

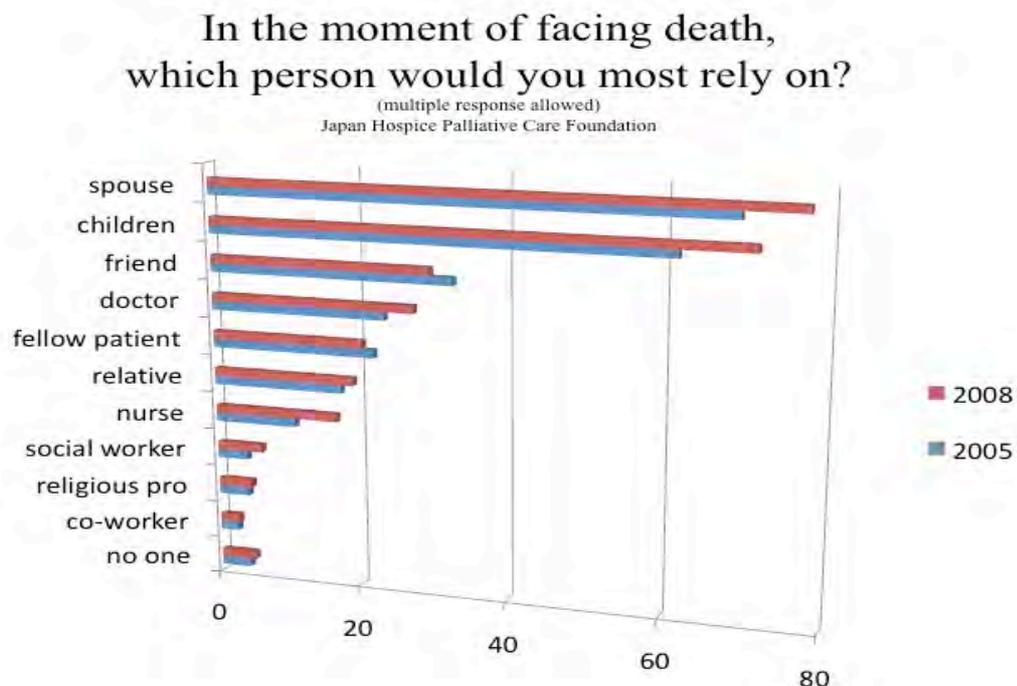
Tear Down the Wall:
**Bridging the Pre-Mortem and Post-Mortem Worlds in Japanese Medical and
Spiritual Care**

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Published in *Buddhist Care for the Dying and Bereaved: Global Perspectives*. Edited by
Jonathan S. Watts & Yoshiharu Tomatsu (Boston: Wisdom Publications, 2012)

Introduction: The Wall between Life and Death in Japan

In a 2008 study by the Japan Hospice Palliative Care Foundation¹, the question was posed to general respondents, “In the moment of facing death, which person would you most rely on?” Their responses were in descending order: spouse/partner (77.4%), children (71.4%), friends (30%), doctor (27.8%), acquaintance with same condition (20.8%), relatives (19.4%), nurses (17%), social worker (6.3%), religious professional (4.7%), work colleague (2.7%), and no one (4.9%). Compared to the results from the same survey taken in 2005, there were significant increases for spouses (+8.2%), friends (+10.3%), nurses (+5.8%), and doctors (+4%).



¹ “In the moment of facing death, which person would you most rely on? (shi-ni chokumen-shita-toki-no kokoro-no sasae,” Japan Hospice Palliative Care Foundation, <http://www.hospat.org/research2-12.html>.

This data brings out two significant points that my chapter will focus on. The first is the lack of reliance on religious professionals. Considering that death is usually thought of as a time of intense spirituality or religiosity when one confronts mortality and faces what lies beyond, it is rather shocking and alarming that in Japan religious professionals are at the bottom of this list with only a tiny minority showing faith in them. In recent times, there has been much negative propaganda around Japanese Buddhism for losing touch with society and becoming stuck in the moneymaking business of “Funeral Buddhism” (*soshiki bukkyo*). This above survey is very concrete evidence of this situation and the loss of confidence by the public in Japanese religious professionals, who are in a high majority Buddhist priests as around 90% of the Japanese population is said to be Buddhist.

Over the past century and a half since the advent of the modern era in Japan, the role of the Buddhist priest has been circumscribed to the point where he is now mostly a ritualist presiding over funerals and memorial services. Unlike in the past, Buddhist priests and institutions no longer care for people before they get sick, while they are sick, and in their dying days and moments. Professionalization has increasingly relegated what were once the roles and activities of priests in general counseling, support for the ill and dying, funeral preparation, and so forth to licensed experts. Priests without the proper modern credentials and licenses are thus no longer respected or welcome in a world of highly trained experts and professionals that make up the modern medical system.

