Continuing Bonds to Interconnected (*en*) Society

Thirty years ago, the great Yale-educated scholar of Japanese religion, Tom Kasulis, concluded that the genius of Japanese Buddhism was "intimacy"[5]; he developed this into a full-fledged philosophy of culture in *Intimacy or Integrity*.[6] Ironically, the intimacy of relationships fundamental to the Japanese religious worldview that Kasulis experienced thirty years ago when studying in Kyoto and meditating at Myoshin-ji Temple has largely disappeared. Just as Japan has reverted from the least death fearing to the most death fearing culture, it has moved from a culture centrally valuing intimacy and relationships to one that is all too frequently devoid of serious intimacy. Ironically, Japanese society depends on the Buddhist derived concepts of *in* (causality/ responsibility), *en* (interconnectedness), and *on* (sense of obligation or gratitude)—all basic to relationship and intimacy. When these values are forgotten, Buddhist society cannot function.

This has a further ramification for ethics education. Young people in both America and Japan ask why they should care about future generations when they inherit a world so full of problems. Many feel that they might as well just live for whatever they can get out of life and forget the next generation. However, if every morning, we bow to our ancestors, expressing our thanks for inheriting their land, house, education, books—even for this body that we would not have if it were not for them—then we realize our interconnectedness to the many past generations that make the present possible. Only when we realize this dependency on the sacrifices of many previous

[5] In Japanese, the term might be *kizuna* or *tsunagari*, meaning intimacy in relationship with people, nature, and the invisible.
[6] Tom Kasulis, *Intimacy or Integrity: Philosophy and Cultural Difference* (Honolulu: University of Hawaii Press, 2002).

generations do we also begin to think about what kind of world we want to leave behind after we are gone. If I am always aware that my ancestors restricted their own lifestyles in order to leave this forest or river in a relatively unpolluted state for my use, then the least I want to do is to preserve this same forest or river for my progeny. In technical terms, this is known as the problem of responsibility towards future generations, or intergenerational responsibility. The crisis of much of American education in failing to educate its youth in intergenerational responsibility is related to the American failure to recognize their indebtedness to previous generations.

The way to teach the young about these concepts might begin by teaching them about family altars. It might also begin by taking class excursions to look at where our food comes from, how our water comes to us, and the whole process of how we are maintained. If we lose our *in* (causality/responsibility), *en* (interconnectedness), and *on* (sense of obligation or gratitude), then there is no brake on suicide; there is no inherent reason to live if we are just meaningless atoms in isolation. Japan's ongoing eleven-year epidemic of more than 30,000 suicides attests to this. It is the participation in larger structures and our interrelationships with other people that gives meaning to life.

Theology witnessed a long discussion in the 1960s and '70s about the grounds of ethics. The monotheistic stance typically held that divine command is the ultimate ground for ethics. John Hick argued that God's ultimate justice and judgment is clearly not evident in this life, so that without afterlife, there would be no ground for ethics. Against this, relativist and materialist East Asians argued that ethics is socially grounded; for society would collapse if ethical rules were not followed. Christians retorted that if ethics are purely social, then outside of their own societies, Asians have no reason to behave ethically. The atrocities of Japanese soldiers, for example, illustrate the danger of socially-dependent ethics when people are removed from their own social contexts. To this, East Asians respond that monotheist ethics can license brutality of the chosen "believers" against pagan infidels, from the crusades to Hitler's ethnic cleansing.

Ironically, the monotheists were right about ethics breaking down when society breaks down, but Asians were right about consciousness of interconnectedness being essential. If monotheists, who consider their ethics revealed from God, are the only people who can dictate ethics to the world, we will have wars until the end of time, because different revelations provide different realities. Whereas if we are aware of our interconnectedness, then the central ethical question becomes: how must humans

cooperate to keep the planet sustainable? Sustainability implies reducing individual desires to a level compatible with the fulfilling of others' desires throughout the future.

In sum, Japan portrays a curious juxtaposition: On the one hand, in the face of changing demographics, medical technology and welfare economics, it finds itself increasingly incapable of addressing the psycho-social needs of elderly patients. On the other hand, Japan's long-sustained Buddhist tradition includes rich resources for understanding and psycho-socially supporting such elderly patients. This is not to critique either medical technology or welfare economics, but rather to suggest that a more humbly human approach to aging and dying is requisite for a sustainable future. Traditional Japanese Buddhism provides one such approach, based less on religious faith than on a sober contemplation of the human condition.

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