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Making Healthy Religion

On a muggy summer afternoon in 2015, I was walking in Kyoto when I happened to come across a bookstore offering a large sale. As I perused some of the books set out on the sidewalk, one in particular caught my eye. It was titled *The Reason a Zen Priest Aims to Be a Doctor*. The author was Tsushimoto Sōkun, a former Zen abbot who had resigned from his temple to enter medical school. As I skimmed through the pages, I lighted upon the following passage.

> What on earth is it that parishioners expect of us priests? For the sake of the argument let's say that they only expect us to conduct funerals and memorial services. This would be truly sad. As Zen priests trained in fundamental Buddhist practices, what is it we can do to contribute to society? Is this not something that priests must individually consider as a theme in their activities? For example, problems in education, social welfare, and volunteer activities are all areas in which we can expect religionists [*shūkyōsha*] to play a role.[1]

The view that modern Japanese Buddhist priests only interact with their parishioners during funerary and memorial rites is a stereotype that is hard to shake. In fact, it has dominated public and academic discourse on Japanese Buddhism for well over a century.[2] One way modern Japanese Buddhists have sought to combat this stereotype and emphasize their value to society is by engaging in social welfare activities.

This chapter locates the practice of spiritual care in Japanese hospices within a broader historical narrative of Japanese religious engagement in medicine during the twentieth century. I focus especially on institutionalized forms of social welfare provided by Buddhist and Christian hospitals that showcase the more "public" contributions of religious groups in medical care.[3] Although the Japanese hospice movement did not take off in earnest until the 1990s, a closer look

at the first half of the century reveals a flurry of activity by religious groups in the fields of medical welfare that helped lay the groundwork for the hospice movement. For example, in the late nineteenth and early twentieth century, Buddhist and Christian groups in Japan were particularly active in building hospitals and medical dispensaries, often legitimizing their work by focusing on medical charity (*jizen*) as both a tenet of religious practice and a symbol of modernization.[4]

These types of activities are connected to contemporary spiritual care in two ways. First, Japanese Buddhists frequently mobilize the discourse of Buddhist decline, along with historical precedents of Buddhist engagement in medical welfare and care for the dying in premodern Japan, to promote the contemporary Vihāra movement. Second, religious hospitals established during this period later became key sites for purveying the philosophy of hospice and spiritual care in Japan. Accordingly, this chapter will survey the contributions of Christian and Buddhist medical missions that began in the Meiji period up to the immediate postwar period (ca. 1945–60) to show how these efforts later set the stage for religious involvement in hospice care. In particular, it will demonstrate how Christian groups came to play a disproportionate role in the establishment of religious hospitals that later became influential centers for the practice of spiritual care. I then turn to examine the origins of the hospice movement itself in the 1970s and '80s at several Christian hospitals, and the development of the Vihāra movement shortly thereafter. This is followed by an analysis of how two key historical events in 1995—the Hanshin earthquake and the sarin gas attack by the religious group Aum Shinrikyō—helped pave the way for the spread of spiritual care in clinical settings more broadly in the twenty-first century.

Ultimately, this chapter will seek to place spiritual care in Japan—in discourse and on the ground—within its broader historical and institutional context. It will address such questions as: What role did Japanese religious groups play in medicine before the advent of spiritual care? Why are there so many Christian hospitals in Japan? How did religious groups become involved in hospice care in the first place? By filling in the historical background of hospice care in Japan, it shows how the narrative of Buddhist decline has remained an engine for Buddhist engagement in modern medicine and how Christian medical missions paved the way for Christianity's pioneering role in the Japanese hospice movement. This longer view of Japanese modern religious engagement in medicine also helps to problematize a view that depicts socially engaged Buddhism in Japan as relatively recent phenomena.[5] More importantly, calling attention to the early history of social welfare activities by religious groups helps us better understand the ways Japanese religious groups have taken it upon themselves to try and play a "healthier" role in society.

MOBILIZING HISTORY: IMAGINING A "GOLDEN ERA" OF BUDDHIST MEDICAL WELFARE

Inoue Enryō (1858–1919), Japan's most prominent Buddhist thinker and reformist during the Meiji period (1868–1912), spared no words in roundly critiquing the lack of Buddhist engagement in charitable works (*jizen jigyō*). In 1898 he wrote:

> In each of the Buddhist sects, although perhaps inadequate, the encouragement of learning and spreading of teaching is being done to some extent, but in regard to reaching the first level of charity [*jizen no ichidan*], we can say that we have not even begun to undertake this. Although Buddhism originally had charity at its basis [*moto*], and it has been understood that the Buddha mind [*busshin*] is to have great compassion [*daijihi*], though compassionate, in fact, the lack of charitable works is something I find truly hard to comprehend.

Inoue then went on to compare Buddhism with Christianity: "The reason why Christianity is valued today in the West is because it promotes charity for the benefit of others. Consequently, if Christianity coexists [in Japan] with Buddhism in the future, and becomes officially recognized like Buddhism, Buddhism must compete in conducting charitable work. Therefore, today it is imperative [for Buddhists] to make these preparations."[6] In this passage Inoue links the success of Christianity in the West to its charitable work for the benefit of others (*ritateki jizen jigyō*). Inoue also critiques Japanese Buddhists for only conducting charitable work that had some self-interest involved (*jiriteki jizen jigyō*) and warns that Buddhist groups may fall behind their Christian rivals in Japan.

Not all Buddhists were as explicit as Inoue in using Christian charity work as a foil for furthering a vision of Buddhist social welfare, but this passage shows the palpable sentiment among Buddhist reformers in the Meiji period that Buddhism had "degenerated" from its lofty teachings. According to this now well-trod narrative, Buddhism had become complacent under the Tokugawa government's temple registration rules that provided a stable parishioner base during the Edo period (1603–1868), retreated from charitable activities, and ossified into a religion solely dedicated to funerary and memorial rites.[7] In order for Buddhists to demonstrate their worth to modern society, they needed to expand their expertise from care for the already dead to those who were still living, in order to show they could play a "healthy" role in Japanese society.

Since there was a strong view among early twentieth-century Buddhist scholars, and to a certain extent even today, that Japanese Buddhism had "degenerated" during the early modern period, Buddhist scholars often look further back in history for the "golden era" of religious engagement in social welfare.[8] Much of this historiographical discourse on religion and social welfare in Japan is embedded in a vision of reforming Buddhism to emphasize its contributions to contemporary society. For example, Tsuji Zennosuke (1877–1955), a professor at Tokyo Imperial University and Japan's preeminent prewar Buddhist historian, was one of the most

influential voices in the discourse of Buddhist "degeneration." As part of his effort to show just how far Buddhism had fallen, he published a thick volume titled *Historical Records of Charity and Relief* (Jizen kyūsai shiryō; 1932), which began as a project to collect historical documents for display at a charity hospital in 1919. Beginning with the earliest records of Japanese history and continuing up until the Meiji Restoration, Tsuji's book was a chronological anthology of records of charitable works, often by Buddhists, in Japanese history. Likewise, Asano Kenshin (1898–1939) published a similar volume titled *The History of Buddhist Social Work in Japan* (Nihon bukkyō shakai jigyō-shi; 1934) that highlighted the social work undertaken by past Buddhists. Asano wrote in his preface to the book, "Buddhism holds, over the past twenty-five centuries, a record of prior achievements in social relief. Surely today, and surely especially after the Meiji restoration, it might be thought that the field of modern social work was recently begun by Christians, but this is certainly not the case. This is because already from of old, in our Japan, Buddhists hands have been involved in and directed a wide range of various types of social work."[9] Here Asano, like Inoue before him, promoted a vision of revitalizing and reforming Buddhism by citing past examples of Buddhist engagement in types of social work that were often credited solely to modern Christians. His book sought to emphasize Buddhism's own long tradition of social work activities.[10]

