

The Heart of Practicing Spiritual Care

Spiritual care in Japan is not only based on supporting the *kokoro* of patients through daily care, but also on cultivating the *kokoro* of caregivers themselves in ways that imbue their work with “spiritual” meaning. A veteran Christian doctor explained it this way.

I think you can define spiritual pain, but spiritual care cannot be defined. So, for instance, you could say that any kind of care that makes the patient feel valued [*taisetsu*] is spiritual care. For example, let’s say a patient wants to eat a watermelon in the middle of the winter. You search through various stores and bring it to the patient to eat. In a sense, I think this too is spiritual care.¹

From this doctor’s perspective, spiritual care was ultimately a matter of the *kokoro*. It is also a type of care that was more or less intuitive and could be provided by all the hospice staff. Staff members were simply asked to value the patient in their own *kokoro*. Another nurse expressed a similar sentiment:

In the past we used an interview guide [for assessing spiritual pain] . . . but I don’t think just listening [to patients answer questions] in a certain order is spiritual care. It’s more about the way you carry yourself as a caregiver. Just asking [the patient] to talk about their spiritual pain isn’t enough for the patient to open up. I think it might be more about saying good morning and providing daily care. These individual things add up to spiritual care. Within this kind of care, you affirm that person’s existence so he or she can think, “It’s okay for me to live today”—that is when you develop a relationship with patients so they will share things with you naturally.²

As this nurse suggested, spiritual care in practice rarely involved directly addressing a particular religious need or existential crises in patients. Rather, spiritual care began with managing one’s own *kokoro* while practicing regular care with the aim of making patients feel comfortable. This idea echoes the predominant view among both chaplains and hospice staff that spiritual care is less about *what* is being done and more about *how* it is conducted. This includes what I have termed

vocal care, resonating care, and supportive care. These categories may not be comprehensive (they are certainly not mutually exclusive) but help focus attention on the *way* spiritual care is practiced rather than on the content of the care. In short, these categories examine what spiritual care looks, sounds, and feels like.

CHAPEL SERVICES

The day begins in many hospices with morning assembly (*chōrei*). This is an opportunity for the entire hospice staff to come together and affirm their vocational mission. In religious hospices that have a chaplain on hand, the morning assembly often takes on religious overtones. At Christian hospices for example, the morning assembly may double as a chapel service led by the chaplain that involves a scripture reading, hymn, or song, followed by a short inspirational story or sermon, and prayer. At one Protestant hospice, a Christian doctor was invited to open the workday by sharing a short Bible story from the Gospel of Luke on how Jesus instructed his disciples to cast their fishing nets over the other side of their boat after failing to catch anything all night. The doctor explained to fellow staff members that sometimes when she was exhausted by her work, she would react poorly to a suggestion from a nurse. However, just as Jesus's suggestion to the disciples resulted in a catch of fish so heavy that it could not be hauled in, so too, this doctor suggested, should staff remain open to being corrected by others. At another Catholic hospice, there was no scripture reading or prayer, but the morning assembly began with everyone singing a hymn. After singing, each day a different staff member took turns to share a short uplifting story or recent episode from their daily life that could help set a positive tone for the workday. When the morning assembly took the form of a chapel service, patients and families were also encouraged to participate. At one hospice, the chapel service was even broadcast over the public announcement system and made viewable by patients on their TV sets.

At a Buddhist Vihāra ward I visited, the day both began and ended with a short service called *omairi*. *Omairi* typically refers to visiting a temple, shrine, or an ancestor's grave for purposes of worship, prayer, or paying respect. In the Vihāra ward, this name was repurposed for their chapel service. At the appointed time, staff and patients would enter a small Vihāra hall where they took prayer beads and a small volume of sutra excerpts in hand. Participants followed the Vihāra priest in reciting the "Verses of the Serious Vow" (*Jūseige*) in the morning and the "Verses of Praises to the Buddha" (*Sanbutsuge*) in the afternoon while facing the Buddhist altar at the front of the room. At another Vihāra ward, a similar *omairi* service began by chanting the "Threefold Refuge" (*Sankiemon*) and then the "Heart Sūtra" (*Hannya shingyō*) while facing a seventeenth-century bodhisattva image from Burma. The foreign provenance of the image was intentional since it stressed the trans-sectarian nature of the hospice.³ Each recitation took about five minutes. During the afternoon *omairi*, one of the Vihāra priests also delivered a short sermon of about ten minutes that was humorous or inspirational.

At one such service I sat next to a patient called Minami-san, a quiet elderly woman whose face broke into a hundred wrinkles when she smiled. I held her glasses case while she weakly but accurately chanted in unison with the priest. During his sermon, the Vihāra priest shared a story from his childhood. His parents owned a gas station, and his mother was originally from a temple family. One night while he and his brother were studying for school exams, they heard a loud noise. Their mother had fallen down the stairs and was bleeding profusely. They immediately called an ambulance; on the way to the hospital they kept asking her if she could remember her name. The only thing she said to her son before she fell unconscious for ten days was to “value the *nenbutsu*” (Buddhist prayer). Now, the priest says, when he visits his elderly mother, he recalls all the sacrifices she made for him as he carefully shaves her wrinkled face. When he does this, he is always touched as he considers how each wrinkle represents a moment of sacrifice and hard work in her life. Minami-san smiled and nodded beside me as she listened to the story. It was a story that she, and her lined face, could appreciate.

