

Soul Searching in the Japanese Hospice

The elderly Japanese hospice chaplain leaned back in his chair and looked at me. I had just finished summarizing my research project on spiritual care in Japan. His hospice, which we had toured together, was in an airy building enfolded by greenery. From Tokyo it took about an hour by train, followed by a ride on a shuttle bus to the top of the hill where the hospice stood. It was a nice, quiet location, with a distant view of Mount Fuji framed in the large glass windows in the common room. The building, greenery, and large windows projected a space of serenity. It seemed like a good place to die. In the chaplain's office, I had my notebook and pen ready. To start things off, I asked, "What is your approach to spiritual care?" With a twinkle in his eye, the chaplain replied, "I've been working at this hospice for more than five years and I am still not doing spiritual care." He chuckled. Then what was he doing? Little did I know that he had just put his finger on what would constitute a major challenge in my research: spiritual care in Japan does not always look like what you would expect.

Soul searching suggests deep reflection. At the end of life, it evokes an image of a patient pensively staring at the walls, perhaps feeling what hospice workers call "spiritual pain." This term was popularized by Cicely Saunders (1918–2005), the founder of the modern hospice movement, who used it to describe a pain caused by a "desolating sense of meaninglessness" that accompanies the process of dying.¹ In North America, for instance, spiritual care is commonly framed as a mixture of sacramental and psychotherapeutic forms of care that focus on helping patients find religious consolation or address the existential "meaninglessness" brought about by impending death, as well as the anxieties caused by guilt, loneliness, or fear of the afterlife. Accordingly, much of the extant English-language literature on spiritual care at the end of life emphasizes strategies for responding to patients' questions about existential meaning or purpose in the face of suffering. Or it offers to guide them in a search for transcendence.² In the face of such spiritual pain, a hospital chaplain might come by and ask how you are doing. If you belong to a

faith tradition, they may offer you communion, Shabbat candles, or prayer. More often, as the population of nonreligious patients has increased in Europe and North America, the religious dimensions of spiritual care are offered in a more fragmented or less prescriptive manner.³ At its core, spiritual care is depicted as a “ministry of presence.”⁴ Chaplains are expected to “be there” for the patient and to accompany them on their spiritual journey at the end of life.

In Japan, where terms like “chaplain” and “spiritual” invite a blank stare from patients, this framework only goes so far. After all, as the elderly chaplain explained to me, only a small minority of Japanese hospice patients openly articulate a spiritual pain that is centered on existential concerns. Even fewer patients ask for religious forms of care like prayer. In fact, most of the patients that chaplains encounter in the hospice ward seem outwardly dismissive of questions about the meaning of their life, suffering, their relationship with God, guilt, forgiveness, or any other “spiritual concerns” that are typically imagined lying at the core of spiritual pain. Even when patients seem concerned about these issues, often, they would rather not show it. Instead, most Japanese hospice patients direct conversation toward other anxieties—such as a strong fear of becoming a burden on others or an inability to fulfill their social or familial responsibilities. As a result, spiritual care at the end of life in Japan frequently attends to these and other kinds of needs instead.

AIMS AND OVERVIEW

This book aims to depict spiritual care in situ, through ethnographic fieldwork and interviews with hospice patients and workers, to provide a richer understanding of the way contemporary Japanese approach the end of life, and how spiritual care is provided by hospice workers in ways that they feel will meet patients’ most common end-of-life needs. Spiritual care in Japan often goes beyond helping patients address their “spiritual pain” through counseling, religious support, or being a sympathetic presence. More often, spiritual care in Japan is conducted in the margins of daily care, such as through special hospice events or in the course of prosaic activities that chaplains and other hospice staff view as conduits for a kind of spiritual care that makes patients feel valued and appreciated at the end of life.

This is readily seen in the following chapter, “The Rhythms of Hospice Care,” which focuses on the daily routines of care by doctors and nurses. I offer glimpses of the way patients are discussed during morning conferences, shadow a doctor as she does her rounds, explain how new patients are informed of their prognosis, observe how patients and their families are cared for in their last moments, and describe the intense emotional labor that medical workers must perform throughout the day. As I detail these daily rhythms of care, I pay special attention to how doctors and nurses interpret their daily medical responsibilities in relation to spiritual care, such as stressing the importance of care for the heart (*kokoro*) and helping patients “be themselves” as they approach death (*jibunrashiku shinu*).