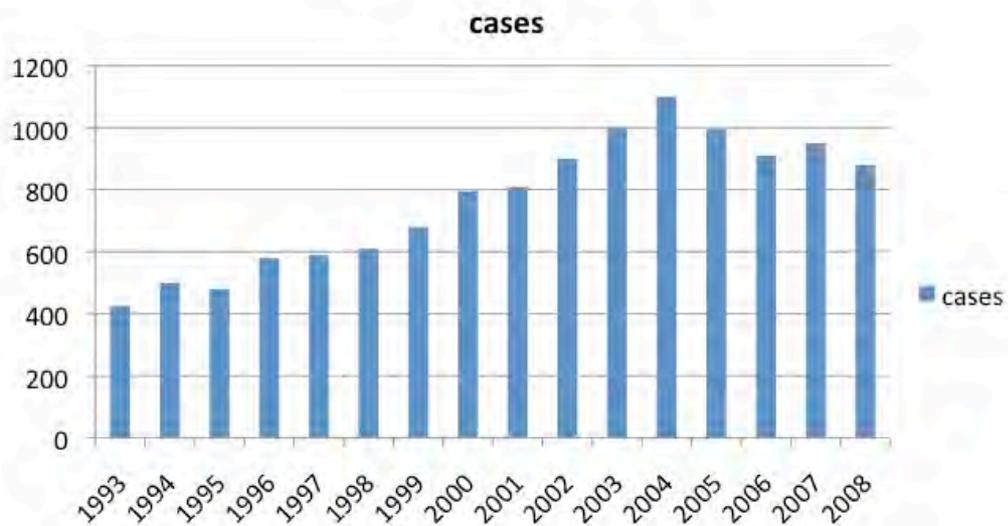
The second significant point for my paper that this survey brings out is the surprising reliance on medical doctors as perceived confidants for patients. There has developed a tendency for Japanese in recent times to depend on doctors not just for physical care but also for mental and emotional support. As we can see in the above survey, they are the first care professionals depended upon in the critical moment of facing death, surprisingly ahead of nurses who are usually the main medical caregivers. This data does not just apply to patients but also to families who rely heavily on the support and guidance of the doctor.

The problem with this structure and culture, however, is that doctors are not properly trained in providing such emotional and mental care and thus are unable to adequately deliver this service to their patients. This point is seen in the increasing number of lawsuits in recent years against doctors, which almost tripled in a ten-year

span from the early 1990s to early 2000s.² Tellingly, suits were initiated most often because of emotional frustration by families with the attitude and manner of the doctor and the lack of mutual trust from little personal interaction, rather than actual medical malpractice.

Medical Lawsuits in Japan

source: Japan Supreme Court



In sum, the situation that we have arrived at in Japan is a strong wall between pre-mortem and post-mortem worlds. The pre-mortem world is dominated by medical professionals, who focus solely on the physical needs of patients and very quickly remove themselves from the scene when a patient becomes terminal. There is then a liminal period in the final dying stages before the Buddhist priest enters the scene right after death and becomes very active. As the alienation between temple priest and parishioner deepens in Japan, it is only in unusual circumstances that a priest is on the scene before death occurs. As we will see in other chapters in this volume, there is not such a strong separation between these worlds in not only the West but also in other Asian and predominantly Buddhist societies like Thailand and Taiwan. For example, the United States has developed a strong system of team care in hospitals that includes

² Overall lawsuits remained steady during this period, reflecting an actual decrease of other types of suits. "The Situation and Problem of Medical Malpractice: The Heart of Improving Basic Policy for Medical Malpractice," National Diet Library. Issue Brief No. 433 (December 11, 2003) & The Supreme Court of Japan public data, http://www.courts.go.jp/saikosai/about/iinkai/izikankei/toukei_01.html.

highly trained chaplains (of which Buddhists are a rising number), while Buddhist monks in other Asian countries are more closely involved in the dying process. In these Asian societies, secularization has not advanced as far in Japan, so the role of doctor and priest is not so strongly alienated.

This specialization of roles, from the doctor as purely physical mechanic to the priest as purely spiritual mechanic, leads to a fundamental alienation from the human relationship with the patient/follower. When one considers the work of a doctor or priest, one might think that their intense experiential work with people in great suffering would deepen their awareness and create a critical wisdom and compassion. However, the opposite seems to be true. As mentioned above, there are an increasing number of lawsuits against doctors mostly due to their lack of feeling and compassion to their patients. A common scene today in Japan is a doctor staring into his computer screen reading off medical information and statistics on longevity and mortality as he attempts to communicate to a patient their illness. At the same time, there are an endless number of complaints about priests showing up for funerals, doing the necessary rituals, receiving their offering cum fee, and leaving without making any real connection with the grieving family. This situation is well illustrated by our Jodo Shu Research Institute's study that shows many priests do not even bother to give a dharma talk at the funeral; that when they do, it is usually no more than 5-10 minutes; and that the impact is very little to none on the bereaved family.

Survey on Dharma Talks at Funerals in Japan

#1 In general, about what percentage of priests give dharma talks at funerals?

