NOTES

PREFACE

1. “Religious identity” continues to be a fraught term in Japan (and elsewhere), where individual religious practices and beliefs are not always exclusive to one type of religion. Anna Sun helpfully distinguishes between explicit and implicit forms of religious identity. By explicit religious identity she refers to the “self-avowed identification of individuals with a specific religious tradition,” while implicit religious identity refers to “people who practice various religious rituals, beliefs, and ethics that are significant or even central to their identity and conception of a meaningful life, yet they do not necessarily acknowledge it as the source of a religious identity for cultural, historical, social, or political reasons.” This study considers both types, but especially implicit religious identity, which is more prevalent in Japan. Anna Sun, “To Be or Not to Be a Confucian: Explicit and Implicit Religious Identities in the Global Twenty-First Century,” Annual Review of the Sociology of Religion 11 (2021): 216.

1. SOUL SEARCHING IN THE JAPANESE HOSPICE

5. An important English-language exception is Susan Orpett Long’s study of end-of-life care in Japan, which remains one of the few extended ethnographic treatments of this subject. Long pays particular attention to the role of cultural scripts in determining what is a “good death” for Japanese. However, while she does discuss spiritual care in passing, it is not the focus of her study. Most of her fieldwork was also conducted in the 1990s, when hospice care in Japan was still finding its feet and attention to spiritual care was not yet widespread. Susan Orpett Long, *Final Days: Japanese Culture and Choice at the End of Life* (Honolulu: University of Hawai‘i Press, 2005). See also “Negotiating the ‘Good Death’: Japanese Ambivalence about New Ways to Die,” *Ethnology* 40 (2001): 271–89, and “Reflections on Becoming a Cucumber: Images of the Good Death in Japan and the United States,” *Journal of Japanese Studies* 29, no. 1 (2003): 33–68. Another ethnographic study in Japanese is an unpublished dissertation by Arita Megumi, who conducted fieldwork at a hospice in central Japan. Her study examined the way patients faced the end of life from the perspective of developmental psychology and showed through interviews with patients that the crises that many Japanese face prior to death tend to be less personal and more relational, having to do with how they conceive their relations to family members or society. Arita Megumi, “Shōgai hattatsu shinrigaku’ kara toraeru shi: Makki gankanja to no taiwa kara,” (PhD diss., Kyoto University, 2007). On the need for more ethnographic studies of hospice care, see Matsuoka Hideaki, “Tāminaru kea ni okeru supirichuaritī: Bunka jinruigaku kara no shiten,” *Kokusai keiei, bunka kenkyū* 12, no. 1 (November 2007): 73–85.


13. Ibid., 1.


15. Katō Akihiko has argued that half of newlyweds who were born in the 1920s chose to live with one or both of their parents compared to only 20% of newlyweds born in the 1960s. Yet, the number for both groups converged to 30% beyond the ten-year mark of marriage.
This indicates that although Japan's postwar generation initially chose to live separately from their parents, such arrangements were often temporary. In many cases, the oldest son or daughter later returned to live with his or her parents for reasons related to household succession, property inheritance, and support of their elderly parents. Kato Akihiko, “Chokkei kazokusei kara fūfu kazokusei e wa hontō ka,” in Köhoto hikaku ni yoru senso Nihon no kazoku hendō no kenkyū, ed. Kumagai Sonoko and Ōkubo Takaji (Tokyo: Nihon Kazoku Shikai Gakkai Zenkoku Kazoku Chōsa linkai, 2005), 139–54; “The Japanese Family System: Change Continuity, and Regionality over the Twentieth Century,” Max Planck Institute for Demographic Research (March 2013), accessed September 21, 2017, www.demogr.mpg.de/papers/working/wp-2013–004.pdf.


21. In Japan’s CiNii article database, the number of search hits for “palliative care” in the period from 1984 to 2021 outnumber “hospice” 9,429 to 2,641. However, in the Asahi newspaper database, the number of articles that mention “hospice” in that same period outnumber “palliative care” 4,392 to 3,027 (September 26, 2021). Hospice care is sometimes also referred to as “terminal care” (tāminaru kea), but this has largely fallen out of favor.