In chapter 3, “The Heart of Spiritual Care,” I turn my attention to how hospice chaplains care for patients. In Japan, chaplains at the bedside are aware that it is rare to have an opportunity to offer prayer, recite sutras, conduct sacramental rites, or candidly discuss religion and existential issues with dying patients who have never even heard of spiritual care. Accordingly, chaplains spend much of their day attending to patients in ways that go beyond traditional models of pastoral counseling, religious support, or being a sympathetic presence. I outline three broad categories of spiritual care that chaplains and other medical staff provide and argue for the particular importance of “supportive care,” which stresses the importance of supporting the patient’s ability to die in a way that reflects who they are. I also outline how Japanese patients and staff offer less resistance to this indirect and supportive approach to spiritual care. Despite the often-repeated mantra in spiritual-care literature that it is more important to *be* there for patients than to *do* something for patients, I show that hospice staff and chaplains in fact *do* many things in offering spiritual care. While many past studies on spiritual care in Japan offer idealized models of spiritual care or demonstrate the larger religious and social contexts for such spiritual care, they often lack attention to the actual lived practice of spiritual care in the hospice setting. What does a typical day look like for chaplains? What are some of the concrete ways in which they interact with patients? What practical principles guide their work? These are questions that have yet to receive concentrated attention.⁵

It is important to interject by saying that this type of spiritual care is not necessarily unique to Japan. At many points in my research, North American practitioners of spiritual care would listen to my findings of what goes on in Japanese hospice care and say, “That sounds just like what I do.” Even in societies where many patients are highly religious, such as the United States, hospital chaplains are starting to gravitate toward a kind of care that is fundamentally relational and supportive of the patient rather than explicitly religious.⁶ This is exactly why the study of spiritual care in Japan has a broader global significance. As a highly secularized non-Western modern nation with a population that is aging faster than anywhere else in the world, Japan represents an important case study for understanding how spiritual care is provided to hospice patient populations that identify themselves as nonreligious.

Chapter 4, “The Meaning of Spiritual Pain,” pivots from caregivers to patients by scrutinizing spiritual pain—the clinical term that refers to the existential suffering that dying patients are said to experience in the face of death. By collating interviews with hospice patients, I examine several reoccurring themes in the types of anxieties dying patients face at the end of life and where they turn for support. I then show how the anxieties Japanese hospice patients voice call into serious question the clinical category of spiritual pain, even while, in some cases, they support it. Many Japanese patients are unlikely to openly express their anxieties in religious or existential terms. Nevertheless, there remains a fundamental tension

in the concept of spiritual pain because chaplains suggest that spiritual pain can also be latent, repressed, or sometimes just poorly articulated by Japanese patients. This shows how, on one hand, discourses of spiritual pain and care can serve the needs of religious professionals and medical workers at least as much as the needs of patients. On the other hand, chaplains genuinely believe that spiritual pain can be manifested in subtle ways that elide the clinical gaze.

This book also uncovers how Japanese hospice workers and scholars of spiritual care are soul searching—quite literally—to define the nebulous concept of spirituality. The most basic question that spiritual caregivers in Japan grapple with is, “What is spirituality?” The English word “spirituality” is usually left untranslated and simply transliterated into Japanese *kana* syllabary as *supirichuariti*. In recent years, many studies have been published by Japanese hospice workers and scholars that aim to delineate the spiritual from the physical and psychosocial dimensions of hospice care.

In chapter 5, “The Invention of Japanese Spirituality,” I explore several such definitions of spirituality and spiritual pain and show how these studies invariably present spirituality in clinical settings as a discrete dimension of personhood, which resides in all patients and becomes awakened in the face of an existential crisis like death. This medicalized view of spirituality echoes the World Health Organization’s definition of palliative care, which distinguishes between the spiritual, physical, and psychosocial dimensions of personhood. However, I suggest that these efforts to define spirituality in hospice care tend to ignore the diffuse ways in which hospice workers actually attend to the spiritual needs of patients in practice. By critically engaging with the invention of the term “spirituality” in Japan and looking at how this ambiguous concept has been applied in clinical settings, I demonstrate the way the term “spiritual” and its cognates work as floating signifiers; they primarily function as negotiable boundaries. That is to say, they help different stakeholders in the hospice movement to maintain or contest the acceptable parameters of religious care for dying patients. I also detail how this search for spirituality is part of a global conversation in which both Japanese and other understandings of spirituality are being transposed and reappropriated across cultural boundaries. Ultimately, I suggest that spiritual care in Japan is better described as a type of care for the *kokoro*—a concept with less historical baggage that also better captures and illustrates the importance of the affective dimensions of religious practice and identity in Japan.