The growing Buddhist interest in playing a more active role in social welfare was also expressed in the monthly Buddhist journal *Kyūsai* (Relief), which was published between 1911 and 1919 by the Jōdo Shinshū Ōtani Sect Charity Association. This journal featured numerous articles on historical examples of Buddhist social work as well as news reports about recent social welfare activities in Japan. The first issue of this journal explained that underlying the formation of the association and the journal was a strong consciousness of charitable works as "one of the pressing issues of the time," and one in which many were "waiting on the strength of religionists" to do something. Moreover, the Ōtani sect felt especially obligated to act as "other religions draw on their own unique convictions to follow this path and are competing in their contributions."[11]

Invoking past examples of Buddhist charity and social work, as well as referencing the contemporary work of Christians, helped inform the call by reform-minded Buddhist priests for greater social engagement. In other words, Inoue Enryō's early perception that Buddhism had become "corrupt," abandoning its premodern ideals that placed "charity at its center," served a double purpose. Medieval precedents of social welfare activities provided evidence of a long history of Buddhist involvement in such activities and legitimized Buddhist expertise in fields like medical welfare. At the same time, such precedents also allowed reformists to promote a vision for increased social engagement by invoking the supposed lapses of modern Buddhism. This imagining of the past "golden era" of social welfare authorized and naturalized contemporary Buddhist social engagement, while the call for reform provided a sense of urgency. Without establishing

their expertise, Buddhists would be forced to make the argument for modern social engagement from scratch. Without the sense of a modern crisis, present-day Buddhists would lack a key motivation for social engagement. This two-pronged approach in which Inoue looked back to the Buddhist "golden era" while simultaneously bemoaning modern "degeneration" has continued to color scholarship on contemporary Buddhism as well. As Mark Rowe notes, the "give it your best, Buddhism!" (*gambare Bukkyō!*) approach of scholars who hearken back to the golden era of Buddhism or highlight the innovative activities taken by a few contemporary Buddhists only serves to amplify the narrative of degeneration.[12] It is this narrative that motivates a twentieth-century Zen priest to become a doctor: the fear that twenty-first-century parishioners will otherwise "only expect us to conduct funerals and memorial services."

BUDDHIST DEATHBED RITUALS AS A PRECEDENT FOR HOSPICE CARE

A more specific inspiration for Buddhist engagement in contemporary hospice and spiritual care comes from the premodern Buddhist practice of "deathbed rituals" (*rinjū gyōgi*), which provided dying persons in medieval and early modern Japan with a set of ritual tools to maintain a state of right mindfulness (*shōnen*) at the moment of their death. These rites were performed to ensure an auspicious rebirth in the next life. To ensure right mindfulness, a spiritual companion called a "good friend" (*zenchishiki*) often assisted the dying by helping them to chant a prayer to the Buddha (*nenbutsu*) in their last days and hours, providing encouragement and managing the deathbed environment so that it was conducive to right mindfulness.[13] What made these premodern deathbed rites especially appealing to modern proponents of spiritual care was the image of a Buddhist priest helping dying persons reach a state of spiritual equanimity during their last days. For instance, a collection of deathbed ritual texts edited by one of the founders of the Vihāra movement makes a direct correlation between these practices and modern hospice care in the book *Deathbed Rituals: The Origins of Japanese Terminal Care*.[14] The former head of the Nichiren Vihāra Network also refers to the early seventeenth-century deathbed ritual text as having "content rich in suggestions for us today despite its historical background in the early Edo period,"[15] while another contemporary study of esoteric deathbed ritual texts suggests that both medieval deathbed rituals and contemporary palliative care share the common goal of seeking a "desirable death."[16]

On the surface, it might seem strange that modern Buddhists sought to distance themselves from stereotypes of "funerary Buddhism" by stressing their historical expertise in care for the dying. After all, was not care for the dying on the same continuum as care for the dead? In the case of hospice care, however, the primary difference was monetary. Since funerary rituals are notoriously expensive

in Japan, the Buddhist priest was often cast in the popular media as a greedy figure that only appears at the parishioners' homes after they die. In a memorable scene from Itami Juzo's 1984 film *The Funeral*, a Buddhist priest arrives in a fancy limousine to conduct a funeral. In contrast, the Vihāra movement has thus far shown an absence of financial motives and relies heavily on the work of volunteers. Even still, the so-called links between deathbed rituals and contemporary hospice care can generate confusion on the role of contemporary Buddhists in spiritual care. To be sure, drawing attention to the history of deathbed rituals helps to show that Buddhist priests were historically more than just funerary ritualists. But premodern deathbed rituals also differ in significant ways from the practice of spiritual care in contemporary hospices. For example, medieval deathbed ritual texts often instruct the accompanying priest to exclude family members from the deathbed since their presence might arouse thoughts of emotional attachment and thus hinder the dying from attaining right mindfulness. Such instructions show how deathbed rituals arose out of soteriological concerns that emphasized an auspicious rebirth, rather than the contemporary hospice ideal of a painless, gentle death, where caring family members surround the patient. The perceived soteriological stakes in premodern deathbed rituals were also much higher than today. Japanese in the medieval period were painfully aware that not dying in a state of right mindfulness opened the possibility of being reborn into hells or other undesirable realms. In contrast, with a few exceptions, hospice patients in Japan today only rarely raise such concerns. Despite these differences, since deathbed rituals provide the closest premodern analogy to spiritual care, they are often invoked by contemporary Buddhists as the origins of Japanese Buddhist spiritual care.

THE ROLE OF CHRISTIAN MEDICAL MISSIONS

Although Buddhism has a longer history of medical welfare activities in Japan, a case could be made that Christian medical missions in modern Japan had a much stronger impact on hospice care. This is quite remarkable in light of the fact that Christians have never constituted more than a few percent of Japan's population.[17] The initial impact of Christian medical missions can be traced to the period from 1823 to 1910, when it is estimated that more than two hundred foreign medical workers made their way to Japan to practice medical care. Nearly a third of these workers who arrived during the Meiji period were Christian medical missionaries.[18] Although the rapid acquisition of modern medicine in Japan eventually eclipsed the need for medical missions, the marks that missionaries left on the medical field in Japan were indelible. Not only did missionaries found many medical institutions that are still open in Japan today, but their example helped spur the development of Buddhist medical welfare as well.[19]

By 1883, eighteen Christian medical missionaries had arrived in Japan.[20] Yet it was not certain if they were really needed. In the report on "The Position of Medical Missions" made by Theobald Palm of the Edinburgh Medical Mission at the 1883 General Conference of Protestant Missions held in Osaka, he makes clear that Japan was not a typical field for medical missions.