24. The most comprehensive account of chaplaincy training programs in Japan thus far is Fujiyama Midori’s Rinshō shūkyōshi: Shi no bansōsha (Tokyo: Kōbunken, 2020). I have largely excluded detailed discussion of spiritual care training programs and education from this study since the details surrounding the establishment and curriculum of chaplaincy training programs in Japan have begun to receive increased attention. For more on spiritual care education, see Nathaniel Michon, “Awakening to Care: Formation of Japanese Buddhist Chaplaincy,” (PhD diss, Graduate Theological Union, 2020); and Kenta Kasai, “Introducing Chaplaincy to Japanese Society: A Religious Practice in Public Space,” Journal of Religion in Japan 5, no. 2–3 (2016): 246–62.

35. Ibid., 171.
37. For instance, Shimazono Susumu describes the efforts of Japanese Buddhists to become involved in activities like spiritual care as something that society views with “potential and hope,” and asks his nonreligious readers to use the opportunity of learning about “spirituality” to rethink their understanding of themselves as “outside” religion. Gendai shūkyō to supirichuariti (Tokyo: Kōbundō, 2012), 140, 7. Likewise, Kashio Naoki, another scholar of religion, explains public interest in the topic of spirituality as connected to the “universal spiritual desires” of persons who unsuccessfully try to drown out their modern problems through technology during times of uncertainty. “Supirichuariti to wa nani ka? Gendai bunka no reiseiteki shosō,” in Bunka to reisei, ed. Kashio Naoki (Tokyo: Keio Gijuku Daigaku Shuppan, 2012), 3. Kashio has also published a book that is optimistically titled, “The Spiritual Revolution: The Potential of Contemporary Spiritual Culture and the Opening of Religion” (Supirichuariti kakumei: Gendai reisei bunka to hirakareta shūkyō no kanōsei [Tokyo: Shunjusha, 2010]). Hayashi Yoshihiro, a scholar of philosophy and religion, also expresses his hope that spirituality will serve the members of Japanese society whose...
hearts have “lost their bearings.” Toi to shite no supirichuariti: “Shūkyō naki jidai” ni seishi o kataru (Kyoto: Kyoto Daigaku Gakujutsu Shuppankai, 2011), iii.


2. THE RHYTHMS OF HOSPICE CARE

1. For example, the Japanese title of Natsume Soeseki’s famous novel Kokoro (1914) was left intact in its English translation.


13. Giving the dying water is also a ritual of parting between the family and the dying person that goes back to medieval times. It is now often symbolically reenacted during the funeral, but the rite may have arisen from the custom of moistening the mouth to facilitate the continuous chanting of the Buddha’s name (nenbutsu) at the time of death. Jacqueline I.


3. THE HEART OF PRACTICING SPIRITUAL CARE

1. Personal interview, January 22, 2015.
3. Since the role of the bodhisattva is to take on the sufferings of all beings, a bodhisattva image was seen as more appropriate for the hospice.
5. Supirichuaru kea jirei kentōshū sakusei gurūpu, ed., Supirichuaru kea jirei kentōshū: Taio ni konan o kanjita bamen to sono imi (Osaka: Japan Hospice Palliative Care Foundation, 2011), 130.
16. Shinran (1173–1263) was the founder of the Shin Buddhist sect.
17. Personal interview, January 29, 2015.


23. Even if they are not used, these religious spaces establish a certain atmosphere. For example, Nakahara Toyoko utilized James Gibson’s work on “affordances” to discuss how the physical features of the hospice were designed to “afford” patients spiritual care. Thus, an empty chair facing the Buddhist altar might invite or afford the patient an opportunity to pray even if they do not actually use it. Nakahara, “Gan kanja ga bihōra ni nyūin shi byōtō to iu kyōdōtai no kōseiin ni naru kaitei” (paper presented at the Bukkyō Kango Bihāra Gakkai, Higashi Betsuin Temple, Kanazawa, Japan, August 30, 2015).

24. A chaplain at a Protestant hospice in Kyūshū also echoed this description of spiritual care. He explained that the design of hospice facilities, small talk with patients, and various events and activities all functioned as a form of “spiritual support.” Kiyota Naoto, “Hosupisu kanwa kea ni okeru supirichuaru kea no teigi” (paper presented at the Nihon Supirichuaru Kea Gakkai Gakujutsutaikai, Kōyasan University, Wakayama, Japan, September 12, 2015).

25. Personal interview, June 8, 2015.


62–63.