		%	Number
1	0~20%	19.8	20
2	20~40%	28.7	29
3	40~60%	30.8	21
4	60~80%	24.8	25
5	80~100%	5.9	6
Total		100.00%	101

#6 Objectively speaking, about what percent of these talks touched people's hearts?

		%	Number
1	0~20%	47	47
2	20~40%	34	34
3	40~60%	12	12
4	60~80%	6	6
5	80~100%	1	1
Total		100%	100

This survey was given to 890 funeral homes in the Kanto area by the Jodo Shu Research Institute in 2008.

In both cases, the common point is the very low level of communication skills in both doctors and priests. They have become master mechanics in their craft, but they have lost sight that their materials are living human beings whose mental, emotional, and spiritual needs have a fundamental impact on their physical well-being. It has become my personal challenge to break down these walls that separate the pre-mortem and post-mortem worlds, the medical and spiritual worlds, and the caregiver and patient worlds. Through the fundamental process of human relationship, I believe we can find the way towards authentic and holistic care for those in suffering. Concretely, I am trying to bring religious and medical professionals together to better understand each other's worlds, changes, and needs.

Developing Doctors as Compassionate Care Givers

Structural Barriers to Holistic Care in Japan

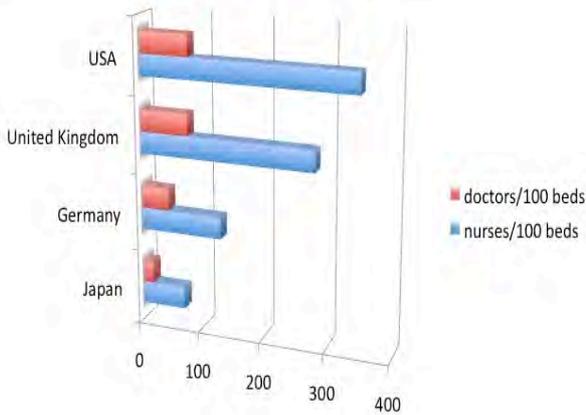
The problem of poorly trained doctors has its roots in the systematic reductionism of care in the Japanese medical system, which reduces all forms of suffering (physical, social, emotional, and spiritual) into medical, physical ones. For example, psychological care in Japan through trained psychiatrists and psychotherapists has been reduced to largely administering pharmaceutical medicine to reduce and sedate anxiety. Spiritual care needs are usually unacknowledged by not only medical professionals but also families and patients themselves. This situation explains why there is no system of trained spiritual care professional or chaplains working in Japanese public medical facilities.

I have met a number of very concerned doctors with good motivation to provide personal emotional care for patients. However, the constraints and pressures of the present Japanese system make following such motivations almost impossible. One of the principle constraints is the case overload that doctors and nurses in Japan face compared with other countries. Based on OECD statistics from 2008, Japan had 15.6 doctors and 69.1 nurses per 100 beds, while Germany had 43.4 and 130.2, England 76.8 and 280, and the United States 78.4 and 346.8 per 100 beds respectively. What is interesting is that the number of beds and average length of stay is in opposite proportion with Japan having an average of 13.8 beds per 1,000 citizens staying for an average length of 18.8 days, while Germany has 8.2 beds for 7.6 days, England 3.4 beds for 7.1 days, and the United States 3.1 beds for 5.5 days. Thus, although Japan has proportionately a fifth of the number of doctors and nurses compared to the U.S., there

are more than four times as many available beds with patients staying on an average of more than three times longer during their hospitalizations.³

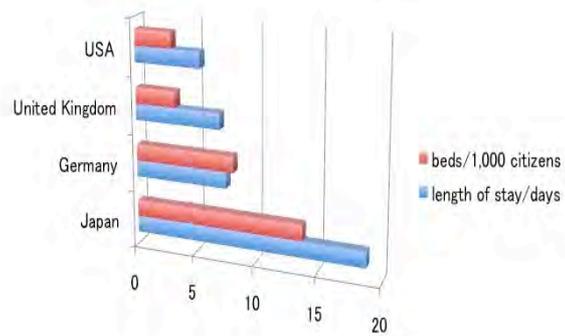
Comparative View of Doctors and Nurses

compiled from OECD statistics for 2008



Comparative View of Hospitalization

compiled from OECD statistics for 2008



Carl Becker in his chapter has discussed this point in terms of the unnecessary over medicalization of the Japanese health care system. The result of this system on the ground is that doctors and nurses just do not have the time to attend to the personal needs of patients as they frantically handle as many medical situations and emergencies as they can. This situation is exacerbated by the lack of team care in Japanese hospitals where other caregivers, especially chaplains, would play an important supporting role. One progressive response to this situation would be to divert financial resources away from maintaining so many beds and patients for long term hospitalization towards paying for more professional caregivers, like chaplains, who could improve shorter term care for patients and support overburdened medical professionals.