> A medical missionary is generally sent to people destitute of medical assistance. In Japan, however, this is not the case. . . . Of the recent efforts of the Government of this country to promote a national and scientific practice of medicine by the establishment of medical schools and hospitals and the employment of foreign teachers, and of the degree of success attending them, it is unnecessary for me to speak. Probably in no department have foreign ideas and practices been so well assimilated as in this. . . . Hence, while in many countries a medical missionary would be besieged with applicants for relief as soon as the report of a few successes becomes known, in Japan he finds himself in competition with a Government Hospital which probably has a European medical officer at its head, or, if not, a staff of well-trained Japanese physicians.[21]

As Palm's report makes clear, Japan had little need for medical missionaries. In the discussion that followed Palm's 1883 report, James C. Hepburn, a senior medical missionary, also agreed that "Japan at present day was not a field for medical missions."[22]

The view that medical missions were no longer requisite in Japan was confirmed seventeen years later at the 1900 General Conference of Protestant Missions held in Tokyo. There, Wallace Taylor, a doctor and missionary sent from the American Board of Commissioners for Foreign Missions, noted that while medical assistance had been helpful in the past, such assistance would now "not only be considered of doubtful propriety but would be a burden rather than a help."[23] He added that whereas Japanese patients were previously attracted to medical missionaries because they believed them better qualified than Japanese doctors, the large number of competent and qualified Japanese doctors now removed the necessity for foreign physicians. In contrast to Palm, however, Taylor went on to qualify his remarks by suggesting a need for medical work among the poor.[24] Although Palm had warned seventeen years earlier against introducing a "pauperizing system into Christian hospitals," Taylor presented a favorable view of charity hospitals.[25]

> Hence the field and opportunity for medical charities is large and wide in Japan, and the desirability, if not the necessity, of establishing medical charities that will be a laudable example for the developing Christian communities to follow; and a stimulus to the government and the people in general to provide in some adequate measure for and to care for their sick-poor and those unfortunate classes, the blind, the deaf and dumb, the insane and the leper, is equally desirable.[26]

Taylor calculated that while the expenditures for medical charities in the United States were about one dollar per unit of the population, in Japan expenditures

amounted to a mere one-sixth of a cent. To illustrate the immensity of the need for charitable medical care in Japan, Taylor further noted that the Presbyterian Hospital in New York had run a deficit of $80,000 in 1898, a good portion of this amount representing its medical charities. This sum, he said, exceeded the amount expended on medical charities in the whole Japanese empire.[27] Taylor went on to claim, "Japan has scarcely made more than a beginning in the highest form of civilized and Christian benevolence, that of medical charities."[28] In conclusion, he argued that, while small-scale medical missionary work had been appropriate in years past, the real need in Japan was for medical charities.[29] In the following decades, many missionaries and Japanese Christians responded to Taylor's call to establish medical charities that could stand as witnesses to Christian benevolence.[30]

BUDDHIST MEDICAL MISSIONS

Even as Christian medical missionaries played a prominent role in Meiji era medical work, Buddhist groups were not far behind. For example, the establishment of the Kyoto Ryō Hospital in 1872 was made possible with the support of Buddhist leaders of the Jōdo and Rinzai sects and Japan's first public psychiatric hospital was established on the temple grounds of Nanzenji in 1875.[31] Beginning in the late 1880s, a string of Buddhist medical dispensaries began offering medical relief.[32] In 1909, for instance, the Saisei Hospital was established on the grounds of Tōji temple in Kyoto by the Shingon association Sofū Senyōkai (lit., "Association for Enhancing Our Founder's Teachings") and became one of the most prominent Buddhist charity hospitals of the Meiji period.[33] In its first four years, the Saisei Hospital treated 18,159 new patients.[34] The Sofū Senyōkai itself was established six years earlier by reform-minded Buddhists aiming to expand their religious influence, bring about Buddhist prosperity, and reform society. One of the leaders of the Sofū Senyōkai described the mission of the new charity hospital as: "Recognizing the common evil of the divergence between religious faith and the medical world, [our mission is] to heal the illnesses of the body and *kokoro* through the mutual interdependence of the medical way and religion."[35] As this statement shows, care for the *kokoro* of patients was on the minds of religious groups well before the notion of spiritual care was later developed in the hospice context.

Like their Christian counterparts, many Buddhists framed the importance of their medical work as charity. For example, the Saisei Hospital declared itself willing to follow the example of its Shingon patriarch Kūkai in practicing compassion and saving the world (*jiai saisei*) by not seeking payments from patients, although sincere donations would be accepted.[36] These Buddhist forays into medical charity especially intensified especially after 1911. In February of that year, a new Imperial Rescript announced an imperial donation of one and a half million yen for the establishment of the Saisei Association (Saiseikai) to provide medical services to the poor and needy of Japan. This event was widely reported on in the press and

galvanized Buddhists to provide even more medical relief. It also propelled the publication of the Buddhist social welfare journal *Kyūsai* between 1911 and 1919, which provided a forum for reform-minded Buddhists to discuss the importance of social welfare.[37]

OUTGIVING THE OTHER: CHRISTIAN AND BUDDHIST MEDICAL WELFARE

As this flurry of activities by both Christians and Buddhists suggests, the Meiji period was a formative moment for Japanese religious engagement in modern medicine. For Buddhists in particular, the sense that Christians were outdoing them in charitable activities remained an important motivating force for social engagement.[38] Christian missionaries also lambasted Buddhists for not doing enough. In 1915, Sidney Gulick lamented Buddhist inactivity while also drawing on the discourse of Buddhist "decay." "With the decay of Buddhism in recent centuries, however, little philanthropic activity has survived. With the revival of Buddhism, Buddhists have again undertaken philanthropic work; they have established orphan asylums, schools, ex-convict homes, and various benevolent enterprises for the poor, the old, and invalids; but not yet do they seem to appreciate the moral and industrial situation, or undertake anything commensurate with their numbers and resources."[39]

Such statements paint a pessimistic picture of Buddhist engagement in social welfare during this period, but must be assessed carefully. According to Yoshida Kyūichi, there were approximately 485 Buddhist social welfare institutions by the end of the Meiji period (1912).[40] On the Christian side, Yajima Yutaka counts only 124 Christian social welfare institutions that were founded during the same period.[41] Other historians have reached different figures, but all agree that the number of Buddhist institutions exceeded their Christian counterparts by no small margin during the first few decades of the twentieth century.[42] In terms of medical services, however, it seems that the Buddhist efforts did lag behind Christians. The Jōdo sect embraced the slogan, "one temple, one social service" (*ichi jiin ichi jigyō*) in the 1930s, but in reality most temples could at best only afford to provide religious edification or education activities (*kyōka katsudō*) and local childcare.[43] Therefore, although the actual number of social welfare institutions within the Jōdo sect more than tripled between 1922 and 1939, the majority of these institutions were limited to religious education activities or childcare, and less than one percent of the listed institutions provided medical care.[44]

These numbers also do not reflect the overall quality of social-welfare activities. For instance, Christian missionary Wallace Taylor bemoaned the lack of asylums for the blind, deaf, and dumb and homes for sufferers of leprosy in his report to missionaries in 1900. Although he acknowledged that such asylums existed,

he dismissed them on the basis that "when we come to visit these institutions, and inquire into their organization, and learn upon what conditions patients are received, we are forced to the conclusion that they are not medical charities in any legitimate sense of the word."[45] Even if Taylor were not biased in his report, it is likely that both the numbers and descriptions of social welfare activities by religious groups fail to reflect the more complicated reality on the ground. For instance, during this period many Buddhist temples were still recovering from the financial and political pressures brought about by government policies that had triggered the "eradication of Buddhism" movement (*haibutsu kishaku*) in the early Meiji period.[46] In some cases, Christians literally "filled in" for the Buddhists by establishing social welfare institutions in vacant temples.[47] The combination of Buddhist financial struggles, and the financial support that Christian medical missionaries enjoyed from their home supporters, became an important reason why so many Christian medical institutions were established in early twentieth-century Japan.