Volunteer priests or ministers from the local community also helped give chapel messages. On a hot summer day, I joined one patient, two doctors, and three nurses while a local Buddhist priest gave a short talk after the *obon* festival, which honors the visit of ancestral spirits. He spoke of visiting a parishioner, an old grandmother, who liked to use cucumbers, eggplants, and toothpicks to fashion a miniature horse and cow for display during *obon*. She did this to encourage ancestors to come visit her quickly (horse) and leave slowly (cow). This year, her grandson wanted to participate in this activity and fashioned an animal out of a gourd. The priest humorously pondered what the gourd might represent. Perhaps the rough skin of a wild boar? He used this story to suggest how many young parents have not done a good job explaining old Buddhist traditions to younger generations. He then praised grandmothers and grandfathers—his intended audience—who have made an effort to pass on such important traditions.

Staff attendance at the morning assembly and other services varied widely. When the morning assembly took place before the day shift, staff participation was usually voluntary. In such cases, only a few staff, if any, would participate. At one Christian hospice that suffered from low staff attendance in chapel, the chaplain related how he then began going to the nurses’ station to start the day with prayer, saying: “If they can’t come to me, I should go to them.” At yet another hospice, assembly was counted as part of the workday and staff attendance was mandatory except for those who were attending on patients. In reality, however, since many nurses and doctors made checking the status of their patients a priority in the morning, attending assembly was more of an afterthought. For others, listening to the organ while sitting in the chapel or reciting a sutra was seen as an opportunity to collect themselves before rushing into their busy day. Patient attendance also varied. If patients could still walk on their own and were either deeply religious or bored, they might attend. Most often, however, bedridden patients with no strong interest in attending were content to stay in their rooms where they might be still

finishing breakfast or dozing. One Vihāra ward recorded that 38% of 187 patients attended at least one *omairi* service between 2008 and 2011.⁴ Yet when I visited this hospice in 2012 and 2014, there were rarely more than two or three patients in attendance.

WHERE DOES RELIGION FIT IN?

In general, other than morning assembly or *omairi* type services, religious care for patients plays a minor role in most Japanese hospices. By religious care, I refer to those activities and interactions with patients that are openly framed in the language of particular religious traditions, that include chapel services, prayer, scripture recitation, or open-ended conversation on religious topics between patients and chaplains. In fact, even the *omairi* services in Buddhist hospices were framed as a traditional cultural rite that many nonreligious Japanese might conduct at home in front of their Buddhist altar. Taniyama Yōzō, who formerly served as a Vihāra priest, states that in his experience, only one out of a hundred patients ever expressed interest in learning more about Buddhism, despite the presence of a Vihāra hall and daily *omairi* services.⁵ A popular textbook on spiritual care also explains in its opening that, “In the Japanese clinical setting, the majority of patients, family members, and medical workers tend to refuse religious interventions. In fact, you could say that there are hardly any real opportunities to lessen the spiritual pain of patients through religious care.”⁶ Likewise, several Christian chaplains I spoke with estimated that approximately 80 to 90% of patients did not or were unable to communicate interest in religious or existential subjects while in the hospice.⁷ At another hospice affiliated with a Buddhist new religious group, Risshō Kōseikai, a doctor noted, “We thought we needed chaplains on call twenty-four hours a day, 365 days a year, and so we were able to create such a system with everyone’s cooperation. However, after a year or two had passed, we found that there was no demand from anyone to talk with such chaplains.”⁸ Ultimately, this hospice chose to discontinue having a full-time chaplain on call.

While many chaplains explained that only a few patients ever outwardly expressed interest in conversing about religion, family members of patients sometimes felt that patients did receive religious care anyway. For example, a survey of 378 bereaved families indicated that nearly a quarter of family members believed that patients received some sort of religious care during their stay in a religious hospice. Of those who felt they did not receive religious care, 44% explained that this was because the patient had a poor image of religion or was not in need of religious care, and 38% explained that this was because their physical condition prevented them from receiving such care. For those who did receive care, “more than 80% of the families of patients who received religious care felt that attending a religious service, listening to religious music, a religious atmosphere, and meeting with a pastoral care worker was ‘very useful’ or ‘useful.’”⁹ The discrepancy between

the hospice workers' claim that religious care is rare, and the patient family's view that such care did in fact take place, may be because patient families had a looser conception than chaplains in their understanding of what might constitute religious care.

WHY IS RELIGIOUS CARE SO RARE?

There are several explanations for why hospice chaplains in Japan have few opportunities to provide religious care. First, many patients have only a faint idea of who chaplains are or what their work entails. In some cases, even other hospice staff have only a vague idea of the chaplain's role. One chaplain at a Christian hospital in Tokyo explained how many doctors and nurses hesitated to refer patients to him since they were never quite sure when it was a job for the chaplain. To encourage familiarity with their work, many chaplains eschew their official title and the foreign sounding word "chaplain" in favor of more self-explanatory titles such as "counselor" (*kaunselā*), the "hospital priest" (*byōin no obōsan*), or simply "pastor" (*bokushi*). When introducing themselves to patients, chaplains also rarely describe their work as providing spiritual care. Although the term "spiritual care" is used among staff and recorded in medical charts, chaplains prefer to explain this aspect of their work to patients and families with a more familiar word, such as caring for the *kokoro* of patients. This included the way I presented my own research to patients as well. Since most patients had no idea what "spiritual care" meant, I explained that I was conducting research on end-of-life care for the *kokoro*.