A final aim of this book is to show how contemporary Japanese religious groups, and especially contemporary Buddhists, are looking to spiritual care as part of the answer to the ongoing soul searching about their role in Japanese society. Statistical indicators of Japanese religiosity have consistently shown the declining importance of religion in Japan.⁷ After the new religious group Aum Shinrikyō carried out a sarin-gas attack in the Tokyo subway system in March 1995, many Japanese came to view religion with deep suspicion. In the aftermath of this attack, which

claimed thirteen lives and injured over six thousand others, public trust in religious organizations was deeply eroded.⁸ Even in regard to death rites, which remain a traditional bastion of Buddhist influence, surveys continue to show a decline of religious beliefs and practices.⁹ Today, when I ask my Japanese university students (who were all born after the Aum attack) what the word “religion” means to them, they regularly respond with adjectives like “scary” (*kowai*), “suspicious” (*ayashii*), and “creepy” (*kimoi*). This generally negative impression of religion has been a consistent feature of Japanese society for at least the past two decades, if not longer. As Japanese religions have seen their public role and prestige in society shrink, for Buddhists in particular, there has been much handwringing about being pigeonholed as nothing more than funerary specialists.

In this context, a small but growing number of Buddhists have come to see their involvement in hospice care as having the potential to combat longstanding negative stereotypes about the work of Buddhist priests as confined to funerary and memorial rites.¹⁰ For religious professionals in Japan more broadly, including Christians and members of new religious groups, the establishment of new vocational roles in hospitals, a paradigmatic modern social institution, represents a potential avenue to dispel the suspicions and preconceptions many Japanese harbor toward organized religions. Care for the *kokoro* represents an opportunity to demonstrate the positive role religion can play in Japanese society. However, this soul searching on the part of religious professionals is by no means new. Rather, as I demonstrate in chapter 6, “Making Healthy Religion,” the vision of promoting spiritual care in the hospice is embedded in a longer history of religious engagement in modern medicine, dating back to the late nineteenth century, that reveals a persistent attempt on the part of modern Japanese religious groups to show the “healthy” role that religion can play in society.

This book begins by describing the day-to-day nuances of spiritual care and then sequentially zooms out to situate spiritual care in its broader theoretical and historical contexts. The details on the daily practice of spiritual care in chapters 2, 3, and 4, which are primarily ethnographic, will not only appeal to scholars and students of Japanese religion, but also to healthcare practitioners around the world with an interest in what spiritual care looks like on the ground in Japan. Chapter 5, which examines theoretical discourse on spiritual care in Japan, offers a deep dive into debates about the dividing lines between religion and spirituality from the perspective of Japanese clinical and academic literature on spiritual care. This chapter will appeal to chaplains engaged in spiritual care as well as scholars interested in critically interrogating the application of “spirituality” in health care settings. Chapter 6, which documents the history of religious engagement in medicine and the birth of hospice care in Japan, may be of particular use to those with an interest in the history of socially engaged Buddhism as well as the historical relationship between religion and medicine in Japan more broadly. Chapter 7, “Last Thoughts,” tries to bring this all together.

THE NEED FOR HOSPICE CARE IN JAPAN

Japan is currently in the midst of a dramatic demographic crisis with profound implications for its society. As of 2020, 28.7% of Japanese were aged sixty-five or older—the highest percentage in the world.¹¹ By 2065, this number is expected to rise to a staggering 38%, meaning that more than one out of three Japanese will be sixty-five or older.¹² This rapid aging is driven by Japan's low birthrate, which currently hovers at about 1.4 births per woman. This number actually represents a slight improvement over an even lower rate of 1.2, which was recorded between 2003 and 2005. Although the Japanese government has worked urgently to institute various policies that encourage families to bear more children, these have only been marginally successful, and the birthrate remains well below the replacement fertility rate of 2.1. Accordingly, Japan's total population is expected to decline by about forty million people, from its peak of 128 million in 2008 to approximately eighty-eight million in 2065.¹³ This progressive graying of Japan's population has already begun to put extreme pressure on families who must care for their elders at the end of life.¹⁴