RELIGIOUS MEDICAL WELFARE IN THE POSTWAR JAPAN

The economic devastation left in the wake of the Second World War gave rise to further opportunities for medical welfare by religious groups. For instance, in 1955 Presbyterian missionaries helped to establish Yodogawa Christian Hospital in a historically poor area of Osaka.[48] This was the same hospital that would later play a leading role in the hospice care movement. However, at the time, not all local Japanese doctors welcomed the establishment of such hospitals. In 1953, the head of the local medical association sent a letter to the Presbyterian Church in the United States asking them to reconsider their plans for the hospital on the grounds that it "threatens the living of those who are practicing medicine" and "inserts confusion into the medical system of Japan."[49] In a letter defending the project to the Presbyterians back home, the lead medical missionary explained that the Welfare Ministry, as well as U.S. Occupation officials in Tokyo, had encouraged them to pursue this project and that the selection of the site was made in consultation with the Osaka prefecture health department. According to local officials, the selected location for Yodogawa Christian Hospital was a very needy area of Osaka with a significant deficiency of hospital beds. The missionary also argued for the establishment of the hospital on the grounds of charity.

> Of course, we do not expect a profit, nor do we think any hospital out here should have any profits. We expect to use our mission subsidy to help carry the charity work we feel is so badly needed. We also expect to charge private paying patients enough to help with this free work. However, we have assured the local doctors that we will not be a "cut rate" institution and will be extremely careful about who we take as charity or part charity cases.[50]

In a letter of reply to the local medical association, the missionaries assured local doctors that the hospital would start with about twenty beds and not attempt to compete with local medical facilities, but rather endeavor to be "of aid" for "unmet needs."[51] Local doctors were initially skeptical. However, by 1958, they were won over and eventually invited Yodogawa Christian Hospital to join the local medical association.[52]

After 1961, however, the rationale of charity as a reason for medical missions had largely dissipated. In this year, National Health Insurance became available to all Japanese citizens, and the establishment of hospitals by religious groups also began to taper off. According to Japan's 2017 Christian Yearbook, there were ninety-three medical institutions in Japan that were affiliated with Christian groups or operated with a Christian mission statement.[53] Forty-five qualified as hospitals (*byōin*), meaning they had at least twenty beds, while the rest were primarily clinics. Of these forty-five Christian hospitals, thirty-four (76%) were established before 1960. These data suggest that, as the Japanese economy revived in the 1960s and health care became accessible to all citizens, Christians scaled back their involvement in establishing new medical welfare institutions. But the hospitals they founded remained. By this point, however, Christian hospitals like Yodogawa Christian Hospital were less likely to emphasize their charitable mission and more likely to emphasize other goals such as a vision of holistic care and spiritual healing. For example, Yodogawa's mission statement declared that their hospital was "dedicated to the glory of God and the salvation of man through the ministry of healing, bringing the power of love and the highest competence of modern science to bear on the social, physical, mental, and spiritual needs of patients, in the conviction that healing will not be complete until, through Christ, the person is reconciled to God."[54]

This statement was later shortened to the motto of "whole person healing," which was defined as "a medical ministry in Christ's love, serving the patient as a total unity of body (*karada*), mind (*kokoro*), and spirit (*tamashii*)." The inclusion of "spiritual needs" of patients and the focus on "whole person healing" in this mission statement later helped position Yodogawa Christian Hospital to be at the forefront of the spiritual care movement.

On the Buddhist side, medical welfare and charitable activities after the immediate postwar period slowed down as well.[55] Unfortunately, there is no comprehensive list of Buddhist hospitals today, but a cursory review of statistics on social welfare published by individual sects suggests a relative paucity of medical institutions.[56] For instance, in 2006 the Honganji branch of Jōdo Shinshū listed 859 social welfare facilities, including 726 nursery schools and eighty-nine elder care facilities. Significantly, no hospitals or clinics were listed.[57] To my knowledge, there are currently only a handful of hospitals today that are publicly affiliated with Buddhist groups or operate under Buddhist principles.[58] The reasons for this are not readily apparent. For example, the psychiatric hospital founded at Nanzenji in 1875 later became a private institution and was removed in 1882 due to financial

difficulties. Likewise, the Juzen Hospital (established 1902) only remained open for several years. Even the largely successful Saisei hospital at Tōji (established 1909) was forced to close in 1946. The most probable explanation for these closures is that as public medical care became ubiquitous and affordable for all classes of Japanese society, the need for medical charity became less pronounced and Buddhist groups simply turned their attention to other issues.[59]

In contrast, many Christian hospitals remained open even as their missional emphasis turned from charity to holistic healing, and eventually expanded to include hospice care. In 2017, approximately thirty-three Christian hospitals in Japan provided some form of hospice care, and all but nine of these hospices were founded before 1960.[60] Many of these hospitals employed Christian doctors, had Christian mission statements that emphasized spiritual as well as physical healing, and had hospital chaplains on staff who were available to lead chapel services and visit patients. This existing infrastructure, plus the overseas ties that many Christian hospitals held through their religious affiliation, were instrumental in paving the way for the establishment of hospice care at these institutions.

Although they have not been a focal point of this study, new religious groups in Japan were also active in medical welfare throughout the twentieth century. For instance, the roots of Tenrikyō's large hospital in Nara go back to 1935. This hospital was expanded to a six-hundred-bed hospital in 1966, and a hospice was finally established in 2018. Like many other religious hospitals, the Tenrikyō hospital espouses a mission for holistic medicine that attends to the "body, *kokoro*, and manner of living" (*karada, kokoro, kurashi*) of patients. Likewise, the Risshō Kōseikai established a hospital in 1952 and eventually its own hospice in 2004. There too, the hospital adheres to the mission of holistic medicine that treats the "body, *kokoro*, and life" (*karada, kokoro, inochi*) of all patients.

Interestingly, although relatively recently formed religious groups like Tenrikyō and Risshō Kōseikai have been historically viewed with suspicion by the Japanese public, it did not follow that their medical welfare activities were only aimed at helping improve their public image. For instance, since the early twentieth century, Tenrikyō believers have been proactive in providing social and medical services for those who suffered from Hansen's disease. But those who engaged in such activities typically framed their work in terms of concern for the betterment of the less fortunate, or of their own spiritual development, rather than of trying to demonstrate their worth to society.[61] Similarly, recent ethnographic work on the Risshō Kōseikai has drawn attention to how their social welfare activities are not just instrumental actions aimed at self-benefit, but integrate both self-benefit and altruism in complex ways that defy simplistic judgments about their aims.[62] Social welfare activities like the building of hospitals are seen as "a way to put their faith into practice" (*shinkō o jitsugen shite iru*).[63]

Overall, however, the establishment by religious groups of hospitals, clinics, as well as other social welfare institutions helped show the "healthy" role they were playing in society. Many groups initially mobilized and justified their work

in medical missions by focusing on the importance of charity (*jizen*) as both a tenet of religious practice and a symbol of modernization. Christian medical missionaries like Wallace Taylor lauded the opportunity that charity hospitals in Japan provided to stand as "the highest form of civilized and Christian benevolence," and Buddhist intellectuals like Inoue Enryō criticized the Japanese Buddhists for their "lack of charitable work." Eventually the rapid acquisition of modern medicine by Japanese in the prewar period, and the extension of the National Health Insurance program in the later postwar period, eclipsed the importance of medical missions as a form of charity. But many of the hospitals remained and eventually became important training sites for the introduction of hospice care and the development of spiritual care.