32. Personal interview, July 2, 2015.


34. Barbara Carroll also examines spiritual care in Britain to suggest that for most nurses the spiritual dimension permeates all forms of care. “A Phenomenological Exploration of the Nature of Spirituality and Spiritual Care,” Mortality: Promoting the Interdisciplinary Study of Death and Dying 6, no. 1 (2001): 81–98.
4. THE MEANING OF SPIRITUAL PAIN


All but one of the interviews presented in this chapter were conducted over a six-month period in 2015, at a Protestant hospice in western Japan. Every week, I called the head nurse of this hospice to find out if any patients were available to be interviewed. Although I initially planned to speak with several dozen patients, at this particular hospice I was only able to interview eight. The lengths of interviews averaged between twenty to thirty minutes. The shortest was thirteen minutes and the longest was fifty-three minutes. All but two of the interviews were audio recorded. I also conversed informally with approximately two dozen more patients while conducting fieldwork at multiple Christian, Buddhist, and nonreligious hospices from 2014 through 2015 and the summers of 2012, 2013, and 2017. I have included one of those patients (Mizuno-san) in this chapter.


13. In general, as many chaplains explained to me, most patients are reluctant to discuss religious questions they might have. In a 2003 study that examined eleven hospice patients for evidence of spiritual distress, none of the interview data included statements related to the category of “transcendence.” Kawa et al., “Distress of Inpatients,” 488. Similar results were also found in a 2006 survey on what constituted a good death. Researchers found that of thirteen hospice patients surveyed, only two responded that having faith was important for a good death. Kei Hirai et al., “Good Death in Japanese Cancer Care: A Qualitative Study,” *Journal of Pain and Symptom Management* 31, no. 2 (February 2006): 144.


17. Personal interview, May 7, 2013.


23. Jong and Halberstadt, *Death Anxiety*, 104–5. Terror-management theory argues that since humans are aware of their own mortality, this creates existential anxiety, which is dealt with by seeking either literal or symbolic immortality. Jong and Halberstadt, *Death Anxiety*, 40.

24. This echoes several studies that suggest that while conscious or overt levels of death anxiety may be low in terminally ill patients, unconscious or covert anxieties can become slightly heightened with proximity to death. Feifel, “Religious Conviction.” See also Bert Hayslip Jr. et al., “Levels of Death Anxiety in Terminally Ill Persons: A Cross Validation and Extension,” *Omega* 34, no. 3 (1997): 203–17.
25. This is reminiscent of the story Doi Takeo tells in the opening to *The Anatomy of Dependence*. Doi is pressed by his American host to accept some ice cream, but after politely refusing at first, he is disappointed when they don’t offer it again. Doi uses this story and others to introduce how *amae* (dependence) governs Japanese social relations. *The Anatomy of Dependence*, trans. John Bester (Tokyo: Kodansha International, 1981), 11.


27. Tenrikyō is a religion that was founded in the mid-nineteenth century by Nakayama Miki (1798–1887).


30. Hoshino Tomihiro (1946–) is a well-known Japanese Christian artist and poet. A former gymnastics teacher, he was paralyzed from the neck down after an accident at the age of twenty-four. He then began painting and writing poems by holding a brush in his mouth and is known for the inspirational quality of his works that celebrate the beauty of nature and the resiliency of the human spirit.


32. Kashiwagi, “Yamu hito no tamashii,” 42.


5. THE INVENTION OF JAPANESE SPIRITUALITY


2. By invoking the “invention” of spirituality, I am consciously drawing on Jason Ānanda Josephson’s study, *The Invention of Religion in Japan* (2012). As Josephson reminds us, the provenance of “religion” (shūkyō) as a concept in Japan is quite recent. The term only gained purchase in Japan as a boundary-drawing exercise that sought to demarcate religion from other categories such as the secular, science, or superstition. It was not an unveiling of a universal academic or ethnographic category. *The Invention of Religion in Japan* (Chicago: University of Chicago Press, 2012).


5. *Suzuki Daisetsu zenshū*, vol. 8 (Tokyo: Iwanami, 1968), 18. In describing the *tamashii* as round, Suzuki may be alluding to the etymological associations between *tamashii* and *tama*, which refers to a gem or round object.