The growing need for hospice care in Japan is not only tied to Japan's rapidly aging population, but also to important changes in the structure of Japanese households that have affected the ability of families to care for their elders. Over the last several generations, the relative number of nuclear families has risen in Japan, while the number of three-generational households has declined. The number of single-member households has also risen. These changes are often attributed to the rise of conjugal ideals that emphasize living apart from one's parents, as well as the space constraints of urban living. Thus far, however, these changes have not completely undermined the traditional Japanese stem family since many children will move back home to care for their parents in their hour of need.¹⁵

Even still, the resilience of traditional family structures in Japan are being tested today in new ways. Simply put, even if children are willing to move back home to care for their parents, without large-scale immigration or a change in Japan's low birth rate, there are simply not enough children to care for their elders. In the past, daughters-in-law traditionally bore the responsibility of living with and caring for their husband's parents. However, this task has become increasingly onerous, as the number of married women who choose to remain in the workforce has grown. Moreover, if a daughter-in-law is an only child, she is likely to be held responsible for the care of her own parents as well. In rural areas, where depopulation is particularly acute, the problem is compounded by a lack of job opportunities that would allow children to return to their hometowns. This demographic crisis has no immediate solution in sight as Japan's birthrate remains stagnant and the possibility of large-scale immigration remains politically unpopular. Coupled with Japan's life expectancy rates, among the highest in the world, the prospect that a growing percentage of the current population will live well into their eighties and

nineties presents a genuine dilemma. Who is going to care for their elders as they approach the end of life?

WHERE TO DIE?

For most Japanese, the default place to die is the hospital. This is particularly true for cancer patients. Currently, cancer accounts for nearly a third of all deaths in Japan and remains the leading cause of death among those between the ages of forty to eighty-nine. In 2019, 4.3% of Japanese cancer deaths occurred in a nursing home, 12.4% at home, 69.9% in a hospital or clinic, and 13.4% in a hospice. Although only slightly more than a tenth of cancer deaths currently take place in a hospice, this number is trending upward. For example, in 2000 only 2.5% of cancer deaths occurred in a hospice and 90.6% of cancer deaths took place in a hospital.¹⁶

There are many benefits to dying in a hospital. First of all, it is convenient. In fact, dying in a hospital may be the only realistic option for those who live in rural areas with no hospice care nearby. Dying in a hospital also ensures that patients retain access to life-extending treatments until the very end. Having full access to a range of diagnostic and treatment services is no small consolation for patients who wish to extend their life as long as possible. For example, one patient I met during my fieldwork had been battling cancer for more than a decade before finally entering a hospice. She had undergone every possible treatment and had visited countless specialists. She told me that some patients liked to complain about the side effects of multiple treatments, but she had a different perspective: “I say, if you don’t like it, you can go home. Your cancer will just get worse.” Although this patient eventually embraced hospice care when she had run out of treatment options, it was clear that battling cancer until the very last minute was important for her. Refusing to go gently into the night helped her cope with death.

However, for most patients, dying in a hospital is far from ideal. This problem was laid out most clearly by Yamazaki Fumio in his 1990 bestseller *Dying in a Japanese Hospital*, which was later made into a film. Yamazaki shares the stories of five patients who died horrible medicalized deaths, contrasted with five patients who died dignified, humane deaths, and argues that Japanese hospitals were too focused on treating the disease at the expense of the person. Yamazaki describes an interaction between one patient and his doctor: “The concern of the doctor in charge of him rapidly receded once it was seen that the treatment had little effect. When he came on his rounds, he didn’t look Kinoshita in the eyes. All he did was to encourage him in a loud voice. Then he hurried away. He was interested only in the cancer, not in Kinoshita as a person.”¹⁷ Yamazaki concluded by calling on medical workers to treat patients more holistically, with fewer medical interventions, with fuller and more honest prognosis disclosure, and to make spiritual care available to all patients. Basically, he called for more hospice care.



FIGURE 1. A tatami-mat hospice room (Photo by author).

WHAT DOES HOSPICE CARE LOOK LIKE?

The word “hospice” stems from the Latin *hospe*, meaning “hospitality.” It originally referred to places of shelter that religious orders in medieval Europe provided to travelers and the sick.¹⁸ Medieval European hospitals were religious houses that were built as spaces where the soul could be cared for, where illness-generating sins could be removed, and the pious could exercise charity. Care for the immortal soul was therefore paramount in importance—much more so than care for the mortal body.¹⁹ Religious care was therefore integral, if not foundational, to the mission of medieval hospices.

