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Last Thoughts

I had just finished my last interview for the day. As I slipped my notes into a clear file and returned the recording device to my bag, the nurse I had been speaking with lingered in the room. I sensed she wanted to ask me something.

Sure enough, she soon blurted out, "Have you ever met someone who committed suicide?"

I was caught off guard. "You mean like a patient?"

"Yes. In your past dealings with patients, have you ever met someone like this?"

I racked my brain. "Umm . . . well let me see. I've met many patients who told me they wanted to hurry up and die. But I don't think I've ever met a patient who actually did it. Some patients have told me that in the past they tried to commit suicide. Why do you ask? Have you?"

It was only when I looked up at her that I realized she was staring at me intently. I did not notice it right away, but her eyes were beginning to water behind her glasses. "Yes . . . before I came here."

"Was this something that motivated you to work in the hospice?"

"Yes . . . " She paused. It finally dawned on my dull brain that she was on the verge of crying. "Kind of." I waited for her to go on, but she smiled with embarrassment as she removed her glasses and wiped her eyes with a finger. There was a long pause, and I tried to give her some space. I resumed packing up my things and tried to think of something to say. She looked out the window at the gray clouds and changed the subject.

"Did you come in the rain?"

"Yes, I did."

"Do you live far away?"

"Actually, I live on this train line. In fact, my wife grew up in this area."

"Oh, wow. That's nice."

My bag was packed and I wanted to return to her question, but I wasn't sure how. I reached down and picked up the paper cup I had left on the table. It was still

full of lukewarm green tea. I tried to stall. "Well, I don't want to waste this." I drank a little more than half of it. But I was still at a loss for the right words. Putting the cup down, I said, "Ahh, that's nice." She laughed, and I could see that she was still wiping her eyes and trying to compose herself. After a brief pause, I thanked her again and left the room.

As soon as I left the room, I knew I had blundered spectacularly. How could I have been so stupid as to not realize that she was trying to share something very close to her heart? How could I have been so inept in my response? Something in my interview had prompted her to recall a formative experience with a patient, but the moment to let her share this story was now gone. The rain sprinkled down on me as I walked to the train station, but I didn't care. It felt appropriate. There was a gnawing sensation in my stomach. I knew that I would be haunted for a long time by the sight of her eyes brimming with tears that were filled with a deep pain.

This was not the first time during my fieldwork that a nurse or doctor began to tear up during an interview. At the end of an interview, I often asked doctors, nurses, and chaplains if they would be willing to share a story about a memorable patient. I was aware that when I asked this question, I was treading on sacred ground. Thankfully, one nurse told me after an interview that she felt relieved and healed by sharing her memories of past patients. But I knew that I was only scratching the surface. Just like patients were constrained in sharing their concerns with hospice workers, hospice workers were constrained in speaking with me. Their stories about past patients were also stories about their own deep experiences of loss.

I begin this final chapter on this note to emphasize how many stories I have left behind. As with any ethnographic effort, I am under no illusion that I have chronicled anything close to a complete picture of spiritual care in Japan. This is particularly the case in considering the final and ultimate concerns of patients. There is a certain futility in putting the actual patient's experience of death and dying into words.[1] Paul Gauguin puts it more eloquently in his 1898 masterpiece *D'où venons-nous ? Que sommes-nous ? Où allons-nous ?* (Where Do We Come From? What Are We? Where Are We Going?).[2]

Gaugin wished this painting to be his swansong. In 1897, Gauguin received word of the death of his daughter. Struggling with this news, he poured his energy into the large painting (measuring 139.1 cm × 374.6 cm), which he later claimed to be his best work and a summation of all his ideas. After completing the painting, he then unsuccessfully tried to commit suicide.[3]

The painting depicts a number of figures at different stages of life. As Gauguin later explained in a letter:

> To the right at the lower end, a sleeping child and three crouching women. Two figures dressed in purple confide their thoughts to one other. An enormous crouching figure, out of all proportion, and intentionally so, raises its arms and stares in

FIGURE 11. Paul Gauguin, *Where Do We Come From? What Are We? Where Are We Going?* (1898). Photograph © 2023 Museum of Fine Arts, Boston.