7. Ibid., 15.


9. Ibid., 264.


12. For example, mindfulness and reiki therapies based on Asian religious traditions have also traveled dialectically across the North Pacific and gained much popularity in medical settings outside of Japan. See Justin B. Stein, “Hawayo Takata and the Circulatory Development of Reiki in the Twentieth Century North Pacific” (PhD diss., University of Toronto, 2017).


21. For an overview of broader shifts in how the word “spirituality” was used and understood in Japanese popular culture, see Horie Norichika, *Poppu supirichuariti: Mediaka sareta shūkyōsei* (Tokyo: Iwanami, 2019).


33. Ibid., 180.


40. For example, see Tanida, “Supirichuaru kea,” 2.


42. Kasai Kenta traces the source of this interest to a news article published in the *Nihon Keizai Shimbun* in February of 1999. Kasai Kenta, “WHO ga ‘spirituality’ gainen no


44. WHO Expert Committee on Cancer Pain Relief and Active Supportive Care, Cancer Pain Relief and Palliative Care: Report of a WHO Expert Committee (Geneva: WHO, 1990), 50–51.


48. Ibid., 263.


51. This overlap in labor was noted as early as 1933 by Carl Jung in a book chapter titled “Psychotherapists or the Clergy.” C. G. Jung, Modern Man in Search of a Soul, trans. W. S. Dell and Cary F. Baynes (New York: Harcourt, 1933).


55. Ibid., 166.


57. Cadge, Paging God, 129.

58. Katia Garcia Reinert and Harold G. Koenig, “Re-examining Definitions of Spirituality in Nursing Research,” Journal of Advanced Nursing 69, no. 12 (2013): 2622–34. This concern reflects the high amount of religious care that is provided to patients in North America. Koenig, King, and Carson argue that to avoid confusion with psychological care, definitions of patient spirituality should be limited to only those who are pursuing a “religious way of life” or the “transcendent.” If this definition was applied in Japan, however, there would be very few instances of “spiritual care” left to consider. Harold G. Koenig, Dana E. King, and Verna Benner Carson, Handbook of Religion and Health (New York: Oxford University Press, 2012), 46–47.


62. For instance, the well-known Davidic psalm, “The Lord is my shepherd” (Psalm 23), includes the line “He [the Lord] restores my *tamashii*.”
64. Kashiwagi, “Yamu hito,” 42.
70. Kashiwagi, “Yamu hito no tamashii,” 39. As recently as 2015, when pressed, Kashiwagi still admitted a preference for the word *tamashii*. Panel Discussion, Japan Society for Spiritual Care Annual Conference, Koyasan University, Wakayama, September 13.
72. Ibid., 33–37.
73. In his native German, Kippes focuses on *geist* (spirit) rather than *seele* (soul) as the locus of spiritual care. In Germany, spiritual care is most commonly referred to as *seelensorge* (lit., soul care), which is conducted by a *seelensorger*. Kippes is no doubt aware of this but chooses to focus on the alternative term for chaplain, *geistlicher*, which allows him to make his point about the centrality of the *geist* as the object of spiritual care. Kippes, *Supirichuaru kea*, 156.
76. Ozawa later began refraining from using this diagram in presentations after readers began to mistakenly attribute it as reflective of Murata’s original theory. Ozawa now prefers to emphasize the importance of interpersonal spiritual care that is more dialogical and not just supportive. Personal communication, September 29, 2021.
78. Ibid., 43.

83. Ibid., 14–17.


85. Kubotera Toshiyuki, “Supirichuara na mono e no tamashii no sakebi,” in Iyashi o motomeru tamashii no kawaki: Supirichuariti to wa nanika, ed. Kubotera Toshiyuki and Hirabayashi Takahiro (Hyogo: Kwansei Gakuin Daigaku Shuppan, 2011), 151, 152, 158. This is also echoed by other authors. For example, Hirayama talks about the “work” (hataraki) of spirituality. Hirayama Masami, “Hitan to supirichuara kea,” in Iyashi o motomeru tamashii no kakwaki, ed. Kubotera Toshiyuki (Saitama: Seigakuin Daigaku Shuppankai, 2011), 124, 126.

86. The nominalization of “spiritual” is important since it suggests that it is a discrete “thing.” As an adjective, the “spiritual” becomes thinner, and its meaning becomes wider. Andō, “Supirichuariti’ gainen no saikō,” 8–9.