In this way, we can see all the more reason that Japan desperately needs to adopt the practice of team care in which doctors and nurses share their work with other care professionals, specifically “spiritual care professionals.” I use this term “spiritual care professional” in contrast to “religious professional,” which I define as the average priest who is trained in the teachings and doctrines of a particular denomination and in the care of a congregation. “Spiritual care professionals,” on the other hand, are trained to

³ Japan has actually halved its average length of stay from 34.4 days in 1994. *OECD Health Data 2010: Frequently Requested Data*, http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html.

go beyond sectarian and even strictly religious sensibilities. They are skilled in dealing with not only patients and their families but also medical staff. “Spiritual care professionals,” or what we call chaplains in the medical field, may spend as much time tending to the emotional needs of the medical staff as their patients and families. The concept and practice of such professionals will be taken up in much more detail in later chapters in this volume.

Looking at the previous statistics on Japanese medical care, we can easily come to understand that stress, burn out, and ill health are common among nurses and doctors in Japan. However, the doctors and government bureaucrats who control the system are still deeply ingrained in western attitudes towards medical care that are now at least twenty years out of date. As this entire volume shows, we can find, not only in the west but also increasingly in countries in Asia like Taiwan, chaplains from all religious backgrounds, spiritual care centers in hospitals, and team care amongst a variety of medical professionals and qualified care givers. However, Japan lags far behind in providing even competent psychological care much less spiritual care for its hospital patients.

Another major cause of this situation had been the gradual adoption in Japan of the Evidence Based Medicine (EBM) system for prioritizing types of treatment, allocating budgets accordingly, and receiving remuneration from the national insurance system for such treatment. Since mental, emotional, and especially spiritual care usually fall out of the bounds of care that provides tangible physical and medical benefit, it becomes even more difficult for doctors to provide such care for patients, even if they have the time and interest to do so. Simply, a doctor who spends extra time getting to know a patient personally or trying to handle a patient’s personal anxiety around his/her treatment will not only not be remunerated for such care but is technically wasting time since they could be administering actual medical treatment to another patient. Furthermore, while insurance will pay for a first psychological consultation, further psychological care is only remunerated when medication is given.

The hopeful news is that this situation might ironically lead to the kind of breakthrough that we need in Japan. Rev. Thomas Kilts, a Tibetan Nyingma Buddhist priest and CPE⁴ Supervisor (profiled in a later chapter in this volume), reports that the widespread application of EBM in the United States forced doctors to abandon any

⁴ Clinical Pastoral Education (CPE) is an officially recognized system of training religious professionals to work in public ministry, especially hospitals. Later chapters in this volume will discuss this in detail.

attempts at mental, emotional, and spiritual care.⁵ This led to a movement to prove the necessity of such holistic care and that such expertise could not be provided by doctors but by new groups of professionals in these fields. The key in the movement to legitimize such care was building the scientific data and evidence that showed that patients tangibly improved in their medical and quality of life conditions due to mental, emotional, and spiritual interventions.⁶ The next important step was showing that this care saved hospitals, insurance companies, and governments money. These advancements became the tipping point in the present movement towards spiritual care facilities and integrated team care in hospitals in the United States. This movement has also assisted “spiritual care professionals” to overcome the reluctance of many modern families towards interacting with and depending on religious people in hospitals and medical environments. A similar situation exists now among many modern urban Japanese who generally have strong sentiments against engaging with Buddhist priests in medical environments and often look at them frocked in their black robes as omens of death.

Working with Doctors as a Spiritual Care Professional

These concerns have been fermenting in my consciousness over the years, and not just through my work as a Buddhist priest. From 1989 to 1991, I studied at the Harvard Divinity School, where I was able to take courses on medical ethics. I was surprised to find in the United States that there was cross registration for courses between the medical and divinity schools and that medical students could study about ethical, spiritual, and religious issues as part of their training. Furthermore, at Harvard particularly, we had very interactive and experiential courses that involved role-plays around how doctors handle difficult ethical and human issues. These are educational components that we cannot find in Japanese medical or divinity schools, even at elite ones like my own Keio University School of Medicine.

In 2004, after meeting and having discussions with the Dean of the Keio University School of Medicine, I pursued a position as a lecturer for doctors in training. In Japan, there are a number of doctors who also are ordained Buddhist priests, yet their identity as priests is kept strictly out of view in their medical practice. In this way, although I

⁵ Interview with Thomas Kilts, July 24, 2008.

⁶ Jon Kabat-Zinn is one of the earliest examples in his pioneering work on the tangible benefits of meditation and mindfulness practice for medical patients. For a selection of Kabat-Zinn’s more formal research publications, see <http://www.umassmed.edu/Content.aspx?id=42440>.

have not done any survey, I am perhaps the only Buddhist priest who is teaching non-medical subjects in a Japanese medical university *openly as a Buddhist priest*. I have brought my experience from Harvard to my classes in which the students engage directly in ethical issues and human relationships in medical care. In general, my courses are very unique in Japan where medical schools spend little or no time at all training their doctors in such ethical and human relationship issues. Even at the Keio University School of Medicine, young Japanese medical students typically spend day after day attending mandatory courses in the nuts and bolts of medical care and hospital management for the national exams for doctoral qualification. Furthermore, my courses are only part of a small elective curriculum. In this way, many students may graduate and become doctors with absolutely no background in how to actually deal with patients and their families as people. In the end, they will learn through a slow and difficult process of trial and error during their residency and eventual formal practice.