Many centuries later, the first modern hospice, Saint Christopher’s Hospice, opened its doors in London in 1967 under the leadership of Cicely Saunders, a Christian nurse, social worker, and physician. In Japan, the first hospice ward opened in 1981 at a Christian hospital, and many more were established after palliative care came under the aegis of Japan’s national health insurance in 1990. As of 2020, there was an estimated 453 palliative care wards in Japan. On average, each hospice has about twenty beds, and in 2019 the average length of stay was 28.5 days.²⁰ Officially, hospice care is described in the regulations of Japan’s Ministry of Health, Labour and Welfare as “palliative care” (*kanwa kea*), and this term is used interchangeably with the more traditional term “hospice” (*hosupisu*) in the popular media.²¹ I rely on the more popular terms “hospice” and “hospice care.”

There are several different types of hospices in Japan. First, there are hospices that exist as a ward within a larger hospital building (*innai byōtō*). This type of

hospice is by far the most common and represents 85% percent of Japanese hospices. The second type represents about 13% percent of hospices, and are located in a separate building on hospital grounds (*innai dokuritsu*). These hospices have several advantages over those that are located inside the hospital. These include greater freedom to design the facility to make it feel more homelike, along with additional perks, such as allowing patients to smoke without falling afoul of hospital regulations. A third type of hospice, of which there is only a handful, exists independently from a hospital (*kanzen dokuritsu*). A fourth type of hospice care includes palliative-care teams (*kanwa kea chimu*) that are assembled within a larger hospital to treat cancer patients who are scattered across different wards. In 2017, nearly 15% of Japan's 7,353 hospitals had such teams in place to help treat terminally ill patients.²² Finally, home hospice (*zaitaku kanwa kea*) is provided by a growing number of small clinics and home-visit nursing stations that help care for Japanese cancer patients who prefer to die at home.

This study focuses on the first three types of hospices, where patients spend the end of their life in designated hospice wards. Although the flexibility that palliative care teams and especially home hospice provide for Japan's overcrowded hospitals is growing in importance, hospice wards where terminally ill patients are physically grouped in a designated hospital wing or building continue to be the norm in Japanese hospice care. I also refer to some hospices as Buddhist, Protestant, or Catholic. Buddhist hospices are sometimes referred to as *Vihāra* wards and chaplains are called *Vihāra* priests. The term *Vihāra* means "abode," and traditionally refers to monasteries, retreats, or places of rest. This term was coined to provide an alternative to the word "hospice," which carries Christian associations.²³ These religious hospices and *Vihāra* wards were founded by religious groups that continue to uphold the spirit of their respective denominations in their mission statement and in the provision of religious services, materials, and spaces to patients who request it. But this does not mean that those who work in such hospices are necessarily religious. Hospice staff might occasionally happen to share a similar religious background as that of their workplace, but since most hospitals face a constant shortage of nurses and doctors, the religious mission of the hospice usually has only a slight bearing on who is hired. The same goes for patients. On occasion, patients may seek to enter a hospice that complements their religious views, especially in urban areas where different choices are sometimes available. However, long waiting lists typically preclude such choosiness and so selecting a hospice based on availability and location is usually a much stronger determinant. It is not strange at all to hear of devout Buddhist patients being cared for in a Christian hospice or a devout Christian being cared for in a *Vihāra* ward.

Although all members of the hospice team in Japan are expected to practice spiritual care, the primary givers of spiritual care in hospice settings are chaplains. Most chaplains are either ordained or have some form of religious training and background, but this is not always required.²⁴ Because most Japanese hospice

wards are located within a larger hospital system, the chaplains' work in the hospice may represent just a small portion of their daily responsibilities. Visits to the hospice range from every day to just a few times a week, depending on the size of the hospital and the number of chaplains available. Some chaplains may also only work part time. For example, at one hospice, a Lutheran pastor visited just twice a month. At another hospice, a Catholic chaplain visited patients once a week while also teaching part-time at a nearby university. At yet another hospice in Tokyo, a local Christian pastor and two Buddhist priests were on call to serve as chaplains, but only when necessary. In hospices that maintain a strong religious affiliation, however, a chaplain typically works full time.