> astonishment upon these two, who dare to think of their destiny. A figure in the centre is picking fruit. Two cats near a child. A white goat. An idol, its arms mysteriously raised in a sort of rhythm, seems to indicate the Beyond. Then lastly, an old woman nearing death appears to accept everything, to resign herself to her thoughts. She completes the story! At her feet a strange white bird, holding a lizard in its claws, represents the futility of words.[4]

Sometimes we need art when words fail. Gauguin's painting poses a diachronic narrative, but it also synchronically captures everything at once. Birth and death are juxtaposed, as well as the tension between this world and the Beyond. Finally, the viewer's eyes are drawn to the "strange white bird" in the lower corner, which mutely expresses the futility of finding a clear answer to the questions Gauguin poses in the upper left corner of the canvas. According to one hospice chaplain I met in Japan, this painting deeply resonated with the dying patients he showed it to. As the phrase, "my life flashed before my eyes" conveys, imminent death can juxtapose a medley of memories and feelings that can be difficult to put into words. Gauguin's "strange white bird" reminds us that sometimes there are also wordless gaps in ethnography that are not meant to be filled. This is where art comes in. Great artists can create works where even opposites are coherently contained in the same space.[5] Unfortunately, I am no artist. In these last pages, however, I will try to compensate for these failings by reviewing some of the main themes from this study in my own rough, broad strokes.

THE "HEART" OF JAPANESE RELIGION

At the beginning of this book, I posed a question: since most Japanese pray at a Shinto shrine, get married in a Christian chapel, lead a secular life, and have a Buddhist funeral, what role does religion play at the end of life? The question of how religious beliefs and practices connect in contemporary Japan's mostly secular society has been something of a puzzle for scholars of Japanese religions for some time. Yet sometimes the puzzle is only in the eye of the beholder. For example, after hearing this saying for the first time, one of my Japanese university students was intrigued. She told me, "I had never thought of that." In other words, the common Japanese religious or nonreligious disposition only becomes a puzzle when it is transposed into a question that identifies distinctive modes of religious belief and practice. For many "nonreligious" Japanese who still take part in such religious activities, there is no puzzle at all. Rather, religion organizes life in Japan in subtle ways.[6] It rings in the New Year, it sets the schedule for summer vacation, and it presides over many of life's most important transitions. It is unconsciously omnipresent and yet consciously remote at the same time. None of this is typically felt as a contradiction for those who participate in it.

This puzzle plays out in a similar way in hospice care as well. For some hospice patients, religion not only organizes their life, but also helps them transcend or

overcome deep-held anxieties in the face of death. Such patients provide a particularly important rationale for legitimizing the religious work of chaplains, who sometimes struggle to articulate their role in the hospice to other medical workers. Patients who openly find comfort through religious support also offer chaplains validation of their suspicion that perhaps other patients may have latent or repressed religious concerns that require care.

But most hospice patients rarely talk about religion at all. Patients are far more likely to express anxiety about being a burden on their family and dismiss existential concerns that "cannot be helped." In practice, chaplains and other hospice staff usually conduct a type of spiritual care that eschews explicitly religious support in favor of helping patients "be themselves" by supporting the *kokoro* of patients in relatively pedestrian—but still meaningful—activities and through the maintenance of relationships that help the patients feel valued and appreciated at the end of life. This is not to deny that patients who self-identify as not religious necessarily fail to appreciate religious care. Many such patients told me about how much they enjoyed listening to the Buddhist sermons or listening to hymns that reminded them of the Christian schools they had attended in their youth, or of celebrating various religious holidays in the hospice. Such comments reinforce the conclusions drawn by Jesse LeFebvre in his study of Christian wedding ceremonies in Japan, where he argues that most Japanese simply define themselves as "not religious" (*mushūkyō*) to signal their distance from religious behaviors that are considered "deviant, atypical, or extraordinary." What most Japanese mean when they say they are "not religious" is merely that they are not cognitively committed to any one particular religious tradition; nonetheless, they may still participate in a variety of religious activities with affective sincerity and often do so through the work of religious professionals who offer an eclectic range of religious services to them.[7]

The importance of the affective dimensions of religious practice in Japanese society also helps explain why spiritual care is often centered on supporting the *kokoro* of patients. The *kokoro* serves as the seat of feelings, but it also symbolizes the mind and the self. Kawaii Hayao, who introduced Jungian psychotherapy in Japan, famously described this reluctance to identify with one religion as the "empty center" (*chūkū kōzō*) that lies in the *kokoro* of many Japanese persons.[8] While Kawaii is prone to overstate the uniqueness of the Japanese psyche in ways that calls for cautious analysis, there is something to be said for the explanatory power of the image of an open *kokoro* that is circumscribed by occasional participation in and affective appreciation for a broad range of religious practices. In such ways, the puzzle of religion at the deathbed in Japan challenges the penchant to measure Japanese religious identity or affiliation in terms of belief and practice and demonstrates the need for more analysis of the role that feelings play in the forming of Japanese religious and nonreligious identities.[9]