The two courses that I have been teaching are: “Preparation for Death, The Situation and Issues in Terminal Medical Care: Thinking about Life through Looking at the Hospice Experience” and “The Expected Image of the Doctor: Thinking about Quality of Life and Bio-Ethics through Informed Consent.” These classes are held on the one-day per week that the medical school sets aside for all elective courses, which is only available for 3rd year students. We are now in the process of changing this system under the guise of “medical professionalism” and will offer such courses to all six grades of medical students. With the entire day set aside for one class, I am free to organize my classes in a more experiential manner. In this way, my class is held over five hours from lunch to the evening, and we are able to delve deeply into a number of difficult issues in patient care.

For example, in my class on informed consent, I invited in a professional actress to play the role of a patient who must be told difficult medical news. I took this idea from one of my Harvard courses. Having a real actress instead of a fellow student in the role of patient enables the encounter to be much more intense and real. One role play revolved around the young doctors having to explain to a woman that she had stage four cancer and had six months or less to live. Another role-play involved telling a woman that her six-month-old baby had congenital heart failure and would probably not live beyond the age of two. The young doctors varied greatly in their ability to communicate with the patient, and the actress also varied her responses from outright anger to silent shock. One particularly interesting interaction was with a young doctor who was very

sincere and good intentioned but had very poor communication skills. As he stumbled to impart the news to this woman about her child, he made critical mistakes in his use of words and expressions. At one point, he recommended to her a bereaved family support group, even though the child was still alive and the woman was just being confronted with news that her child did not have a healthy prognosis much less was terminally ill. At this point in the interaction, the actress went into silent shock, and as this good-natured doctor continued to fumble about, she stormed out of the room.

After each of these individual role plays, I have the students evaluate each other's "performance," and we then have time for a wide ranging conversation on the issues that come up. Typically, we will spend an entire hour on one role-play and ensuing reflection. I always emphasize to students that there are no fixed answers and that we arrive at solutions through sharing the feelings and the experience of suffering with patients and their families. On the day when we had the above-mentioned interaction with the well meaning but unskilled doctor, I happened to have an Indonesian forensic doctor looking in on the class. Coming from a strongly religious country such as Indonesia, he was shocked to see that a doctor would try to impart this news without the aid and support of a religious professional, which he says is common in Indonesia. The young doctors in response were both surprised and curious to interact with this highly trained doctor, who also had a very strong religious faith and viewed the role of religious professionals in caring for patients and family members as a natural and essential part of the medical process.

At first, most of the role-plays that I set up revolved around informed consent and telling bad news directly to patients. However, my students remarked that in Japan, while informed consent as a presentation of a patient's diagnosis has become quite common at over 70%,⁷ truth telling as a communication of prognosis is still not commonly practiced. Doctors may outline a course of treatment directly with a patient and their family. However, in the case of a critical illness, the doctor will initiate further consultations and decisions with the family only. Although they may encourage families to tell their relative their prognosis, the prevalent denial of death in today's Japanese society stops them from doing so. Therefore, through their recommendation, I

⁷ This is a marked increase over the 1990s when informed consent towards patients was around 29%. Nobuo Konuma, "Research Concerning the Switch to Palliative Care from Active Treatment in Cancer Treatment" (gan iryo-ni okeru sekkyoku-teki iryo-kara kanwa kea-he no tenkanten-ni kansuru kenkyu) Presentation on results from 1993 International Cooperative Research (1993), www.pfizer-zaidan.jp/fo/business/pdf/forum2/fo02_026.pdf.

developed some case studies and role-plays for dealing with families, which more directly address the present needs of doctors. Furthermore, the students felt that doing role-plays in which one broke bad news to a patient or their family completely at one time was also somewhat unrealistic. Thus, I have also recently developed extended role plays in which doctors repeat an interaction with a patient or family over two or three meetings and thus practice divulging the full extent of their condition more gradually. In this way, I do my best to receive the student's critical viewpoints and provide them with skills that they can use in the present situation while also guiding them towards a more ideal situation in the future.

Bringing Priests Back Into Life Care

Structural Impetus Towards Engagement

This chapter has thus far concentrated on how religious people, like myself, can influence the medical system and support medical professionals to better care for the holistic needs of patients. However, this is only half of the problem. Unfortunately, as resistant as medical professionals are to the idea of spiritual care, religious professionals in Japan seem to be as equally uninterested in offering genuine spiritual care to people who are ill and dying. As I outlined at the beginning of this chapter, many Buddhist priests are not able to satisfactorily care for the spiritual needs of their lay congregations, especially in their specialized role of providing post-mortem rituals for the bereaved. Ironically, there is no comparative course at the Buddhist university where I teach young priests in training, Taisho University, to the one that I teach at the Keio University School of Medicine. Neither the students nor the administration seems interested in a program that trains priests to be chaplains or counselors to those in critical environments like hospitals, prisons, nursing homes, and psychological care centers. As we will see in Rev. Yozo Taniyama's chapter, the few such initiatives at Buddhist universities in Japan have generally failed.