Even if patients were familiar with spiritual care, however, many patients are simply not in the hospice long enough to receive it. In 2000, for example, 92% of patients stayed in hospice for at least a month; but by 2019 this number had shrunk to 37%. Likewise, the number of patients who stayed for at least two months has declined in the same period from 20% to just 2%.¹⁰ As anticancer treatments and drugs have improved, patients can choose to pursue aggressive medical treatment at the end of life without suffering the painful side effects that previously motivated patients to give up treatment earlier. Thus, many patients (and especially their families) prefer to extend treatment longer and only enter the hospice after all their medical options have been exhausted or treatment becomes too physically taxing.

What this means for hospice workers is that instead of getting to know a patient over a month or two, hospice staff must increasingly acquaint themselves with a patient over a space of weeks. Moreover, since these weeks come at the very end of life, many patients arrive in serious condition, making the window of opportunity for communication difficult. Many patients can barely eat, are heavily sedated, or have trouble breathing. In short, with an increase in the number of patients with low communication abilities, there are simply fewer opportunities to have meaningful conversations with patients. This point was driven home in my fieldwork

when on many occasions nearly all the patients I visited were sleeping. Or perhaps even more tellingly, over six months of weekly visits to one hospice, the head nurse could only recommend nine patients who would make good interviewees for my research.

Another reason religious care is rare is because many Japanese remain suspicious of religious professionals. In a 2012 survey conducted by the Japan Hospice Palliative Care Foundation (JHPC), more than half of respondents stated that they felt “religion would support their *kokoro* when facing death.” But in an earlier 2008 version of the survey that asked *who* would support their *kokoro* the most when facing death, most of the respondents indicated their spouse and/or children (77% and 71%), friends (30%), or even their doctor (28%), while only 5% percent felt a religious professional would help support their *kokoro*.¹¹ In other words, it is not so much that Japanese patients have a poor image of religion, so much as a poor image of religious professionals.

This suspicion felt toward religious professionals became particularly exacerbated after the new religious group Aum Shinrikyō carried out the sarin gas attack in the Tokyo subway system in 1995. In the aftermath of this attack, new legal restrictions were placed on religious groups and the widely broadcast images of Aum adherents supposedly being brainwashed instilled a deep suspicion of religious groups for many Japanese. Although historically speaking, the public suspicion toward and government crackdowns on certain religious groups was not anything new, the Aum affair represented an important paradigm shift in the public perception of religious groups from that of working for the public good and deserving of tax exemption, to that of potentially dangerous and in need of close supervision.¹² In such a climate, religious workers in medical settings were forced to temper their approach. For example, one Catholic hospice chaplain explained that prior to 1995, she would often introduce herself to patients as a “religious provider” (*shūkyō teikyōsha*) and patients would respond relatively positively. After the Aum incident, she began describing her work as simply “*kokoro* care” to avoid a negative reaction. This kind of self-censorship resembles what Isaac Gagné labels “reflexive secularization,” which is a process by which religious organizations intentionally transform the religious elements of their tradition into forms that are more palatable for a secular audience as a way to continue to attract new members or maintain their position in society.¹³

The cumulative effect of this cultural and historical context is that chaplains only occasionally draw on their religious expertise in their dealings with patients. Instead, their explicitly religious roles are mostly confined to leading morning assembly or other religious services where they lead sutra recitations, sing hymns, pray, or give an inspiring sermon. Instead, chaplains and other hospice workers define the spiritual care they provide to patients as having less to do with religious care and more about approaching patients with a *kokoro* that shows empathy, respect, and concern to help them feel valued at the end of life.

VISITING WITH PATIENTS

When I first met Sister Yamada, who served as a chaplain at a Catholic hospice in Japan's western island of Kyūshū, I was impressed by her practical approach to patient visitation. She explained that there were basically two kinds of patients: those who are forward-looking (*maemuki*) and those who are backward-looking (*ushiromuki*). She explained, "As for those who are counting the days until they die, they are impossible to help. If they are backward-looking, you can't really help them until they realize they are looking the wrong way." Her job, she felt, was to help patients realize how precious their lives were.

As I shadowed Sister Yamada on her rounds, several of the patients we visited were sleeping or only slightly responsive. Then she introduced me to Uejima-san, who during our first meeting gave a peculiar introduction of herself, saying, "I am cancer. Cancer is my friend. We are doing well together." In the Japanese language, it is not uncommon to say, "I am cancer" (*watashi wa gan desu*). This means that a person "has" cancer. When I explained that I was interested in how hospices provided care for the *kokoro* of patients, Uejima-san responded, "The *kokoro* is weak." Sister Yamada chimed in, "If you can say that you are friends with cancer, your *kokoro* is not weak! Not only that, when you say that you are happy in the hospice, this is like medicine for the *kokoro*." The second time we visited her, Sister Yamada asked her again how she was doing.

UEJIMA: Good.

SISTER YAMADA: You look well today, too.

UEJIMA: Really?

SISTER YAMADA: It sure would be nice if things stayed this way.

UEJIMA: But you never know when things will change.