THE BIRTH OF HOSPICE CARE IN JAPAN

Interest in establishing a hospice in Japan first began to gather momentum in the 1970s, and it received a boost after Elizabeth Kübler-Ross's bestselling book *On Death and Dying* (1969) was translated into Japanese in 1971. One of the pioneers in the Japanese hospice movement was Kashiwagi Tetsuo, the Christian psychiatrist who worked at Yodogawa Christian Hospital. In 1973, a year after Kashiwagi returned from his medical residency at Washington University in St. Louis, he encountered a dying patient in Japan whom he referred to as S. S was experiencing extreme anxiety about death and was referred to Kashiwagi by a colleague. As Kashiwagi spoke with S, he realized that no doctor could treat this patient without additional help since he was facing a range of issues including severe physical pain, psychological anxiety, family and financial issues, as well as spiritual anxiety. It was at this moment that he recalled something he had learned in the United States called "The Organized Care of the Dying Patient." Kashiwagi decided to create a similar team at Yodogawa Christian Hospital, which included a doctor, nurse, social worker, psychiatrist, and a chaplain, to meet weekly and discuss patients' needs. This was, Kashiwagi claims, the beginning of hospice care in Japan.[64]

In 1979, 1980, and 1981, Kashiwagi was sent by Yodogawa Christian Hospital to visit and receive further training at several hospices in Britain and the United States. There, he learned about hospice care directly from figures like Cicely Saunders. Kashiwagi explains that during his visits, Saunders checked his impulse as a Christian psychiatrist to focus on the spiritual and psychological aspects of hospice care. Kashiwagi recounts the following advice from Saunders:

> Let's say that I was diagnosed with cancer and went to a hospital. The first thing I would want is not for an experienced psychiatrist to listen to my irritated feelings or a chaplain to pray that my pain will go away quickly. I would first want a proper diagnosis of what is causing my pain; followed by a determination of what would be the best medical drug, dosage, schedule, and method of administration. As a Christian psychiatrist, it is splendid that you yearn to build a hospice. But this is not enough for

FIGURE 10. Japan's first official hospice (Photo by author).

> a patient to endure pain. You cannot do this as a psychiatrist. It is important to have faith, but prayer alone is not enough to take away pain.[65]

According to Kashiwagi, these words had a great impact on him. After he returned to Japan, he undertook further medical training in internal medicine while also raising funds for building a hospice. Kashiwagi also drew attention to hospice care by publishing a book in 1978 on team approaches to care for the dying, and laid out a vision for hospice care in a 1983 book that went through fifteen printings in the first three years.[66] This marked the beginning of Kashiwagi's prolific publishing career that proceeded at the pace of about one book per year.

In the meantime, others in Japan were becoming active in promoting hospice care as well. In 1974, Kawano Hiroomi (1928–2003), a Christian physician, published a book on support for the dying and in 1978 founded the Japanese Association for Clinical Research on Death and Dying, which continues to host Japan's flagship conference on hospice care. In the same year, the Japan Society for Dying with Dignity was founded, and the establishment of hospice care was set as one of its goals.[67] At last, Japan's first official hospice opened in 1981 at Seirei Mikatahara Hospital in Shizuoka. Seirei Mikatahara Hospital was founded by the Christian activist and politician Hasegawa Tamotsu (1903–94) in 1930, and the hospital upholds the mission of "neighborly love based on the Christian spirit."[68]

After gathering sufficient funds, Yodogawa Christian Hospital opened Japan's second hospice under Kashiwagi's supervision three years later in 1984.

It is important to note that to this day, Yodogawa Christian Hospital remains a religious corporation (*shūkyō hōjin*) under the jurisdiction of the Presbyterian Church, USA, and is staffed by several full-time chaplains who visit patients and conduct chapel services while upholding their mission of "whole person healing." Since both Seirei Mikatahara Hospital and Yodogawa Christian Hospital already had Christian chaplains on staff, the availability of chaplains to join the hospice team allowed them to begin practicing spiritual care immediately.

In 1987, Japan's third and first nonreligious hospice opened at Kokuritsu Ryōyōjo Matsudo Hospital, which eventually became part of the National Cancer Center in Chiba. In contrast to the first two Christian hospitals, Kokuritsu Ryōyōjo Matsudo was a public hospital and it was reportedly difficult for religious workers to be involved in the care of patients. Instead, they made sure to provide plentiful greenery and wild birds to help patients relax their *kokoro*.[69] In 1989, a fourth hospice was begun at the Christian Salvation Army Kiyose Hospital in Tokyo, and in 1990, a doctor who also pastored a local church established Japan's fifth hospice at Eikoh Hospital in Fukuoka. At this point, four out of the five earliest hospices in Japan were founded at Christian hospitals. But after April 1990, when hospice care fell under the aegis of Japan's National Health Insurance, the number of hospices grew rapidly. In that year, the physician Yamazaki Fumio also published his national bestseller, *Dying in a Japanese Hospital*, which deplored the medicalization of death in hospitals and called for more hospice care. By 1995, the number of hospices had increased to twenty-three, of which nine were affiliated with Christian hospitals. By 2020, the total number of hospices in Japan reached 453. Approximately thirty-three of these remain affiliated with Christian hospitals, most of which employ Christian chaplains who provide spiritual care.

THE VIHĀRA MOVEMENT

On the Buddhist side, the Vihāra movement unfolded soon after Christian hospitals began to establish hospices. One of the first essays by Buddhists on this topic was published in the 1984 annual report of the Japanese Buddhist Association for Social Welfare Studies (Nihon Bukkyō Shakai Fukushi Gakkai; NBSFG). In his essay, the author tackled the subject of what Buddhists could do to help the elderly deal with anxiety over death.