The one hope at present is through the crisis facing many Buddhist temples with declining numbers of membership and followers seeking other alternatives to caring for the dead. In the next generation or two, many more temples will shut down in addition to the ones in the countryside shuttered due to depopulation. There is one estimate by Takanobu Nakajima, Professor of Business and Commerce at Keio University, that by 2060 the present number of 76,000 temples will become as few as 6,000 due to

population decline, disinterest in religion, and marginalization as a niche business involving funerals only.⁸

A second critical factor facing Buddhist temples is that the Japanese government, led by bureaucrats in the Ministry of Finance, are making the “public benefit corporation” (*koeki hojin*) law, under which temples attain their tax-free status, more strict. This movement is due to Japan’s increasing public debt, much of which is caused by the intense strains in the medical and social welfare systems due to the growing number of elderly and declining birth rate. Furthermore, many government officials no longer see temples as having a public benefit function, since they act as havens for tax-free business earnings in the lucrative funeral business of Japan.⁹

While the headquarters of the major Buddhist denominations have shown increasing concern, especially over their legal status, a number of self-motivated priests at the grassroots level have actually begun to confront the role of Buddhism in society through activities in a wide spectrum of critical social issues, such as suicide, youth problems, and poverty. While this movement is encouraging, it reflects a small number of remarkably keen and motivated priests. A wider mobilization of average priests needs to take place to create a real paradigm shift. In this way, our Jodo Shu Research Institute held a major public symposium in February 2010 on the suicide problem in Japan as well as grief care for the bereaved. The symposium was especially aimed at such rank and file priests and sought to introduce practical activities for priests to bridge the post-mortem world of grief care with the pre-mortem world of preventing suicide. In general, the average priest needs to first recognize how his role and the temple’s role in society have become deeply marginalized. They then must make the extra effort to connect with people in an effort to bridge the gap between the pre-mortem and post-mortem worlds, because there is very little structure or culture left connecting them with the common people.

Home Care: Re-engaging at the Grassroots

The first, most practical form of engagement is through visits by priests to the homes of

⁸ Takanobu Nakajima, “Is There a Path Towards Reviving the Temple?: Let’s Think about the Needs of Citizens Today (*otera saisei-no michi-ha aruka: ima-koso kokumin-no neezu-wo kangae-yo*)” (lecture, Japan Buddhist Federation’s Special Public Symposium “Performing Funerals is for Whom? Thinking about the Problem Surrounding Donations” (*soshiki-ha dare-no tame-ni okonau-no-ka? O-fuse-wo meguru mondai-wo kangaeru*), Akihabara Convention Hall, Tokyo, September 13, 2010).

⁹ Yoshiharu Tomatsu. “The Secularization of Japanese Buddhism: The Priest as Profane Practitioner of the Sacred.” (paper, American Academy of Religion, Philadelphia, U.S.A., November 16, 1995).

parishioners and people in their general community. In urban areas like Tokyo, there are many people without a home temple in their community due to the relocation of their families from the countryside in the post-war era. However, there are numerous reasons why such people, as well as regular temple parishioners, need the support of a community temple.

One reason is the increasing demand for home care due to the increasing financial constraints in the public medical system that are pushing patients out of hospitals. This situation is creating a phenomenon call “hospital refugees.” Under present regulations, a patient under full public insurance cannot stay in one hospital for over three months, unless they pay up to \$500 per day in separate room fees. For the growing number of economically challenged Japanese, this is not a choice they can afford. These patients end up being sent to rural hospitals, which are in financial crisis and need patients, far from where their families live, and then have to move again to a different hospital every three months.

These kinds of financial conditions, which Carl Becker has detailed in his chapter, restrict the development of palliative care wards, because palliative care does not bring in as much income as other units devoted to surgery and intensive medical procedures. In this way, the Japanese government plans to increase the number of elderly housing projects with doctors and clinics inside them. However, many patients will continue to be thrown back into the care of families, in which increasing numbers of wives who used to traditionally perform home hospice care need to work to help support the family.

A second major reason for engaging in home care initiatives as a first step is due to the marginalization and lack of acceptance of religious professionals in medical environments. In the three major Buddhist hospice and palliative care units in Japan, which are profiled in this volume (Nagaoka Vihara, Asoka Vihara, Kosei Vihara), as well as at Christian hospitals, there are numerous testimonials to patients showing no interest in using the trained spiritual care professionals on call. The Jodo Shin denomination has done incredible work through their Vihara programs to educate and train over 1,000 priests and temple wives in spiritual care for the dying.¹⁰ However, these programs have not had a major effect, because there is no public medical or welfare facility that will accept them to practice. The priests and priest wives are educated, but due to a lack of places to do real residency and training, they lack fully

¹⁰ *Vihara Activities 20 Year Report*, (2009), http://social.hongwanji.or.jp/html/c11p9_07.html.

developed care skills. On the other hand, Buddhist priests and temples still have the ability to connect to networks of parishioners and local residents. From this basis, priests can find out which households have the need for caring for an elderly or sick family member and take it upon themselves to engage with them, whether it be actual spiritual support or more basic social and material support.