Sister Yamada pursed her lips and paused, sensing that her last remark might have been insensitive to someone to whom death was imminent. Instead of trying to cover up this indiscrete remark or change the topic, she addressed it head on. "It's not good to say something like that to someone who can't stay the same way, is it?"

"No, I suppose not," Uejima replied.

During Sister Yamada's daily rounds, she would often ask patients how they were doing, what they had been up to, and who had visited them. As patients responded, she would praise and compliment them. For example, when family members were present, she would often comment: "How lucky you are to have such a caring family member who spends all this time with you!" Her cheerful approach was also evident during a review session with an intern who was studying spiritual care. The intern shared how she sensed something positive behind one patient's outwardly gloomy demeanor. Sister Yamada advised her to try to pursue these positive glimmers and to mine them further when conversing with the patient. This is not to say that Sister Yamada was always trying to cheer up patients.

As a former hospice nurse, Sister Yamada was well aware of the need for empathy and allowing patients to share their honest feelings. But she also emphasized her responsibility to help patients also find things to be thankful for no matter how depressed they might feel.

VOCAL CARE

Many of Sister Yamada's interactions with patients served as a good example of how she practiced vocal care. Vocal care refers to when spiritual caregivers converse and listen to patients. During such exchanges, words of encouragement are given, personal stories are shared, and deep questions are pondered. This type of care is invariably presented as one of the pillars of spiritual care. For example, medical scholar Tanida Noritoshi argues that in contrast to the traditional approach of evidence-based medicine (EBM), narrative-based medicine (NBM) forms the basis for spiritual care. Spiritual care is essentially about letting patients voice their narrative, and as the listener provides an affirming ear, the patients create meaning for themselves and find healing.¹⁴ Vocal care may occasionally include religious care. Chaplains may read, recite, or sing through scripture with the patient or answer questions about guilt, forgiveness, anger, or the afterlife from their own religious perspective. At one Buddhist hospice, a Vihāra priest described a patient who had confessed to him that she had not conducted memorial services for a fetus she had aborted in her youth. Since she strongly felt that her current illness was due to this lapse, the priest hastily arranged for a Buddhist memorial service that gave her great relief before she died.¹⁵

However, vocal care has become increasingly difficult to practice since many patients are unable to communicate. For example, one patient Sister Yamada visited was rarely conscious. When we visited his room one day, I was caught off guard when, after saying a few words of greeting, Sister Yamada suddenly began singing a hymn to him. After she finished, she leaned in close to his ear to say, "Jesus will protect you and be with you." When I later asked her about this patient, she explained that he had led a very rough life and in his own words, "had done everything but murder and drugs." He was divorced and had no family to visit him. But in his youth, he had attended a Lutheran school for six years and told her that he enjoyed hearing hymns—hence, her spontaneous burst into song.

Another patient had also lost her ability to talk. When we visited, she tried communicating to us but kept waving her hands in frustration since she could not form her words very well. After a while, Sister Yamada picked up a very expensive looking portrait of the patient's grandson from her bedside table. She asked, "Is this photo from his coming of age ceremony?" The patient gestured no. "Then, perhaps for a marriage interview?" She gestured no again, and her face showed her frustration and disappointment. I sensed the patient was about ready to give up, but Sister Yamada persisted, "Then, maybe your grandson just sent this to you

to say, ‘Look, Grandma, I’m all grown up now?’” As soon as the words left Sister Yamada’s mouth, the patient’s hand shot up to cover her eyes and she burst into tears. We stood quietly while she dabbed her eyes with tissues and looked fondly at the photo. She then mouthed the words, “Thank you.”

At other times, it could be difficult to encourage or empathize with patients even if they could still communicate. For example, Takagi-san was in her late seventies, originally from Nagoya, and had returned to her hometown in Kyūshū to die near her sister. Whenever we entered her room, she sat up immediately and continued to sit with ramrod posture on her bed despite Sister Yamada’s best efforts to have her shift to a more comfortable position. Sister Yamada visited her several times, but she never seemed totally relaxed in the chaplain’s presence. She was cordial each time but remained guarded and kept a polite distance every time the chaplain inquired how she was doing.

Shitakubo-san was another reserved patient in his early seventies whom I met in a Vihāra ward. He had lung cancer. Many patients wandered through the ward in their pajamas, but he always changed into a dress shirt before visiting the common areas where he spent many afternoons working diligently on his laptop. He explained that he was the coordinator for his middle-school annual reunion, which was going to be held at the end of that month. It was doubtful whether he would live that long, but he was fixated on putting all the reunion files in order so he could pass these on to a classmate for subsequent years. He was very punctilious and independent. For instance, he firmly resisted allowing the nurses or even his wife to help him go to the bathroom.

When we visited him in his room one afternoon, he was a little sleepy but alert. The Vihāra priest, Reverend Sasaki, first chatted with him about his eldest son who had visited the day before and about his two other children. Shitakubo-san was concerned with who would take care of the family’s Buddhist altar. He doubted his eldest son could do it, and it was not clear if his second son would be willing to move home either. He had considered the possibility of selling the house and dividing the estate between the children, but was worried that once the house was gone the siblings would go their separate ways.