> Recently, in the hospices and end-of-life care institutions that have begun to be built even in our country, there is a demand for religionists to become part of the medical team. Although Christian clergy can participate easily, it is said that it is difficult for Buddhist priests to participate. For example, it is said that there is a resistance to the priest's garb [which is associated with funerals], but if this were really the problem it would be simple enough for priests to visit in their everyday attire. Most likely, it is because even before patients receive support, the feeling of wanting to consult

> with or receive support from a priest is lacking. Unless a relationship of support in ordinary circumstances is established, it will be difficult to support the *kokoro* at the end of life.[70]

As the hospice movement gathered momentum, articles on the need for religious care of the dying began to appear more frequently in the annual reports of the NBSFG. In 1986, another essay reported on the implementation of religious care in a Buddhist nursing home that included the celebration of Buddhist holidays and a sutra-reading club.[71] Two years later, a survey reported on what eighty-one hospital superintendents and head nurses from hospitals in Kyoto thought of having religious workers serve on their medical teams. Somewhat disappointingly for the author, approximately 70% of hospitals felt holding religious services within the hospital was unnecessary, and only 10% felt it was "absolutely necessary" for religious workers to join the medical team. In contrast, 80% of those surveyed were in favor of religious workers visiting patients who subscribed to a particular religion.[72] In the same year, the Japanese Buddhist Association for Social Welfare Studies inaugurated a symposium on "Buddhist Social Welfare and Terminal Care" at their annual conference that was repeated again in 1990.[73]

The first big step toward Buddhist involvement in hospice care was taken in 1985, when Tamiya Masashi (1947–) used the Sanskrit term "Vihāra" (Bihāra), to refer to Buddhist hospice care.[74] For Tamiya, it was essential to stress that Vihāra was not simply an imitation of Christian hospice care but represented a separate tradition of care for the dying that extended back in Japanese history to premodern examples of medical welfare and deathbed rituals.[75] Tamiya also hoped the term would spark a nonsectarian movement. Initially, however, Jōdo Shinshū Buddhists were the most active in orchestrating Vihāra activities.

Tamiya himself was born to a temple family of the Ōtani branch of Jōdo Shinshū and was a scholar of Buddhist welfare at Bukkyō University in Kyoto. In 1986, the Honganji branch of Jōdo Shinshū took the lead by establishing a committee devoted to promoting the Vihāra movement, and in 1987 the nonsectarian Buddhist Information Center (Bukkyō Jōhō Sentā) formed the Buddhist Hospice Association.[76] This group was spearheaded by Koizumi Keishin (1949–), a Jōdo Shinshū priest who had lived for thirteen years in Hawai'i and observed the work of chaplains in hospices there. During a visit he made to the Christian hospice at Seirei Mikatahara Hospital, one of the doctors asked Koizumi why Buddhists had not opened their own hospice since most of the patients at Seirei Mikatahara Hospital belonged to nominally Buddhist families. The secretary of the Buddhist Information Center also expressed concern that Buddhists were shirking their duty, noting, "Buddhism was becoming a religion for the dead rather than the living," and further observing, "the Buddhist hospice suited our attempts to show our concern for the living."[77] In Kyoto, where Tamiya was active, the Kyoto Vihāra Association was formed in 1987, and several committees were established to

research the feasibility of establishing a Buddhist hospice.[78] The Association for Supporting Vihāra also helped raise one hundred million yen for the building of a nonsectarian Buddhist hospice with the support of the president of the Japan Buddhist Federation and the president of Bukkyō University.[79] In 1992, their goals were finally realized with the opening of a twenty-two-bed Vihāra ward at Nagaoka Nishi Hospital in Niigata, a hospital whose superintendent was Tamiya Takashi, the younger brother of Tamiya Masashi. In 1993, a Buddhist nursing course was also established in the Department of Buddhist Studies at Bukkyō University.[80] Meanwhile, Tashiro Shunkō (1952–), a professor at Dōhō University in Nagoya, also formed a group in 1988 that sought to train laypersons to care for those who were dying. Their monthly meetings drew approximately one hundred people and their public seminars drew three times that number.[81] In Kyūshū, medical doctor Tabata Masahisa (1949–) also began the Kunisaki Vihāra Society in 1990, and helped orchestrate study classes on the *Tannishō*, a work said to record the teachings of the Jōdo Shinshū founder Shinran (1173–1263), as an opportunity to think about death and dying.[82]

When Japan's first Vihāra ward was established in 1992, it was initially greeted with much fanfare and was even featured in a nationally televised documentary program.[83] But despite high expectations, a second Vihāra ward was not established for another decade. In 2004, the new lay Buddhist group Risshō Kōseikai launched a hospice at the Risshō Kōseikai Hospital (established 1952) in Tokyo. In 2008, the Honganji branch of Jōdo Shinshū established Japan's first independent Vihāra hospice ward at Asoka Vihāra Hospital in Kyoto. Finally, in June 2017, a fourth Vihāra ward opened at Megumi Hospital in Fukuoka.

The relatively small number of Vihāra wards established in the thirty years since the Vihāra movement was inaugurated suggests that the movement has fallen short of expectations.[84] However, the movement also expanded to include new directions. For instance, although the official goals of the Vihāra movement initially stated a concern for "dealing with life [*inochi*] in society," this was eventually revised to reflect a broader concern that went beyond the life and death context of the hospice by "dealing with suffering [*kunō*] in society."[85] According to a twenty-year review of the Vihāra movement within the Honganji sect, the first two decades of the Vihāra movement could be divided into three periods: the creation of Vihāra (1986–89); the development of regional Vihāra groups (1990–2000); and the reconsideration of Vihāra (2001–8).[86]

The first period included the establishment of committees to study the potential of Vihāra activities and the establishment of regional Vihāra associations in the prefectures of Fukui, Osaka, Nara, and Tokyo. During the second period, the number of regional associations grew to more than thirty, and more than six hundred members undertook Vihāra training. These regional members offered their services at thirty-seven hospitals throughout Japan (including the hospice at Nagaoka Nishi Hospital) and at sixty-seven nursing homes.[87] These services,

however, rarely involved spiritual care. More often, these volunteer services included cutting grass and helping distribute meals to patients with the hope that these activities would help establish the trust necessary between Vihāra volunteers and hospice staff for more active involvement in caring for the *kokoro* down the road. By 2007 the number of Vihāra trainees in the Honganji sect had approached one thousand, with over six thousand regional Vihāra members scattered across Japan. These volunteers continue to serve today at nursing homes and hospitals where they lend a listening ear to the elderly or patients, orchestrate recreational events, and even fix wheelchairs.[88]

Since entering the twenty-first century, however, the Vihāra movement has outgrown the hospice ward. For example, Vihāra activities now also include the distribution of food after natural disasters.[89] The broadening of Vihāra activities from the hospice setting can also be seen in the activities of Vihāra 21, a grassroots nonprofit organization affiliated with the Ōtani branch of Jōdo Shinshū, which oversees housing and day services for the elderly and disabled in Osaka.[90] The expansion of the Vihāra movement to include so many disparate activities begs the question of what, exactly, the contemporary Vihāra movement represents. As one of its leaders, Taniyama Yōzō, has suggested, the contemporary Vihāra movement can be defined narrowly, widely, or very widely. In its narrow definition, Vihāra refers to a Buddhist form of hospice care. In its wider definition, it includes all Buddhist activities and institutions that focus on aging, sickness, and death in the contexts of medical and social welfare. Finally, in its widest definition, Vihāra can include all Buddhist and non-Buddhist social activities that provide opportunities to reflect on "life" and "suffering" including disaster aid, education, and cultural programs.[91] Taniyama suggests that most people use the first two definitions, but in practice, most current Vihāra activities fall into the latter two.