By entering the people's lives before they die, priests may widen their capacity to offer spiritual care at the time of death. From such a basis, a priest can visit a patient who requests them individually in the hospital, although they are not part of the hospital staff. There are priests today, such as myself, who have strong bonds with their parishioners, are aware when they face a critical medical situation, and may come to their bedside to offer ritual, comfort, or simply presence with the family. The point is in order for priests and temples to gain back the confidence and trust of the common people, the government, and professionals in various fields, we must begin to engage in concrete activities that show our usefulness, or "public benefit character" (*koeki-sei*).

Building New Structures

The next level of engagement after this stage is for Buddhist denominations to build more hospitals, PC units, and hospices. At present, Buddhist denominations in Japan have been very active in building schools and universities, yet very inactive in comparison to Christian denominations in building medical facilities.¹¹ If they had their own institutions, they could work to mainstream spiritual care as well as team medical care. As Dr. Moichiro Hayashi of Kosei Hospital founded by the Buddhist denomination Rissho Kosei-kai explains in his chapter in this volume, mainstreaming such care in a major hospital is still very difficult even when the facility has been created by a Buddhist denomination. In this way, the creation of such facilities should begin on a small, grassroots scale; such as the Saimyo-ji Temple-Hospital Care Facility run by Dr./Rev. Masahiro Tanaka in Tochigi prefecture.¹²

In the case of my own Jodo denomination, we have begun to support a grassroots initiative called the One Spoonful Association (*hitosaji-no-kai*), started by a group of young priests to support the homeless in Tokyo for food, medicine, and funeral and

¹¹ Although there are 14 Buddhist denominations with over one million followers respectively [*Diamond Weekly* (September 12, 2009): 76.], there are only three major Buddhist based hospitals in Japan: Kosei Hospital owned by Rissho Koseikai, Tohoku Welfare University owned by the Soto Zen denomination, and Asoka Clinic owned by Jodo Shin Nishi Honganji denomination.

¹² For more details on Dr./Rev. Tanaka's work, see: <http://fumon.jp/e-idx.htm>.

grave services. With institutional support from the denomination, we are planning to expand the services to rent a small building as a temporary house with a small clinic where the dying homeless can spend their last days. As a private institution that receives no public funding and is not part of the national insurance system, we will have complete freedom for our priests to engage in the work in whatever ways they see as necessary. As some of the young priests who are leaders in this work have also been involved in activities to counsel and support the suicidal, they have an understanding of the core values and practices of chaplaincy or “spiritual care professionalism,” such as the need to offer presence and deep listening to people rather than impose religious agendas on them. This project reflects the “ground zero” situation in Japan where we must begin to rebuild religious community structure and culture through working with the most marginalized people whom the society has turned its back on. It is similar to how Buddhist hospice work began in other countries profiled in this volume, such as Cambodia, Thailand, and the United States where publicly ostracized AIDS patients were the first targets of the work.

Conclusion: Bridging the Gap between Worlds

A final level of engagement that I am pursuing is exploring how priests as death professionals can assist doctors to better care for patients and families as well as how to better take care of themselves. The one speciality in which Buddhist priests are recognized as professionals in modern Japan is post-mortem death and memorial rites. Although the survey I cited at the beginning of this chapter indicates that many priests are quite ineffectual in the spiritual care of the bereaved, there are some priests who have become quite skilled through their activities as the head of temple communities in managing human relationships and providing grief care. From this basis, priests often have access to a number of important perspectives on medical professionals pre-mortem care through their relationship with bereaved families. Many bereaved families quickly lose contact with the medical professionals who cared for their family members after their deaths. They have little opportunity to express their honest feelings about the care, both critical and complimentary. Priests often hear these complaints and compliments and, if they had personal relationships with medical professionals, could share these reflections with them. On the other hand, doctors and medical professionals’ who have an intense experience with patients and families on the pre-mortem side can offer priests important perspectives on their real suffering and needs before the wake, funeral, and

memorial process begins.

One of the principle things we can do to influence and raise the consciousness about bridging the gap between pre-mortem and post-mortem worlds is to create mutual study groups that cross not only denominational lines but also professional ones by gathering together people from all types of care giver backgrounds. In this way, I initiated the *Ojo* and Death Project at the Jodo Shu Research Institute in 2006. Thus far, we have held roundtables and public symposia to discuss these issues with medical professionals and Buddhist priests and lay people interested in holistic care, as well as bringing in spiritual care professionals from overseas. Still, while there have been a number of conferences for religious and medical professionals in Japan in the last twenty to thirty years to explore how to help the dying, these conferences have not led to many concrete initiatives. As such, I would again like to emphasize taking on smaller, grassroots initiatives as a way towards building larger systemic change.