After we left his room, Reverend Sasaki explained to me how important it was to have these kinds of conversations with patients. Although Shitakubo-san showed little concern for his own condition, he did worry over what would become of his family. Reverend Sasaki saw himself as playing a mediating role by conveying information to family members who found it difficult to discuss these issues with Shitakubo-san directly while he was still alive. We visited Shitakubo-san again after he returned from an overnight home visit. After chatting about how things went, Reverend Sasaki commented: “Shitakubo-san, you aren’t really the type to outwardly express anxiety [*fuan*], are you?” He replied: “I might just be thickheaded . . . I’m an atheist too.” After we left his room, Reverend Sasaki seemed thoughtful. “I think that he is feeling spiritual pain somewhere. He calls

himself an atheist [*mushinronsha*] but he uses the Buddhist word for ‘life and death’ [*shōji*] and I saw him reading a book about Shinran.¹⁶ Japanese simply just don’t show their religious views up front very much.” Reverend Sasaki also added that Shitakubo-san’s remark about being an atheist may have been a veiled apology for not being able to talk more frankly about religious topics with the Vihāra priest.

By contrast, when I interviewed a chaplain in the cafeteria of an American hospital, a woman who just happened to walk by our table had no qualms in interrupting our conversation to ask the chaplain, “Are you the chaplain? Could you please go visit and pray with my son?” It was nearly impossible to imagine a similar interaction occurring in a Japanese hospital where religious identity is not typically a subject that comes up in passing. There was even a case where a Japanese patient secretly got baptized before entering the hospice. The family discovered this fact only after his death when they read his journal and found his request for a Christian funeral. The nurse who related this story explained that she felt bad when she heard this, since she would have been happy to connect him with a chaplain or provide other opportunities for religious care if she had known he was religious in the first place.

Both chaplains and other hospice staff are aware that many patients are reticent to share their personal, let alone religious, concerns, if they have any. It takes time to connect with patients. As one doctor put it, you don’t want to “step into their *kokoro* with your shoes on” (*dosoku de kokoro ni agarikomu*).¹⁷ This reluctance among Japanese patients to talk candidly with caregivers about their private beliefs or feelings is certainly not unique to the hospice setting. For example, Japanese psychiatrists are also known to emphasize nonverbal approaches with clients by using sandbox, clay sculpture, and especially box garden therapy (*hakoniwa*) to help reticent patients to express their feelings.¹⁸

RESONATING CARE

The difficulty in practicing vocal care draws attention to another way that spiritual care is practiced: resonating care. Resonating care places an emphasis on simply *being* with the patient. In addition to providing a listening ear to concerns, resonating care sees the presence of the spiritual caregiver as itself a form of spiritual care. By *being* with the patient, the caregiver embodies empathy and allows the patient’s suffering to resonate in their own being. Resonating care also claims no overt forms of care techniques other than spending quality time with the patient. As one nurse explained to me, “I think the most important thing is to continually be with the patient. The fact is that there are questions that have no answers. I’m sure that the patients aren’t necessarily seeking answers—and we don’t know the answer anyway. So, in such cases, I try to stay with the patient without running away.”¹⁹

Another nurse echoed this sentiment while explaining how she provided spiritual care to patients who asked difficult questions:

Patients will sometimes worry that they might be burdening their listener, and so they will occasionally apologize [for sharing their worries]. But I try to encourage them to share their thoughts and help them tell their story. Or in cases where there are no answers no matter how much you think about an issue, I say, “It sure is a difficult topic,” and if they don’t give any further response, I say, “Well, let’s think through this together.” Then, if it seems like I should leave, I end the visit, but if it seems like it is okay for me to stay, I often remain with the patient for an hour, or depending on the patient, even two hours without any conversation.²⁰

Prayer might also be included as a form of resonating care. Although prayers are said aloud for the benefit of the patient, they are also silently uttered by chaplains at the bedside of unconscious patients and at the privacy of their desk throughout the day. These prayers help sustain the relationship between the caregiver and the patient, allowing the pain of patients to constantly resonate in the chaplain’s *kokoro*. As Andō Yasunori, a scholar of Japanese religion, notes, spiritual care is less about what is being done and more about the relationship between the medical worker and the patient:

Spiritual care isn’t something that you can say, “This is it!” and put into a manual. Rather, the medical worker and patient encounter each other as fellow human beings, and within each specific interchange, a kind of resonance [*kyōmei*] arises between them. When a “space” is formed where spiritual events (things that are too deep in meaning to be easily dismissed as happenstance) can easily occur or not be hindered, the regular care toward the patient “becomes spiritual” and “takes on the meaning of spiritual care.” In this way, spiritual care is something that is generated in each situation.²¹

Andō posits that anything can be labeled spiritual care if it is done in the right spirit. It also stands in contrast with regular medical care, which is largely defined by the content of care. Adjusting a patient’s morphine titration or helping a patient take a bath is still physical care no matter *how* it is delivered. When asked to define spiritual care, activities such as counseling, praying with, or sitting silently with a patient commonly come to mind. In practice, however, staff emphasize that these activities are not in and of themselves sufficient to be regarded as spiritual care. Rather, various activities that take place in the hospice are imbued with the label of spiritual care by the *kokoro* of the caregiver.