The exact number of hospital chaplains currently serving in Japanese hospice wards is hard to ascertain. According to a 2012 report published by the Japan Hospice Palliative Care Foundation, there were an estimated 176 chaplains working or volunteering at sixty-eight different palliative care wards around Japan at that time.²⁵ However, another study estimated in the same year that there were only sixty chaplains at thirty-seven hospice institutions.²⁶ According to the Hospice Palliative Care Japan Website, in 2017, at least fifty-eight of their 331 member institutions provided some sort of spiritual care to patients or their families through religious workers or volunteers.²⁷ Finally, a 2020 survey of 368 hospices reported that thirty-four hospices (11%) employed at least one part-time or full time chaplain, while a further sixteen hospitals (5%) employed two or more chaplains. Based on these numbers and my own fieldwork, I estimate that there are currently just over one hundred hospice chaplains who are actively engaged in providing spiritual care on a near to fulltime basis in Japan.

UNDERSTANDING SPIRITUALITY

In Japanese, the word “spiritual” (*supirichuaru*) is an English loan word, rendered in the *katakana* script to designate its foreign origins. It is therefore impossible to discuss the spiritual in Japan without acknowledging its recent and foreign provenance. The English word “spirit” and its cognates are derived from the Latin *spiritus*, which was used in the fifth century to translate the Pauline theological concept of *pneuma* or “breath.” In Pauline theology, the “spiritual” (Gk. *pneumatikos*; Lt. *spiritualis*) is contrasted with the “flesh” (Gk. *sarkikos*; Lt. *carnalis*). A spiritual person referred to someone who walked according to the “spirit of God” instead of pursuing his or her own fleshly desires.²⁸ In the centuries that followed, the word took on a number of new associations, referring, for example, to something that contrasted with the corporal world, to ecclesiastical persons and property, or to religious devotion. In the United States, the “spiritual” was further imbued with new meaning during the late nineteenth century when liberal and progressive Protestants began exploring beyond the boundaries of their inherited religious traditions to seek out more mystical, eclectic, and cosmopolitan varieties of religious practice.²⁹

This spiritual realm remains notoriously vague as a category of analysis. Courtney Bender, for example, likens her research on American spirituality to “shoveling fog.”³⁰ Spirituality is equally—if not more—vague in Japan. While a fuller genealogy of the term “spiritual” in Japan will be examined later, here, at the outset, I simply make clear its etymological baggage and emphasize that I do not desire to generate any additional definitions. Rather, my interest in the spiritual is genealogical. I seek to explain how its meaning is negotiated in Japan by different actors in different contexts for different purposes.

A key finding by religious scholars in English-language scholarship is how the term “spiritual” primarily serves to mark boundaries when faced with a diverse range of religious and nonreligious beliefs and practices. Ultimately, I suggest that the use of the term “spiritual” in Japanese hospices also functions as a negotiable boundary. That is to say, it helps sanction or prohibit the acceptable parameters of religious care for patients. I thus build on the work of previous scholars who point out that spirituality it is not merely a flawed scholarly category, but scarcely an objective category at all.³¹ Rather, I seek to emphasize its growing importance as a component of contemporary religious discourse in Japan. In doing so, I also pay special attention to how the popularization of the term “spiritual” in hospice care can sometimes be at odds with an understanding of the *kokoro* (heart) as a key area where Japanese religious identity is enacted.

By taking a step back and observing how the term “spirituality” is used, it is also easier to see the competing interests that lie behind attempts to care for a patient’s spiritual pain. Chaplains, medical workers, and academics all have a stake in referring to spirituality as a concrete dimension of personhood that becomes the specific locus of spiritual pain. As John Lardas Modern points out, the language of spirituality often functions as a new rhetorical device, or grammar, that expresses individual intentions within, against, or alongside religious institutions.³² In other words, spirituality is not really an ontological thing, but rather describes a way of going about things. Spirituality is not to be mistaken for the lay of the land. The reason it is hard to map is because there is no firm territory to map. Rather, spirituality emerges as a discursive shadow that helps to mark claims against, for, or alongside religion. Accordingly, I attend to the way the hospice functions as a space where different stakeholders negotiate the range of meanings that orbit around the concept of spirituality. Ironically, my approach parallels the proclaimed ethos of hospice care itself, which calls attention to the whole person. That is to say, instead of isolating patient spirituality in hospice settings as a discrete object of analysis, I hope to examine it holistically.