One such traditional Buddhist grassroots activity has been the community association (*ko*). The *nenbutsu-ko*, a particular association for developing faith in Amida Buddha who guides people at the time of death to the Pure Land, was throughout Japanese history an important community association for the elderly that transcended sectarian affiliations. The *nenbutsu-ko* served as a traditional Buddhist support system for elderly people and the concerns they develop about their health and eventual death. In modern urban Japan, these *nenbutsu-ko* are neither numerous nor strong. However, I see their regeneration as an important piece to this puzzle of the crisis of health care in Japan.

About fifteen years ago, the core members of my temple here in Tokyo asked to start doing the special practice of one million recitations of Amida Buddha's name (*hyakuman-ben nenbutsu*) every month. This group also wanted to learn a more formal level of sutra chanting. This group consists of mostly retired businessmen and widowed women all over the age of sixty. At these events, we spend a short time chanting and then the real core of the meeting begins with teatime, chatting, and good food. We always have two lead speakers who rotate with each session. In their talks, they raise topics and concerns from their own experiences, and then we form a discussion. As can be expected from this age group, their main topics are about health, sickness, and critical family experiences that often include death. From these conversations, I could see that they did not want to talk just about spirituality but also wanted to talk about the specific aspects of physical health care. In fact, it was impossible to divide the two

topics—the physical and spiritual aspects of health—as the professionalized medical system has worked so hard to do.¹³ As a consequence, I began to invite doctors whom I have met at Keio Medical University to my temple to give the Sunday morning dharma talk. Instead of preaching about religion, these doctors give practical talks on medical issues that are of deep interest to my aging congregation. It comes as no surprise then that on these Sundays my temple is packed with attentive listeners busily taking notes. In this way, we have recreated a *nenbutsu-ko* here in downtown Tokyo.

In conclusion, the key point in this process is that the patients and family can serve as the bridge between the religious and medical worlds. If the people have a strong bond with the temple, they will carry that into the hospital and other medical environments and demand it as part of their care. As we have seen in other countries in volume, the creation of spiritual support and care in medical systems has often come about from the demand of the consumers, the patients and their families. Beyond all the activities to prove to the medical establishment that spiritual care is scientifically verifiable as well as cost efficient and to train chaplains or “spiritual care professionals,” the fundamental need is to engage directly with patients and their families. This is the most important step in creating change in the present structure and culture and, more importantly, to directly meeting the needs of people in suffering.

Indeed, through my reflections on all this research and work, I have come to see how this particular issue of death and dying in Japan serves as a microcosm for all the other social problems we have. In the true Buddhist view of interconnectedness, one can see directly, as Carl Becker has shown in his chapter, the connections to Japan’s economic, human relationship, and spiritual problems. In this way, the wall between the pre- and post-mortem worlds that serves as the central theme of this chapter is simply a reflection of our segmented and fragmented Japanese society. Today, people commonly speak of this situation as *mu-en shakai*—a society of no interrelationship. It is not ironic at all that one can see the Buddhist foundations in this term *mu-en*, in which *en* refers to the “karmic relationship” that we as Japanese have tried to preserve for generations upon generations through our Buddhist forms of ancestor veneration. Yet today, we have arrived at this place of *mu-en*, no relationship, where in particular people are dying

¹³Yoshiharu, Tomatsu, “Funeral Buddhism as Engaged Buddhism: Problems and Challenges in Redefining the Role of the Buddhist Priest in Contemporary Japan,” (lecture, Twelfth Biennial Conference of the International Association of Shin Buddhist Studies, Musashino University, Tokyo, September 9, 2005).

alone without each other's support.¹⁴

From a Buddhist standpoint, I feel it less important for priests to develop new doctrinal and ritualistic applications for dying than it is to become deeply involved with the very experience of death by engaging directly with people before they die. From each individual priest's own personal experience in such work, we will see the development of meaningful Buddhist responses and initiatives. This is the real way to recover the meaning and role of Buddhism concerning death and dying and in turn to recover Buddhism's role in Japanese society at large. As the dying issue is part of a much larger holistic social problem, by engaging in it actively and directly, we can touch the many other social issues that need our attention today and come to a much broader holistic solution to them.

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¹⁴ The *mu-en shakai* was presented in detail in a NHK documentary on January 31, 2010, showing how over 30,000 Japanese annually are dying alone, usually unnoticed by anyone in their apartments or houses, with no one eventually coming to claim their remains from the police.

<http://www.nhk.or.jp/special/onair/100131.html>.

Also see Jonathan Watts & Yoshiharu Tomatsu, *Never Die Alone: Birth as Death in Pure Land Buddhism*, (Tokyo: Jodo Shu Press, 2008).