RETHINKING SPIRITUALITY AT THE END OF LIFE

This study has also sought to cast a critical eye on the concept of spirituality as it is employed in academic and clinical scholarship on Japanese hospice care. Namely, I have shown how the term "spirituality" serves to negotiate the flexible boundaries between religion and the secular to legitimize and valorize the role Japanese religious workers play in the hospice. Scholarly and clinical debates over definitions of spirituality in Japan show how spirituality and spiritual care are defined in ways that different stakeholders can sanction or prohibit the acceptable parameters of religious care for patients. In other words, the spiritual is best understood as a strategic label that negotiates the movable boundaries between the religious and the secular. It is a term that allows chaplains to manage the ambivalent nature of their work, working as religious experts who must minister to patients in nonreligious ways. The semantic ambiguities in the term "spirituality" have also created a cornucopia of definitions in professional and academic literature that seek to establish exactly what the word "spiritual" means in the Japanese clinical context. The net effect of these definitional enterprises has been a reification and medicalization of the concept of spirituality that draws lines between it and the physical and psychosocial dimensions of hospice care. Spirituality is emphasized as a dimension of personhood that all patients have—allowing clinicians to pinpoint the locus for spiritual pain. The turning of spirituality into a dimension of personhood has the advantage of turning chaplains into experts who are qualified to treat the pain emanating from a patient's spirituality. But this also calls into question whether the emphasis on the etiology of spiritual pain also undermines the very original ethos of hospice care; namely, Saunders's original call to simply treat the patient as a whole person.

By focusing on the way lines are drawn differently between spiritual and religious, this study shows some of the ways that more religious forms of care in hospice settings are either marginalized or camouflaged in practice. For instance, chaplains only rarely offer patients explicitly religious care, but rather spend much of their day providing supportive care. Framing their work as spiritual and not religious allows chaplains to utilize what Wendy Cadge calls a "strategically vague frame" that makes their work more palatable to patients, the patient families, and other medical staff members. This vague frame also occasionally creates confusion over how the chaplain's work might differ from that of a clinical psychologist. Many chaplains defend their work to medical colleagues who are confused about the chaplain's role by framing their contribution as religious experts who have something unmovable behind them that patients appreciate, as opposed to clinical psychologists who may not be able to point patients toward anything that might allow them to transcend their situation. To justify their work, chaplains cite cases of patients who report the value of having found something they could hold

on to as they approach the end of life. Although such patients are in fact few, they are important for chaplains to show that their religious training can be of aid in practicing spiritual care. In this way, the ambiguous term "spiritual" can be used to both prohibit and sanction the role religion plays in Japanese hospice care.

SPIRITUAL CARE AS A GLOBAL CONVERSATION

Another key theme of this study is that spiritual care in Japan is part of a global conversation. For instance, North American and European medical missionaries played a prominent role in helping establish Christian hospitals in Japan that later served as training grounds and influential centers for the development of models of spiritual care. Their efforts eventually spurred Buddhists to develop their own vision for hospice care through the Vihāra movement. The application of spirituality as a clinical term in Japan has also been accomplished through the circulation and appropriation of international discourses on spiritual care initiated by figures like Cicely Saunders or organizations like the WHO. Hospice pioneers and chaplains in Japan traveled widely to Britain, the United States, and elsewhere to observe and be trained in the practice of spiritual care. More recently, these conversations have spread to other parts of Asia, as Japanese hospice workers and chaplains interact with their colleagues in neighboring countries such as Taiwan and South Korea. Some of the venues for these conversations include annual conferences organized by the Asia-Pacific Hospice Palliative Care Network as well as informal visits between hospitals. Larger hospitals like Yodogawa Christian Hospital also have regular exchanges with Christian "sister hospitals" in South Korea and Taiwan. Likewise, Japanese Buddhist groups have traveled to Taiwan where Buddhists are active in providing spiritual care to hospice patients, including at the National Taiwan University Hospital.[10] In 2016, the Rinbutsuken Institute for Engaged Buddhism in Tokyo held a special tour of Buddhist chaplaincy training programs and institutions in the United States that included visits to Naropa University in Colorado and the Zen Hospice Project in San Francisco.