SUPPORTIVE CARE

Supportive care refers to creating a hospice environment that helps the patient affirm their value amid the dying process. At the most basic level, supportive care includes designing hospice facilities and care plans in a way that patients feel at home. While it may seem odd to speak of designing hospice facilities with spiritual care in mind, hospices take great pride in their facilities, which are prominently featured in promotional pamphlets. In addition to spacious rooms, common areas and kitchens, soft lighting, flowers, and an abundance of artwork, hospices make



FIGURE 2. A shade to hide the patient's reflection (Photo by author).

a point of removing as many signs of medical care as possible. For instance, oxygen connectors in patient rooms may be disguised, and several hospices I visited featured a rollup shade that could be pulled down over the bathroom mirror so that patients did not have to be reminded of how their body had deteriorated during their stay.

Many hospices also provided patients the option of staying in a tatami-mat room, since many Japanese wish to “die on top of the tatami” (*tatami no ue ni shinitai*), evoking the image of a natural death.²² Even as signs of medical care are removed from view, Christian and Buddhist hospices replace them with religious objects. Rooms and hallways are tastefully decorated with religious artwork and symbols while the chapel, Vihāra hall, or other prayer and meditation rooms

are made available for patients (and staff) to use.²³ At a Buddhist Vihāra ward in Kyūshū, the entire ward was built with Japanese cypress trimming by carpenters (*miyadaiku*) who specialize in the traditional art of building temples and shrines without using any metal or nails. When I visited this hospice shortly after it opened, I was greeted by a lovely cypress fragrance that made me think I had literally walked into a temple.

Supportive care also includes paying attention to and supporting the patient's favorite activities, arranging for social events, and engaging in small talk to help stave off feelings of isolation. It is a form of spiritual care through small touches that in their aggregate helps patients feel valued, appreciated, and supported as they face the end of life. At a Vihāra ward in rural Kyoto, the back garden emerged as an important site of supportive spiritual care. The Vihāra priests spent many hours working outdoors alongside patients, and sometimes even by themselves in the garden. One priest explained to me that even when patients could not join them, it was important for patients to be able to hear the sounds and see rhythms of home life. Often, they ate lunch with patients and their families in the common room. Although the Vihāra priests did also visit patients to provide private counsel on matters related to their death, the most striking image of the Vihāra priests during my fieldwork was how they were simply *living with* patients.

One priest even used the metaphor of riding a bicycle to explain the importance of this type of spiritual care. After asking me how wide a path I thought was necessary to ride a bicycle, he noted that a path really only needs to be as wide as the bicycle tires—perhaps three centimeters. But if you made a path that was only three centimeters wide and asked someone to ride on it, that person would be frightened. It is only because there is space on either side that you can ride the bicycle confidently. In the hospice, he explained, medical care corresponds to the part where the tire touches the ground; it is indispensable to running a hospice. But the Vihāra priest's job is to be the rest of that path. Without the support that the Vihāra priest provides, hospice care would be a scary ride.²⁴

Much of this support is provided in the form of social activities. The hospice is constantly flowing with events and activities for patients. Music therapists come weekly, as do animal therapists, aroma therapists, and even beauticians. Most of these visitors are volunteers or supported by nonprofit organizations. Baristas visit weekly to make coffee; an experienced tea ceremony volunteer makes green tea for patients and family. Musicians come to give small concerts, comedians present a routine, and at one hospice an expert sushi chef even came to prepare and serve fresh sushi to patients.

In addition to weekly events provided by volunteers, hospice staff also arrange for different seasonal events. At Christian hospices, Christmas is a big event: patients gather to sing Christmas carols, receive presents, and take pictures with Santa. At a Buddhist hospice, they held a "fun party" (*otanoshimikai*) during the Christmas season instead. In the springtime, patients are wheeled outside for cherry blossom

viewings, and during the summer, staff might set up a small festival (*omatsuri*) for patients. At a Buddhist hospice, I helped patients make *ohagi* (soft rice cakes covered with sweetened red bean paste) during the autumn equinox. Patient birthdays were also enthusiastically celebrated. Afterward, pictures from these events were given to patients to pin on their wall or to family members as keepsakes.

Many of these activities were led by chaplains. As one Protestant hospice, a weekly “teatime” took place where patients and families sang songs, listened to a short message given by the chaplain, and spent time getting to know other patients while eating snacks and drinking tea. At another Catholic hospice, the chaplain led a weekly gathering called “*kokoro* time” (*kokoro no jikan*), where patients, families, and volunteers sang traditional Japanese songs and then shared stories on a topic like, “something from this week that made me happy.” Vihāra priests were also proactive in arranging activities for patients. When the weather was nice, the priests often wheeled patients out for a nature walk through nearby fields. They were also in charge of the small garden behind the hospice where patients could plant vegetables or flowers. In the fall, harvested onions could even be seen drying on one patient’s veranda.

Special events might also be tailored with certain patients in mind. One patient at a Vihāra ward enjoyed watching films. Upon learning this, the priests set up a screen and projector in the Vihāra hall and brought in couches. The nutritionist made popcorn, someone else made some movie ticket stubs, and they hastily arranged a film viewing for the afternoon. The room was also rearranged so the Buddha image in the front of the room could enjoy the film (a spaghetti Western). The patient was all smiles as she handed in her ticket and entered the makeshift theater with her popcorn.