THE MAINSTREAMING OF *KOKORO* CARE

The broadening of the Vihāra movement beyond hospice care became especially pronounced after 1995, which was a major turning point for Japanese religion and society more broadly. This was the year of the Aum sarin-gas attack, but it was also a low point for Japanese religion in another way. Two months prior to the Aum incident, a deadly earthquake hit the city of Kobe and its environs, which claimed more than six thousand lives. In the immediate aftermath of the disaster, religious groups were largely unprepared to support the victims. As one newspaper editorial lamented at the time:

> Why is it that we do not see the priests there [at the site of the disaster] fulfilling their duty? Only a small portion of clergy and a few religious groups are listening to the silent cries of the disaster victims. They only hold funeral ceremonies and don't practice a religion that uses living words for people. The fact that there are few priests who will suffer alongside the people is enough to make one angry.[92]

Spurred by such criticism, Japanese religious groups began to think in earnest about how they could play a larger role in social welfare activities.[93] When the 1998 Nonprofit Organization Law was passed, this opened the door for religious groups to involve themselves more actively with nonprofit work. By the time the devastating earthquake and tsunami hit the Tohoku region on March 11, 2011, religious leaders seemed to have learned their lesson. On this occasion, religious groups were much better prepared as they immediately rushed to the sites of the disaster to support the survivors.[94]

In addition to helping spur religious groups to seek ways to play a more decidedly "healthy" role in Japanese society more broadly, the events of 1995 also opened new avenues for religious groups to participate in hospice care. One such avenue was a surge of public interest in the idea of caring for the *kokoro* of those traumatized by personal tragedies, natural disasters, or impending death. *Kokoro* care was originally associated with the holistic philosophy of hospice care that placed value on caring for patients not only physically, but also socially, emotionally, and spiritually.[95] For example, a 1985 newspaper article on hospice care described a patient who bemoaned the lack of *kokoro* care offered by staff in a hospital. He was only able to receive *kokoro* care from two other patients, who were members of the religious groups Konkōkyō and Tenrikyō and who could encourage him in his faith during his hospitalization.[96] Likewise, a 1986 editorial describes the support for the establishment of Japan's first Buddhist hospice in terms of its ability to provide "*kokoro* support" (*kokoro no sasae*) and existing Christian hospices were referenced for their ability to provide "*kokoro* medicine" (*kokoro no iryō*).[97] A search in the *Asahi* newspaper database shows that the four earliest mentions of *kokoro* care all arise in the context of care for the dying. As these early occurrences show, *kokoro* care before 1995 was closely associated with hospice care. While there was no consensus on who should provide *kokoro* care, these articles repeatedly called attention to the need for family members, doctors, nurses, religious professionals, and counselors to all address the *kokoro* of Japanese hospice patients.

In the wake of the 1995 Hanshin earthquake, however, references to *kokoro* care blossomed in the media and came also to include broader psychological support for traumatized disaster victims. For example, in the *Asahi Shimbun* and the *Yomiuri Shimbun*, Japan's two largest newspapers, the term "*kokoro* care" (*kokoro no kea*) appeared only four times and nine times respectively in 1994 but surged to 216 and 202 times just a year later in 1995. In June of that year, the Japanese government also announced that 1% of all funds donated by private and government sources toward disaster victims would be earmarked for the establishment of a "Kokoro Care Center."[98]

This mainstreaming of *kokoro* care after the Hanshin earthquake allowed for wider societal recognition of and interest in a type of care that went beyond biomedical approaches for suffering individuals who faced traumatic experiences

related to disaster and death. Around the same time that *kokoro* care went mainstream, religious workers in hospice care started to rely on the label of "spiritual care" to distinguish their work from this broader type of psychological care. As *kokoro* care became associated with psychological trauma more broadly, hospice literature emphasized a view that distinguished between the physical, social, psychological, and spiritual pain of patients. Terms like "spiritual care" helped transmit the nuances of existential and spiritual concerns that were more strongly identified with care for the dying. The introduction of the term "spiritual care" marked a departure from the holistic view of care for the dying that *kokoro* care implied in favor of a more specialized notion of care for a patient's "spirituality."

By the late 1990s, spiritual care became further entrenched in hospice care through the establishment of several spiritual care training programs. In 1998, the Clinical Pastoral Education and Research Center was formed to promote education and training in spiritual care. This was followed by several other training and professional organizations, including the Japanese Spiritual Care Worker Association (2001), the Professional Association for Spiritual Care and Health (2005), the Japan Society for Spiritual Care (2007), and the Grief Care Research Center (2009). In 2012, the Japan Society for Spiritual Care set upon creating a national certification program that would establish the minimum criteria for chaplaincy training and allow for the recognition of spiritual care in Japan as a profession in its own right. The late 1990s also marked the beginnings of a growth in academic and clinical attention to the subject of "spirituality" and "spiritual care" that gained even more momentum after the 2011 earthquake and tsunami disaster led even greater numbers of religious professionals to seek out ways to play a healthy role in society.

HEALTHY RELIGION

The first and more familiar type of "healthy religion" is when religion brings some healthy benefit to individuals. For many centuries, religions in Japan have offered health benefits to its practitioners and continue to do so, whether it be through healing or protective amulets, joining a new religious movement, or practicing mindfulness in one's spare time. This type of healthy religion holds true in hospice care as well where religion is sometimes discussed like a kind of spiritual painkiller. As Marx has famously pointed out, religion can function as a kind of opium.[99] This is not to say that religion is simply an addictive drug. In Marx's day, opium was commonly used as an analgesic. As such, even though Marx held religion to be ultimately harmful, he also pointed out that religion can also help dull the pain of oppressed, heartless, and soulless conditions. In hospice care, where opiates are still used frequently, religious care is sometimes described in almost those exact terms as something that can help take away or soothe "spiritual

pain." In fact, it is not uncommon for a doctor to prescribe both spiritual care and morphine at the same time to a suffering patient.

Healthy religion is also about making religion itself healthy or taking on some healthy role in society. In other words, it is not just about religion making sick people healthy, but using the care for sick people as an opportunity to make religion healthy. Although the primary role of spiritual care is to help the dying, it is at the same time closely intertwined with a broader project that seeks to rehabilitate religion in the public sphere. For instance, as Tsushimoto Sōkun, the former Zen abbot mentioned as the beginning of this chapter, explained, part of the motivation for his new career path in medicine was to "contribute to society" so that parishioners won't only "expect us to conduct funerals and memorial services." A more recent example of this vision of Buddhists playing a more prominent role in clinical settings is found in a small group that calls itself in English the "Institute for Engaged Buddhism," or directly translated, "Institute for Clinical Buddhism" (Rinshō Bukkyō Kenkyūjo). An even more literal translation would be, "Institute for Bedside Buddhists."[100] Their website makes clear that this group is not only pursuing research about Buddhism in clinical settings. Rather, their aims are quite broad and include education activities and wider research on how religion can contribute more broadly to the public good of society.[101] These disparate activities are all gathered under the label of "clinical Buddhism."