The global conversations between spiritual care practitioners help remind us of the important influence of globalization on Japanese religions.[11] The introduction of spiritual care to Japan is not only about the circulation of foreign ideas and practices, but is also a process in which the global and the local interact to produce something new. Cultural and religious borders are places of great resistance and production. Therefore, rather than viewing spiritual care as something that was simply imported to Japan from British hospice care or handed down to hospice workers by the WHO's definition of palliative care, we can see the "glocalization" of spiritual care.[12] Spiritual care is embedded in global discourses on the definition and practice of spiritual care and simultaneously assuming new forms in local spaces. This local context is essential to avoid portraying spiritual care as simply a foreign import to Japan. Instead, hospice workers have been active in defining

and interpreting models of spiritual care in ways that reflect the particularities of the Japanese cultural and religious context. That context includes unfamiliarity on the part of patients and hospice workers about what spiritual care actually means; the large population of hospice patients who describe themselves as not religious; and a society-wide suspicion toward the work of religious professionals in general, let alone in delicate spaces like hospices. As a result, although hospice workers are conscious of the models of spiritual care found in English-language hospice-care literature that presume the regular practice of sacramental care for religious patients or existential counsel to help find meaning at the end of life, in practice, their work follows a model that is more diffuse and supportive of the *kokoro*. That is to say, they often see spiritual care as occurring in the margins of mundane interactions or activities that help patients feel valued, often without even mentioning religion.

By framing these exchanges and negotiations between Japanese and non-Japanese ideas on spiritual care as a conversation, I have also tried to avoid projecting a narrative that sees the development of spiritual care in Japan as a Western or Christian imposition on "Japanese" forms of end-of-life care. Instead, I show how spiritual care in Japan is part of a series of cross-cultural interactions. While Christian discourses from Europe and North America have certainly played a strong role in impacting the practice of spiritual care in Japan, this impact was by no means a one-way street. For example, long before the concept of spiritual care was introduced to Japan, Japanese religious scholars like D. T. Suzuki had already played an indirect role in shaping models of spiritual care outside of Japan through his dialogue with leading figures in humanistic psychology like Eric Fromm and Carl Jung. Similarly, while Japan may be unique in some of the ways that spiritual care is practiced, this study has showed that the "heart" of spiritual care in Japan is far from invariable. Rather, it is dynamic and changing. In order to avoid these pitfalls, I have endeavored to describe spiritual care as a series of interactions, which Nicolas Standaert proposes "does not reject the concepts of impact and response, action and reaction, or means and effect, but considers them to be more descriptive and less evaluative."[13] In this way, the development of spiritual care in Japan can be seen as a series of ongoing interactions between Japan and other cultural settings where spiritual care is practiced, and also as something that is grounded in the local historical, cultural, and institutional contexts of Japanese religious engagement in medicine.

In addition to showing how cross-cultural conversations on spiritual care between Japan and other places are taking place in hospices, spiritual-care training programs, conferences, and publications around the globe, this study has also drawn attention to the importance of studying the role of Buddhist-Christian interactions in shaping the Japanese spiritual care movement as a whole. For example, the arrival of Christian medical missionaries in the late nineteenth century sparked something of a rivalry between Buddhist and Christian groups that

led to the founding of numerous religious hospitals and organizations to provide charitable medical care to the destitute and needy. By the end of the twentieth century, however, Buddhist and Christian groups were largely cooperating with the common goal of establishing a model for religious involvement in care for the dying. This was actualized through the founding of Christian and Buddhist hospices where the practice of spiritual care helped religious groups show the "healthy" role religion could play in modern medical spaces, especially in care for the dying. Religious involvement in hospice care also led to the establishment of several interfaith spiritual care training programs. These ecumenical interactions show that clinical models of spiritual care do not necessarily break down along religious lines. Some Buddhists and Christians agree on the extent to which religion should play a role in spiritual care or on how to define spirituality; others, meanwhile, disagree. This shows how contemporary spiritual care is not framed by the explicitly soteriological concerns that Buddhists and Christians have traditionally subscribed to in their care for the dying. For example, while many Buddhists trace their hospice care expertise to the premodern practice of *rinjū gyōgi* rites in which Buddhist adepts helped the dying achieve right-mindfulness at death, the connections between these two forms of care are mostly rhetorical. In practice, contemporary spiritual care is framed in inclusive psychotherapeutic language rather than through traditional soteriological terms that have denominational inflections.

FINAL WORDS

Religion in contemporary Japan is both shaping and being shaped by care for the dying in modern medical spaces. In the field of hospice care, definitions of spiritual care are marked by important tensions between the demarcation of the religious and the secular, ideals and practice, the needs of patients and the needs of hospice workers, and the assumed presence of spiritual pain in terminal patients and denials by patients about such concerns. Ethnography is a powerful tool that allows us to uncover these tensions. At the same time, there are also limits to illuminating the experiences of dying patients. Sometimes in ethnography, linguistic communication "flattens rather than evokes phenomena."[14] I, too, felt this "flattening" of the patients' experiences as they entered my field notes. The tensions and conflicting accounts that I gathered from hospice workers and patients begged for a new frame to put them in relation with each other—to account for differences and silences in their stories. I wish I could paint like Paul Gauguin, but, perhaps, some things just "can't be helped."