By studying spirituality as a manner of language that seeks to draw boundaries between religion and the secular, recent English language scholarship on spirituality also continues to challenge the way some scholars of religion still lapse into using the term “spirituality,” as if the meaning of the term was self-evident.³³ As Jonathan Herman points out, despite a scholarly consensus that spirituality is best considered as an emic category of discourse rather than an etic category

of analysis, religious studies journals and conferences remain rife with uncritical usage of spirituality as an etic term.³⁴ This shows how scholars are still at risk of reproducing the way spiritual seekers themselves articulate the characteristics of spirituality as forms of interior or private beliefs and practices that stand apart from organized or institutionalized religion. The danger in reproducing this binary between spirituality and religion, however, is that such statements can sound awfully smug. Herman playfully points out that the dichotomy between religion and spirituality could easily be replicated with the male and female reproductive organs. Religions are demarcated from spirituality by their externality, overtness, hardness, preoccupation with size, and misuse of power. In contrast, spirituality is typified as internal, soft, preoccupied with depth, and vulnerable. In other words, when scholars of religion reproduce the characterizations of spirituality through the language of spiritual seekers themselves, their research is in constant danger of confusing scholarly classification with judgment. Definitions of spirituality ultimately project “modern, western, cosmopolitan, religiously liberal values” such as “individualism, interiority, privacy, and non-dogmatic progressivism.”³⁵ In this way, even ostensibly academic studies of spiritual care can wind up celebrating spiritual care as emblematic of the potential for a less rigid, individualistic, ecumenical, and nondogmatic form of religion.³⁶

This view helps reveal the way scholars of spiritual care in Japan also sometimes take the term “spiritual” for granted or even unwittingly celebrate it.³⁷ By contrast, I take a more cautious approach. My interest in the spiritual is not in describing it as a third space, neither religious nor secular, let alone celebrating it. Rather, even while fully acknowledging the importance of providing spiritual care for patients in hospice settings, I also show how clinical appropriations of the spiritual reflects an ongoing definitional project by religious professionals to help negotiate their position within Japanese healthcare settings. In this sense, my approach to the topic of spirituality in Japan resembles other recent scholarship on the category of religion in Japan in that it is constructivist.³⁸

RESEARCH METHODOLOGY

Many years ago, when I was still working as a chaplain, I helped organize my hospital’s annual “Whole Person Healing Study Retreat.” This retreat was dedicated to reaffirming my hospital’s motto of “whole person healing” (*zenjin iryō*), that was originally established by the Presbyterian missionaries who founded the hospital with the aim of serving patients as a total unity of body (*karada*), mind or heart (*kokoro*), and spirit (*tamashii*). On the final day of the retreat, a panel session was devoted to discussing how one could care for the spirit of patients. “What exactly is a person’s spirit?” somebody asked. After some discussion and plenty of confusion, one of the panelists looked to the back of the room where I was manning the video recorder and asked: “Tim-san, how would you describe a person’s spirit?” Caught

by surprise, I offered a clumsy and vague definition off the top of my head. As I now reflect on this moment, it is interesting to consider how I, the only foreigner in the room, was singled out as a “Western” authority to explain the Christian assumptions that formed the foundation for the hospital’s cherished motto. In that moment, I was playing a small part in contributing to a global conversation about what lies at the heart of spiritual care.

The methodological challenges of this study are in many ways akin to that experience in that while I am ostensibly recording a fascinating discussion, I am also contributing to it. Although this study seeks to distinguish itself from some of the normative approaches to spiritual care taken by clinical workers and scholars of religion interested in promoting it, an honest ethnographer knows that complete detachment is a chimera. For example, my fundamental interest in the study of religion has already been shaped in important ways through my experiences growing up as the child of second-generation Protestant missionaries in Japan. My role as a researcher of spiritual care is further complicated since I previously worked as a hospital chaplain. In this regard, staying reflexive about how my own background influences my research is indispensable to dispelling the longstanding myth of a neutral disinterested scholar.³⁹ Holding a perspective that elevates myself as more informed and clear-sighted about spiritual care than the subjects I interview can itself be just as normative a construction of meaning as any wild thing my informants say.⁴⁰ However, while my background certainly colors my perspective on spiritual care, it was also indispensable for conducting my research in the first place. Without growing up in Japan and having worked as a chaplain, it would have been next to impossible to gain unfettered access to hospice patients. Thus, while I do not intend to (and cannot) erase my own role in helping construct the way spiritual care is both understood and practiced on the ground, my ultimate goal is still the same. I want to reflect on the big picture to see what the practice, language, and history of spiritual care can tell us about the role of religion in medicine and about religious identity in Japan today.