87. Taniyama defines “principles” as: “the truth of the universe and nature’s providence”; “the sun, moon, and stars”; “transcendental functions such as dharma, higher power, and the work of the holy spirit”; and “ideals, thought, morals, ethics, mottos.” Taniyama Yōzō, “Supirichuara no kōzō: Kubotera riron ni Nihon no bukkyōsha no shiten o kuwaeru,” in Zoku, supirichuara kea o kataru, ed. Kubotera Toshiyuki and Hirabayashi Takahiro (Hyogo: Kwansei Gakuin Daigaku Shuppan Kai, 2009), 77–98.


91. Taniyama, Panel Discussion, Japan Association for Buddhist Nursing and Vihāra Studies Annual Conference, Kanazawa, August 29, 2015.


95. Ibid., 15.


98. Birth of the Clinic, 112.


100. Ibid., 89. For a classification of the positions taken by various hospice practitioners over definitions of spirituality and models of spiritual care in Japan, see Uchimoto Kōyū, “Supirichuaru kea no gengoronteki tenkai” (PhD diss., Momoyama Gakuin Daigaku, 2014).


102. Ibid., 11.


111. For example, Morita et al., “Existential Concerns.”


114. The imperative to treat the whole person is also found in the writings of the influential Swiss physician Paul Tournier, author of Médicine de la Personne (1940). Tournier relates a story of someone who asked him whether his idea of médecine de la personne would be better expressed as médecine pneumo-psychosomatique, an expression that would add “spiritual” to the idea of patients as “psychosomatic” beings. Tournier voiced his opposition to this idea, claiming that “psychosomatic” was bad enough. Dividing patients even further into three dimensions, the “spiritual, psychological, and somatic,” went against the whole point of his endeavor—to treat those under his care as whole beings. Paul Tournier, Jinsen o kaerumono: Tournier no sekai, trans. Yamaguchi Minoru (Tokyo: Yorudansha, 1987), 68.
1. Tsushimoto Sōkun, Zensō ga ishi o mezasu riyū (Tokyo: Shunjusha, 2001), 120.


5. For example, John Nelson cautions that mainstream Japanese temple Buddhism that fails to “engage” society in new ways is “at risk of becoming roadkill on the freeway leading to a more globalized world.” This gives the impression that up until recently Buddhists were not “engaged” or “experimental” enough. Nelson, *Experimental Buddhism*, 19. For more on socially engaged Buddhism, see Jessica L. Main and Rongdao Lai, “Introduction: Reformulating ‘Socially Engaged Buddhism’ as an Analytical Category,” *Eastern Buddhist* 44, no. 2 (2013): 1–34.


8. Scholars such as Tsuji Zennosuke, Asano Kenshin, Moriya Shigeru, Ikeda Masatoshi, Yoshida Kyūichi, Hasegawa Masatoshi, Tamiya Masashi, and Miyagi Yōichirō have carefully documented charitable works by premodern Buddhists, often glossing them as early examples of social work. For example, Prince Shōtoku (574–622) is often touted as the progenitor of Buddhist social and medical welfare. In addition to helping introduce Buddhism to Japan, Prince Shōtoku is credited with the construction of Shitennoji, Japan’s oldest temple, which included a dispensary (*seyakuin*), hospital (*ryōbyōin*), and home for the needy (*hidenin*) on its premises. Tanaka Takashi, “Shitennoji goshuin engi no seiritsu o ronjite honpō shakai jigyō shisetsu no sōshi ni oyobu: Shōtoku Taishi to Shitennōji shikoin,” in *Bukkyō to fukushi*, ed. Tamiya Masashi, Hasegawa Masatoshi, and Miyagi Yōichirō (Tokyo: Keisuisha, 1994), 153–72. Scholars also invoke figures like the peripatetic priest Gyōki (668–749), who helped construct shelters (*fuseya*) for the elderly, travelers, the poor and the sick, or Empress Kōmyō (701–760), who helped construct a dispensary at the temple Kōfukuji in 730. Moriya Shigeru, *Bukkyō shakai jigyō no kenkyū* (Kyoto: Hōzōkan, 1971), 189–98. Other figures often cited as examples of premodern Buddhist engagement with medical welfare include Chōgen (1121–1206), who built temple baths that were open to the poor and sick, while Ninshō (1217–1303) is said to have dedicated much of his life to the construction of...


10. For more on Asano’s views on Buddhist social work, see Murota Yasuo, *Jinbutsu de yomu shakai fukushi no shisu to riron* (Kyoto: Minerva Shobō, 2010), 142–48.