One day, Reverend Sasaki showed me a picture of a large 1200cc motorcycle. It had belonged to a middle-aged male patient who loved motorcycles so much that he rode his bike to the hospice and parked it on his veranda where he could gaze at it from his bed. His love for the motorcycle was so great that he even used its side mirrors to shave in the morning. Seeing this, several staff members who were also motorcycle enthusiasts arranged to bring their own motorcycles to the hospice and created an impromptu biker rally, much to the patient’s delight. Reverend Sasaski shared this memorable anecdote with me to demonstrate the ways staff tried to make the hospice a place where it was hard for spiritual pain to arise (*supirichuaru pein ga denikui basho*). He jokingly explained, “You might even say that we are doing preventive spiritual care.”

Supportive care stresses the importance of supporting the patient’s ability to die in a way that reflects who they are (*jibunrashiku shinu*). In this regard, it closely resembles the more general emphasis on *kokoro* care. One nurse explained her view of spiritual care as follows:

If patients can still communicate, we find out what their daily life was like up until this point. Or if it is difficult to communicate with them, we get information from

their family and find out what we as a hospital can do to help the patients be themselves. So, if eating was something that held meaning for them, even if it is difficult to eat, we let them taste some food. During conferences, we also discuss what the patients need most, and what it is that we can do right now to support them in being who they are.²⁵

As such descriptions suggest, despite the often-repeated mantra in spiritual-care settings that it is more important to *be* there for patients than to *do* something for patients, the staff and chaplains in fact *do* a lot of things in the practice of spiritual care.²⁶

However, although both medical workers and chaplains openly acknowledge that what they call spiritual care in practice is more about supporting the *kokoro* of patients, they hinted of a tension in their work. In short, many chaplains sensed a gap between the idealized models of spiritual care as found in professional hospice literature and what they actually did on a daily basis for hospice patients. During my fieldwork, some chaplains were even apologetic for not being able to provide me with “better” examples of spiritual care. Vihāra priests were careful to explain to me how although it did not “look” like spiritual care, watching a film with a patient, gardening, or chatting about a family member’s recent visit were all indeed part of spiritual care.

Likewise, a Christian chaplain in Tokyo explained the “lack” of spiritual care in his hospice by noting that many patients who were experiencing spiritual pain were simply unavailable to him due to the negligence of other hospice staff who had a poor understanding of spiritual care. During an afternoon tea break, a Vihāra priest also reminisced in front of me about a period a few years prior when several patients who were interested in discussing religious topics happened to enter the hospice around the same time and the *omairi* services were always full. He joked to the other priest as he flipped through his records that this was the “golden age” of their careers in spiritual care. Christian chaplains also tended to recount the rare cases where patients found religious consolation through prayer, faith, or even baptism as the most meaningful instances of spiritual care. Such explanations suggested that chaplains felt the more mundane supportive aspects of their daily work might not look like spiritual care to their American visitor.

WHERE RELIGION FITS IN AFTER ALL

Apart from chapel services, weekly “tea times,” and other events during religious holidays that are conducted intermittently for the benefit of patients, the explicitly religious role of the chaplain is typically confined to interacting with a handful of patients who are active members of a faith tradition. However, even though I only rarely observed religious language or sacramental care by chaplains in their dealings with most patients, many chaplains stressed in no uncertain terms that their religious training and beliefs were still integral to the practice of spiritual

care. For example, when speaking with a retired chaplain who had worked for several decades at a Christian hospital in Japan, I once asked if there was ever a discussion in the early years of the hospice movement about the difference between providing spiritual care and religious care. He answered, “No, not at all, we were just doing Christian care.” This comment nicely illustrates how, even though religion outwardly plays a very small role in spiritual care, spiritual care practitioners can still conceive of their daily work as an extension of their religious commitment. In other words, the supportive dimensions of spiritual care resembles “lived religion”—a view that rejects the distinction of religion from the profane and instead sees how “religion comes into being in an ongoing, dynamic relationship with the realities of everyday life.”²⁷ As Courtney Bender notes in her study of kitchen volunteers in New York City, in the right context, counting plastic food containers is “as though I’m praying,” and “cutting carrots is really a lot like meditating.”²⁸ Likewise, the retired chaplain’s comment that he was “just doing Christian care” shows that, just as religious life is interwoven in daily practices and not just lived in religious institutions and communities, spiritual care is often simply a matter of putting one’s own religious beliefs into practice through a range of normal activities aimed at supporting patients.

Chaplaincy also suggest that their work is not just an extension of their devotional life, but that in order to be an effective practitioner of spiritual care, having a robust set of beliefs and values that serve as an existential anchor is necessary in order to respond to the deep questions that patients might occasionally pose in the face of death. As one Christian chaplain explained:

Spiritual care isn’t really about “doing” care. Rather it is about questioning who you are. Meeting with patients challenges you. When people interview and do research on spiritual care, I always emphasize to them there is so much that can’t be academically explained. There are lots of things that are not visible that are important parts of spiritual care. . . . A patient once told me: “I sense something stable [*yuraganai mono*] behind you.” This really made sense to me. If I am secure in knowing that God loves and accepts me, I just need to be that way before the patient. This is the basis of spiritual care.²⁹

From this perspective, spiritual care requires willingness on the part of the spiritual caregiver to be honest, vulnerable, and open to learning with the patient.³⁰ But it also suggests that spiritual caregivers must be somewhat secure in their beliefs or values, so they are not at a complete loss when challenged by patients. It is not simply enough to just value the patient as a person, a type of relational care that some hospice workers describe as “horizontal.”³¹ Instead, ideally, spiritual care is also “vertical”—a type of care that draws on a religious background or existential security that allows the caregiver to transcend the moment by helping the patient connect with something beyond themselves. This religious background gives the

spiritual caregiver buoyancy that allows him or her to assist floundering patients in a sea of suffering.