This project of rehabilitating religion in the public sphere through health work has also been picked up by some parts of the Japanese mass media. For example, in 2016 a primetime documentary on the work of Japanese hospital chaplains aired on Japan's national television network (NHK). In the opening segment, the announcer's voice overlaid a video clip of a dying woman with her hands clasped together while a chaplain stayed by her side. "A terminally ill woman. After death, where will she go? In order to take away anxiety toward death, there are specially trained religious professionals. Right now, throughout hospitals and care facilities in Japan, medicine and religion are working together to achieve peaceful deaths."[102] This positive image of medicine and religion working hand in hand would have been unthinkable in the late 1990s when the public image of religion in Japan was at an all-time low. However, in recent years the media narrative has changed its tune from negative portrayals of religion to portrayals of religion as a kind of "therapy."[103]

Many religious groups have sought to gain entry into modern medical spaces and draw on clinical language to define their mission of social engagement. However, it is important to stress that the synergy between religion and modern medicine in Japan is not at all a new phenomenon. While it is tempting for religious professionals to discuss spiritual care as a new opportunity for socially engaged Buddhism, there is a need to be more cautious about this narrative and to acknowledge that religious engagement in modern medicine is rooted in a longer history. As detailed in the earlier part of this chapter, religious groups have been

active in medical institutions through most of the twentieth century. Even the idea of spiritual care is not necessarily new. For instance, as early as 1909, the Buddhist medical hospital established by the Sōfu Senyōkai had set as its goal "to heal the illnesses of the body and *kokoro* [*shinshin nimen*] through the mutual interdependence of the medical way and religion."[104] A longer historical perspective shows that concern and care for the *kokoro* of patients was fundamental to religious involvement in modern medicine from the very beginning.

CONCLUSION

The history of Japanese religious engagement in medical welfare during the long twentieth century helps illuminate several themes that underlie the practice of spiritual care in the Japanese hospice today. First, it shows how Buddhist engagement in medical welfare, and social welfare more broadly, continues to be motivated by a desire to play a "healthier" role in Japanese society. From Meiji era Buddhist reformers like Inoue Enryō to a contemporary Zen priest turned doctor like Tsushimoto Sōkun, over the course of the twentieth century, Buddhists have continued to decry their own lack of social engagement and blame themselves for having "abandoned" their original mission of compassion and charity. Even while emphasizing their "failures," at the same time, the leaders of the Buddhist hospice movement have also turned to premodern precedents, such as the practice of deathbed rituals, to underscore their historical expertise in care for the dying. The historical continuity between premodern and modern Buddhist medical welfare and between deathbed rituals and contemporary hospice care is largely imagined. Instead, modern notions of medical welfare are more closely linked to ancillary developments that began in the Meiji period, including the spread of modern medicine, urbanization, industrialization, and political policies that undercut the authority of local Buddhist temples. Nevertheless, Buddhist historical expertise in matters of health and care for the dying more broadly provides a powerful discursive tool to combat modern stereotypes and has spurred a vocal minority of Buddhists to attempt to carve a vocational niche for themselves in the field of hospice care as well as in medical welfare activities.

Strangely enough, although the Vihāra movement is predicated on an effort to shed the funerary image of Buddhism, it also continues to promote Buddhist expertise in matters related to death. In this regard, one of the peculiarities of the Vihāra movement is the absence of a rationale for Buddhist engagement in hospice care based on the fact that they were already the undisputed authorities on funerary matters. In fact, many Buddhist chaplains I spoke with mentioned how patients and families would often consult them for advice on funeral arrangements. Funerals can even become an important site for bereavement care. At the 2015 Buddhist Nursing Vihāra Conference, for example, a Nichiren priest reported on his efforts to provide bereavement care to family members at funerals.

This included arriving about two hours earlier than normal in order to talk with family members and giving sheets of paper to attendees to write down memories of the deceased during the wake. This priest also tried to pay greater attention to his tone when speaking and generally tried to make the funeral ceremony a more supportive space for bereaved family members to deal with their grief. However, the Vihāra movement has largely avoided making a public case for involvement in hospice work on the reasoning that they are already funerary specialists. Presumably, this is because the Vihāra movement portrays itself as an antidote to negative stereotypes that surround the priest's vocation as a postmortem funerary and memorial ritual expert. Hence, the importance of hearkening back to deathbed rituals to show that Buddhists originally played a role in care for the dying, and not just the already dead.

Another theme in the history of medical welfare and hospice care in Japan is the important role played by religious hospitals, and particularly Christian hospitals, which helped establish and popularize hospice and spiritual care. Christian medical missionaries in late nineteenth- and early twentieth-century Japan played an active role in establishing medical institutions, some of which have grown to become prestigious hospitals today. Although modern medicine quickly became commonplace, Christian medical missionaries worked alongside native Japanese Christians to establish hospitals with charitable missions. These hospitals then went on to become the primary sites for the introduction of hospice care in the 1980s. Although Christian hospices today only represent 8% of all Japanese hospice wards, their pioneering efforts allowed them to play a disproportionate role in dictating the early philosophy of hospice care, and especially in developing models of spiritual care. For instance, in the early years of the Christian hospice movement, which is to say before 1995, the work of chaplains was (and in some places still is) referred to as "pastoral care." One doctor who worked in hospice care during this period suggested that "back then in Japan, spiritual pain equaled religious pain."[105] At Yodogawa Christian Hospital, which pioneered hospice care in Japan, the chaplain's office was originally known as the Evangelization Department (Dendōbu) before later adopting the less imposing appellation of Chaplain's Office (Chapurenshitsu). Christian doctors like Kashiwagi Tetsuo were also influential in framing the importance of hospice care in terms of the mission statements espoused by their hospitals. This early institutional history of hospice care is key to understanding contemporary debates on how spiritual care should be defined and practiced. The prominent role played by Christian groups also helps explain why Buddhists labeled their work with the Buddhist term "Vihāra," as they initially sought to establish their own separate Buddhist model of hospice and spiritual care.

More broadly, the history of medical welfare and hospice care in Japan also shows how religious groups in Japan looked to such engagement, both to show their own healthy role in society and to live out their religious commitments

of showing compassion and charity to those in need. This emphasis on healthy engagement intensified after 1995, a year when two events—the Hanshin earthquake and Aum Shinrikyō's sarin-gas attack on the Tokyo subway—had seismic repercussions for religious groups by promoting extremely negative views of religion. As public interest in the practice of *kokoro* care for victims of trauma expanded, religious workers began forming spiritual-care training programs that would allow them to enter and shape modern medical spaces in new ways.

In closing, it is important to note that even as religious professionals try to expand the vocation of hospice chaplaincy and are vocal about the benefits of spiritual care, religious engagement in medicine remains a small field within Japan's much larger religious landscape. For instance, the Nichiren-shū Vihāra Network was founded in 2001 and its website lists its various activities, regular reports, and upcoming lectures on spiritual care for the suffering and dying. It even sells hand towels (which are ubiquitous in Japanese gift giving) inscribed with their logo. But despite the estimated thirteen million Nichiren parishioners in Japan, only a total 7,801 homepage visits were recorded on their website in 2017.[106] This suggests that there is a danger in overstating the actual interest that some religious groups have in actualizing programs of care for the dying at a broader level. As Levi McLaughlin has noted, even though the Japanese media has increasingly sought to valorize the work of religious groups in psychotherapeutic activities, these depictions are often "curated" and can even serve to marginalize "religious actors who do not fit a sanitized discourse deemed acceptable for public consumption."[107] In other words, although the work of religious groups in care for the dying or other medical and psychotherapeutic activities is often highlighted in the media, by scholars of religion, and in the websites and publications of religious groups themselves, it is important to bear in mind that these activities do not reflect the views or activities of all its members, and especially marginalized religious groups. Even so, the alacrity with which some parts of the Japanese media and academic establishment have embraced the vision of religious care for the dying is remarkable to see. A mere two decades ago, the public image of religious groups was at an all-time low. Yet public opinion may be slowly shifting—perhaps in part because of the efforts of spiritual care staff who have worked to advance a vision for religion to play a healthy role in Japanese society.