18. Of the total number of medical workers, three-quarters were doctors and the remainder included other workers such as nurses, dentists, pharmacists, teachers, and caregivers for sufferers of leprosy. The medical missionaries represented over twenty different denominations, with the greatest number being sent out by the Protestant Episcopal Church, the American Board of Commissioners for Foreign Missions, and the Presbyterian Church in the United States. For a list of medical missionaries during this period, see Soda Hajime et al., eds., *Igaku kindai to rainichi gaikokujin* (Osaka: Sekai Hoken Tsūshinsha, 1988), 155–73. For a historical overview and timeline of Christian social and medical work in Japan, consult Abe Shiro and Okamoto Eiichi, eds., *Nihon kirisutokyō shakai fukushi no rekishi* (Tokyo: Minerva, 2014); and Yajima Yutaka, *Meijiki Nihon kirisutokyō shakai jigyō shisetsushi kenkyū* (Tokyo: Yūzankaku Shuppan, 1982). Also see Elisheva Avital Perelman, “The Exponent of Breath: The Role of Foreign Evangelical Organizations in Combating Japan’s Tuberculosis Epidemic of the Early 20th Century” (PhD diss., University of California, Berkeley, 2011); and Hamish Ion, *The Cross and the Rising Sun, Volume 2* (Waterloo, Ontario: Wilfrid Laurier University Press, 1993), 177–79.


22. James Hepburn also records that he averaged about one hundred patients a day when he opened his first dispensary in 1861. Later in 1867, he reduced his hours to a few hours in the morning and saw an average of fifteen to twenty patients daily. By 1876, his dispensary was only open on Saturday with an average of sixty patients per week. J. C. Hepburn and Michio Takaya, *The Letters of Dr. J. C. Hepburn* (Tokyo: Tōshin Shobō, 1955), 48, 93, 141.


27. Taylor estimates that the total amount spent on medical charity in the Japanese empire (pop. 44 million) was between US$72,500 and $75,000. This compares to US$50 million for the United Kingdom (pop. 39 million) and US$80 million spent for the United States (pop. 80 million). Taylor, “Medical Work,” 545.

28. He does mention several exceptions: “Dr. Ando of Kioto has kept up a free Charity Dispensary for the poor and indigent for the last seventeen years,” as well as the Charity Hospital of Tokio [Tokyo] (Jikei Byōin), another free hospital for the poor and indigent. Taylor, “Medical Work,” 546.


30. For example, missionaries Hannah Riddell and Nellie Cornwall Legh pioneered leprosaria in Kyūshū and Kusatsu; A. M. Tapson founded a home for tubercular patients in Tokyo, and John G. Waller helped build what would later become New Life Hospital in Nagano in 1932. The Salvation Army also built two hospitals in Tokyo in 1916 and 1939. Hasegawa Tamotsu, who was inspired by the work of Christian social relief activists like Ishii Jūji and Kagawa Toyohiko, also helped found the Seirei Mikatahara Hospital in 1930.


32. In 1890, the Buddhist Charity Association (Bukkyō Jizenkai) was formed to provide relief to those who could not afford medical care. Other examples include the Hakonishi Dōwakai Seyakuin in Shizuoka (1889); the Hijiri Kai in Aichi (1890); the Kyoto Seyakuin (1890); the Dainihon Seyakuin in Nagoya (1893). Nakanishi, *Bukkyō to iryō*, 23–27; *Meikyō shinshi*, July 20, 1890. Buddhist charity associations established include: Dai Nihon Bukkyō Jizenkai Zaidan (Shin Jōdo Honganji sect, 1901); Ōtaniha Jizen Kyōkai (Shin Jōdo Ōtani sect, 1911), and the Jōdo Hōon Meishōkai (Jōdo sect, 1914). Nakanishi, *Bukkyō to iryō*, 146.


34. *Kyōsai* 4, no. 3 (1914): 50.