The perceived importance of having a religious background or training for spiritual caregivers is important since this is also one of the ways chaplains distinguish their work from that of clinical psychologists. Chaplains explain that psychologists are fundamentally concerned with treating the patient using specific counseling therapies that are part of mainstream medicine. In contrast, a chaplain is there to simply listen and empathize, perhaps even to cry with the patient. For instance, a Buddhist chaplain working at a nonreligious hospital in Osaka was asked by her supervisors to pursue additional certification as a clinical psychologist even as she continued her work of spiritual care. They explained to her that having a clinical psychologist on staff would help the hospital accrue more “points” that were used in hospital rankings, since chaplains do not count. But even after she became certified as a clinical psychologist, she did not observe much change in her work. Though she drew from her psychological training from time to time when she thought a patient might be suffering from depression or mental illness, her approach to work was essentially the same. This suggests that she did not see her clinical psychological training as adding anything significant to the work of spiritual care; in her mind they represented two different perspectives that informed two different roles. Yet even while she was personally aware of these differences, she also noted that most of the medical staff struggled to distinguish between the differences in psychological and spiritual care.³²

In this way, chaplains readily admitted that religious care only constituted a very small part of their daily activities, but they also pointed out that their work could not be done by just anyone and that their religious identity remained integral to their work. They saw their role as important precisely because a religious professional could offer something that a clinical psychologist or nurse could not. Chaplains believed that although spiritual pain is often expressed in terms of psychological stress, beneath the surface were deeper philosophical doubts, religious questions, and a desire for relief (*kyūsai*) that chaplains from a religious background were better trained to deal with.³³

Even as many chaplains privately viewed their work as an extension of their religious commitments or their presence as buoys that patients could grab hold of in a sea of uncertainty before death, the allergy many contemporary Japanese profess toward religion required chaplains to frame their work in the hospice carefully. In order to encourage the vocation of hospital chaplaincy to become mainstream, chaplains must publicly articulate their roles in psychotherapeutic terms since many Japanese—including their medical colleagues—harbor suspicions that they might have a religious agenda. Consequently, even though chaplains stress the importance of their religious training and identity in private, in public they are careful to present their work as “spiritual” and not “religious” in character.

CONCLUSION

Nurses, doctors, volunteers, and chaplains go to great lengths to help patients spend their last days in a way that “reflects who they are.” This might involve allowing patients to control their own sedative titration, painting their toenails, buying them watermelon in the middle of the winter, or arranging an impromptu motorcycle rally. While these activities might look, sound, and feel different from praying with, counseling, or sitting quietly beside patients in their “search for meaning,” they all form the basis of the hospice staff’s understanding of spiritual care.³⁴ Although the spiritual dimension of hospice care is often treated as a distinct from physical or psychological care in theory, spiritual care in practice often collapses these categories. Hospice staff conduct spiritual care in the margins of regular care and understand spiritual care as anything that make patients feel valued and allows them to be themselves. Chaplains or other staff still support or counsel patients when they have religious or existential concerns; but spiritual care is also understood as something that occurs in the course of a variety of mundane conversations and other activities. Its effectiveness also remains contingent on the motivations of the person extending it, rather than on the content of the care itself. Whereas vocal and resonating care remain the central tenets of professional models of spiritual care that emphasize the need to help patients along in their journey to find “meaning,” in practice, Japanese chaplains are quick to recognize that the cultural foundation for open discussion of religion and existential issues with patients who have never even heard of the term “spiritual care,” or view religious professionals suspiciously, is weak. Accordingly, spiritual caregivers first seek to develop a strong relationship with the patient in hope that after a level of trust is established, patients may feel more comfortable sharing their personal concerns. Or, in light of the fact that many patients appear disinclined or uninterested in bringing up such issues in the first place, spiritual caregivers may rely on simply showing patients how much they are valued. Either way, since many contemporary Japanese typically express few concerns about religious questions of faith or belief, supportive care plays an important role in fostering an environment where patients feel comfortable and cared for.³⁵

Claiming that faith and belief are not as important for patients runs the risk ignoring the experiences of many ardent Buddhist, Christian, or believers of new religions in Japan, but the relative lack of religious care in the Japanese hospice reinforces this point. This is also seen in how chaplains felt a tension between idealized images of spiritual care and what they actually did for patients. While chaplains understood that the companionship they provided patients was important for helping patients feel valued and supported, they also referred to cases of interactions with patients who struggled with existential or religious questions as more representative of “real” spiritual care. Most chaplains I interviewed were adamant that all patients experience spiritual pain—whether they express it outwardly or not. Although chaplains were by no means under the illusion that they

alone had the skills to develop trust with patients and provide a comfortable space for patients to share their spiritual pain, many, if not most, felt that the reason spiritual care was conducted in more of a supportive manner was because hospice staff were not providing patients enough of a safe enough space to express their inner spiritual pain. The question of whether patients are simply unable to express their spiritual concerns in the hospice for cultural, religious, or practical reasons, or if there are simply fewer cases of spiritual concern at the end of life compared to more “religious” cultures, is thus a matter of ongoing debate.