In terms of the scope of my fieldwork, I utilized a multisited approach. One of the primary drawbacks of this method is the lack of depth to be gained by immersion in a single site for a long period of time. It also complicates my findings since I must account for differences across multiple localities. However, conducting research across multiple sites also adds a rich layer of nuance and complexity occasioned by both local variation and the constant renegotiation of the ethnographer’s role.⁴¹ Most of my fieldwork took place during three summer visits to Japan in 2012, 2013, and 2017 and fourteen months of concentrated fieldwork between 2014 and 2015. During that time, I spent time at twelve hospices in Japan as well as three in Taiwan (not addressed in this study), including two weeks of participant observation at a Catholic hospice, two weeks at a Protestant hospice, and two weeks at a Buddhist hospice. I also visited the Protestant hospice on a weekly basis for six months to interview patients. Besides participant observation and informal

conversations with patients and staff during my fieldwork, I also conducted recorded interviews with twenty chaplains, eleven doctors, twenty-five nurses, and nine hospice patients in Japan as well as additional interviews with several doctors, nurses, and chaplains in the United States and Taiwan. All the names of patients and hospice staff I interviewed have been made pseudonymous. Japanese names are given in the traditional way, with the family name first. I also refer to patients with the polite suffix *-san*, which reflects the actual way I addressed them.

Gaining access to dying patients for research is no easy task. Privacy is sacrosanct in medical settings and hospice staff are understandably very protective of their patients. Patients were made available to me based on their willingness and ability to talk and were by no means “typical” hospice patients. A typical patient could not be interviewed due to sedatives they were taking, their weak state, the onset of dementia or delirium, or a lack of strength to voice words. Even for those who were in relatively better condition, their level of pain and energy could fluctuate quickly. For formal interviews, I excluded all patients who had overt pain, difficulty talking, dementia, or who were emotionally fragile. This could mean that, for many weeks, no one was available to talk. One week, I was told that not a single patient could eat, let alone talk with an outside researcher. Patients could also suddenly take a bad turn, or agree to be interviewed but then decline just moments before I arrived. The practical and ethical challenges of gaining access to patients were most cogently driven home after I finished my very first patient interview. During the interview the patient looked fine, could converse clearly, and was in very good spirits. When I arrived a week later, he was gone. I later found out that he had died the day after I interviewed him.

Due to the unique challenges I faced in gaining access to hospice patients, I have not attempted to construct statistically significant claims about how Japanese hospice patients articulate their concerns at the end of life. Even if a researcher were blessed with a rich set of data, creating a comprehensive typology of spiritual pain in Japan would remain a daunting task. As one veteran hospice physician liked to point out to me, if there are one hundred patients, they will die in one hundred ways. At the same time, the particularity of the case studies presented here has what Michael Burawoy calls “societal significance.” As Burawoy writes, “The importance of a single case lies in what it tells us about society as a whole rather than about the population of similar cases.”⁴² In other words, the specificity of each patient’s experience tells us something about the world in which they are embedded. Accordingly, the patients I interviewed are not necessarily representatives of wider patient types. Rather, each case highlights a notable feature of how hospice patients deal with death that helps us understand their cultural, social, and religious environment that is shared by other patients as well.

I also refrained from psychoanalyzing patients, which is neither my goal nor something I am qualified to do. My approach is primarily one of qualitative description, where an encounter or event is described in everyday language

without resorting to conceptual, philosophical, or other abstract frameworks.⁴³ This approach sometimes yields ambiguous, even contradictory, findings and does not result in the sort of clear-cut conclusion that a firm theoretical commitment might offer. Nonetheless, I believe that the inherent challenges of an outside researcher approaching hospice patients made qualitative description the most suitable tool to use.

I was fortunate in that after clearing my research with both institutional review boards and ethics committees in the United States and at each institution in Japan, I was able to leverage my many years spent living in Japan and past experiences as a chaplain to gain access to patients. This was a great privilege. Accordingly, I have endeavored to make their voices a focal point of this study. As I listened to their audio-recorded voices on my computer long after they were gone, I felt a heavy responsibility to get their stories right. I can only say that I tried my best.