35. Yoshida, *Nihon kindai bukkyō* (ge), 139.

36. Ibid. In 1902, the Jūzen Hospital in Tokyo was also launched with Shingon backing and provided subsidized medical treatment for needy patients. Nakanishi, *Bukkyō to iryō*, 36–37; Yoshida, *Nihon kindai bukkyō* (ge), 141. In the same year, the Nihon Himmin Hospital was founded by Yoshida Eryū, an apprentice to a Nichiren priest, with the express purpose of treating the destitute. Nakanishi, *Bukkyō to iryō*, 37. Likewise, in 1911, the Waseda Hospital was established by the Jōdo Shin sect and began subsidizing treatment for needy patients. Yoshida, *Nihon kindai bukkyō* (ge), 142. Other examples of Buddhist charity hospitals include the Teikoku Kyūjōin (Shin Jōdo, 1907); Sensōji Hospital (Tendai, 1910); the Higanin (Shingon, 1914); and the Bukkyō Kyōsaisha Hospital (Sōtō, 1914). Nakanishi, *Bukkyō to iryō*, 58–62.


40. Yoshida Kyūichi, Nihon kindai bukkyō shakaishi kenkyū (Tokyo: Yoshikawa Kōbunkan, 1964), appendix. Of these, twenty-four are listed as providing medical care and fifteen as medical dispensaries. Four of the medical institutions were located in Japan’s overseas colonies in Taiwan and China.

41. Murai Ryūji builds on Yajima’s list to record 155 Christian institutions during the Meiji period. Twenty-five are listed as providing medical care, but he does not record the number of dispensaries. Murai Ryūji, “Bukkyō shakai fukushi gaku ni okeru jinbuntsushi kenkyū: Meijiki bukkyō jizen jigyō no jissensha o chūshin ni,” NBSFG 22 (Oct. 1991): 161–74.

42. According to Morinaga, in 1917 Buddhist social work institutions outnumbered Christian ones 140 to ninety. By 1930, they outnumbered Christian facilities 4,848 to 1,493. Morinaga Matsushin, Bukkyōsha no shakai fukushi katsudō, in Gendai bukkyō o shiru daijiten, ed. Gendai Bukkyō o Shiru Daijiten Henshū Iinkai (Tokyo: Kinkasha, 1980), 371. See also Covell, Japanese Temple Buddhism, 99–101. Nakanishi Naoki finds a similar disparity: in 1920, there were 387 Buddhist social work organizations. By 1926 this number had more than tripled to 1,234, and by 1929 the number quadrupled to 4,849. Significantly, in 1920 only 39% of these organizations were sectarian. However, the number of sectarian organizations rose to 48% in 1926 and 88% in 1929. The large jump in numbers between 1926 and 1929 was due to the inclusion of the additional categories of educational activities (476) and kyōka katsudō (3,042) in the 1929 survey. Nakanishi Naoki, Takaishi Fumito, and Kikuchi Masaharu, eds., Senzenki bukkyō shakai jigyō no kenkyū (Tokyo: Fuji Shuppan, 2013), 7–12.


44. Ibid., 64.


47. For example, James Hepburn opened his first dispensary and hospital at Shūkōji temple in 1861, and Ishii Jūji began his well-known orphanage on the grounds of Sanūji temple in Okayama in 1889. Hepburn and Takaya, The Letters, 44–45.


51. C. Darby Fulton to Dr. K. Kimura, June 26, 1953, Japan Mission Records.

52. Crane, A Legacy Remembered, 401.


55. Some examples of postwar Buddhist medical work include the Shinshū Social Work Association (Shinshū Shakai Jigyō Kyōkai), which helped establish the Obihiro Shinshu Hospital (1949) in Hokkaido. In 1955, Tōdaiji temple also established a foundation for promotion of social welfare and established what would eventually become the Tōdaiji Medical and Educational Center. Ochiai Takashi, “Iryō fukushi,” in Sengo bukkkyō shakai fukushi jigyō no rekishi, ed. Hasegawa Masatoshi (Kyoto: Hōzōkan, 2007), 165–68.

56. Hasegawa Masatoshi has also compiled a survey of social welfare institutions across Buddhist sects based on sectarian reports, but the numbers seem unreliable. He lists a total of five Buddhist medical institutions, but it is not clear why a Red Cross Hospital in Wakayama and elderly daycare center in Osaka are listed as Buddhist hospitals. His sources also only cover up to the year 2000 and omit several Buddhist hospitals. Sengo bukkkyōkei shakai fukushi shisetsu, dantai ichiran; Bukkyōkei shakai fukushi jigyō, katsudō tōkei ichiran (Chiba, Japan: Shukutoku Daigaku Hasegawa Kenkyūshitsu, 2003).

57. Funamoto Yoshide, “Bukkyōkei shakai fukushi shisetsu no genjō to bukkyō shakai fukushi jissen no shishōteki kiban: Jōdo shinshū honganjiha shakai fukushi shisetsu jittai chōsa hōkoku (gaiyō),” in Gendai ni ikiru bukkyō shkai fukushi, ed. Hasegawa Miyuki (Kyoto: Hōzōkan, 2008), 200.

58. For example, the Asoka Hospital (est. 2008) and Sensōji Hospital (est. 1952) in Tokyo.


60. Of these Christian hospices, fourteen were established at hospitals established in the prewar period (1889–1945). These data were compiled from the Kirisutokyō nenkan 2017, and the July 2017 list of hospice facilities on the Hospice Palliative Care Japan website, accessed July 2017, www.hpcj.org/list/relist.php. I am also deeply indebted to Taniyama Yōzō for sharing his personal list of religious hospices with me.


64. Kashiwagi, Teihan hosupisu, 14–15.

65. Ibid., 38–39.


74. According to Tamiya, the first published usage of this term was in his 1986 article: “Bukkyō o haikai to shita hosupisu/bihāra (Vihāra) no kaisetsu o negatte,” Life Science 13, no. 1 (1986): 56–59.
75. Tamiya Masashi, Bihāra no teishō to tenkai (Tokyo: Gakubunsha, 2007), 4–5.
76. Tamiya, Bihāra no teishō, 7.
79. Tamiya, Bihāra no teishō, 36.
80. Ibid., 80.
82. Ugo Dessi, Ethics and Society in Contemporary Shin Buddhism (Berlin: Lit Verlag, 2006), 189.
83. NHK Special, “Furusato inochi no hibi: Nagaoka bihāra byōtō no ichinen,” May 9, 1993.
84. There are, however, some indications that family members of patients are leaving Vihāra wards with a more positive view of Buddhism. Murase Masamitsu, “Kanwa kea byōtō ni okeru bukkyōsha no hyōka: Izoku chōsa kara,” NBSFG nenpō 42 (November 2011): 1–13.
88. JSHS, “Bihāra no ayunda zosen,” 41.
89. Ibid., 18–31.
90. The “21” in their name refers to the twenty-first century, further attesting to their reformist vision. There is also a Vihāra Konomien nursing home in Osaka.
93. For examples of handwringing by religious figures, see Nakamaki Hirochika and Tsushima Michihito, Hanshin daishinsai to shūkyō (Osaka: Tōhō Shuppan, 1996).


96. Asahi Shimbun, “Makki kanja.”


100. The word “clinical” (rinshō) literally means “bedside.”


104. Yoshida, Nihon kindai bukkyō shakaishi kenkyū (ge), 138.

105. Personal interview, January 22, 2015.

106. Accessed December 2017, www.nvn.cc. In October 2015, the counter recorded just over 6,500 visits. In September 2021, the number had reached 10,430. This suggests that the website averages about one thousand visits (not unique visitors) a year. This includes over a dozen of my own visits to the website.


7. LAST THOUGHTS


2. See https://collections.mfa.org/objects/32558 for a digitized image of the painting.

3. Albert Boime, Revelation of Modernism: Responses to Cultural Crises in Fin-de-Siècle Painting (Columbia: University of Missouri Press, 2008), 141.


7. LeFebvre, “Christian Wedding Ceremonies,” 201. LeFebvre draws on the methodology of Ian Reader and George Tanabe’s distinction between cognitive and affective expressions of religious practice. For more on this distinction, see Reader and Tanabe, Practically Religious, 129.


13. Nicholas Standaert observed in his analysis of the cultural transmission of Christianity to China that models predicated on the success or failure of a cultural transmission suffer from two pitfalls: impact-response and essentialism. By impact-response Standaert refers to the assumption that the incoming transmission had an active role that impacted the passive entity. By essentialism Standaert refers to the propensity to mark a cultural entity as having a quasi-invariable essence. Nicolas Standaert, “Christianity in Late Ming and Early Qing China as a Case of Cultural Transmission,” in *China and Christianity: Burdened Past, Hopeful Future*, ed. Stephen Uhalley Jr. and Xiaoxin Wu (Armonk, NY: M. E. Sharpe, 2001), 88–89.