“A wonderful contribution to the emerging discussion on how to develop spiritual, compassionate support for the dying in our society.”

—Anyen Rinpoche, author of Dying with Confidence

“Watts and Tomatsu provide an unprecedented look into modern Buddhist practices of caring for the dying and bereaved. This book is an indispensable field manual for contemplative caregivers, and a must-read for anyone drawn to end-of-life care.”

—Cheryl A. Giles and Willa B. Miller, editors of The Arts of Contemplative Care

“A valuable and amazing resource! These incisive accounts from different cultures offer crucial lessons on what has been lost and gained in our understanding of care of the dying over the past hundred years. This collection is a must for those of us involved in chaplaincy care.”

—Pat Enkyo O’Hara, guiding teacher at the New York Zen Center for Contemplative Care

SINCE ITS BEGINNING, Buddhism has been intimately concerned with confronting and understanding death and dying. Indeed, the tradition emphasizes turning toward the realities of sickness, old age, and death—and using those very experiences to develop wisdom and liberating compassion. In recent decades, Buddhist chaplains and caregivers all over the world have been drawing on this tradition to contribute greatly to the development of modern palliative and hospice care in the secular world at large. Specifically Buddhist hospice programs have also been further developing and applying traditional Buddhist practices of preparing for death, attending to the dying, and comforting the bereaved.

Buddhist Care for the Dying and Bereaved contains comprehensive overviews of the best of such initiatives, drawn from diverse Buddhist traditions, and written by practitioners who embody the best of modern contemplative hospice care programs practiced all over the world today.
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Introduction

Jonathan S. Watts

Buddhist Care for the Dying and Bereaved: Past and Present

Buddhist understandings of death and of practices developed for dying and the specific moment of death have been hallmarks of the tradition since its beginning in India twenty-five hundred years ago. Over the last forty years, they have been an important part of the global revival of Buddhism, especially in the West—from the popularization of the Tibetan Book of the Dead, to Zen poetry about death, to Theravadan meditation on the decaying body, to belief in the welcome of Amida Buddha on one’s deathbed. Today there is a plethora of new titles by various authors on how to use Buddhist teachings and practices to face death and the dying of loved ones—a quick search for “Buddhism” and “death” on amazon.com pulls up 543 entries. These entries by and large focus on how an individual or family member can face and prepare for death, either as an inner journey or as a journey with intimate relations.

Relatively little is known, however, about the number of Buddhist-based initiatives for caring for the dying and bereaved that focus on the development of trained professionals and the building of facilities, though these facilities have mushroomed since the late 1980s. While a number of these initiatives have been created by high-profile Buddhist teachers, like Sogyal Rinpoche and Joan Halifax, who have written heart-moving books on death, their initiatives and others are not as highly publicized in the mass media. In fact, when one
even speaks of “hospice” one is drawn back to its Christian origins in eleventh-century Europe—the Irish nun Mother Mary Aikenhead (1787–1858) and the Religious Sisters of Charity, who created the modern hospice archetype; and Dame Cicely Saunders, the Anglican nurse who founded the first modern hospice, St. Christopher’s Hospice, in London in 1967. As we will see in this volume, Saunders has had an especially major impact on the Buddhist hospice movement around the world.

The modern-day Buddhist hospice movement is, however, one with a long historical precedent. The Vihara Movement in Japan has consciously named itself using the traditional and ancient Buddhist term for “temple,” vihara. Like the term “hospice,” vihara has also had the meaning of a place for travelers to take rest in addition to a place that might offer social welfare and medical care for the poor. Rev. Yozo Taniyama explains in his chapter how the famous Jetavana Vihara established by the historical Buddha himself eventually developed into such a comprehensive center for spiritual, economic, and medical care. The great Indian monarch, Ashoka (r. 270–232 BCE), who is credited with first unifying the Indian subcontinent under one rule, was also known to have promoted the development of herbal medicine and dispensaries through Buddhist temples. This tradition of social service by Buddhist temples, first established in India, eventually spread throughout the Buddhist world. Japan, the last frontier of the ancient spread of Buddhism, inherited this tradition from the beginning with the establishment of Shitenno-ji temple in present-day Osaka in 593. Shitenno-ji was not only the first officially administered Buddhist temple in Japan but also included a hospital, a poor house, and a pharmacy that grew and cultivated medicinal plants. In this way, there is a long-standing template for Buddhist institutions serving as centers of care for the ill and dying.

The historical Buddha himself offers an original template for the role of the Buddhist caregiver. One of the Buddha’s epithets is the “Great Physician”—which refers to his core teaching of the Four Noble Truths examining the nature of suffering as dis-ease, its causes,
its cure, and the course of cure. There are also numerous examples of the Buddha and his close disciples guiding both ordained persons and laypersons through painful physical illnesses to illumination on their death beds; these stories serve as the primary Buddhist template for dying with a monk as a deathbed counselor (in Sanskrit, *kalyanamitra*). However, two striking examples show the Buddha as much more than a deathbed counselor. The first is the story of the monk Putigatta Tissa, who had become gravely ill and had festering sores that emitted smells so foul that all his fellow monks abandoned him. The Buddha, upon finding out about his situation, not only admonished the other monks to care for him but also was the first to go clean his body, his robes, and his room and establish a plan for his further care. The second story, which is detailed in Rev. Julie Hanada’s chapter, is about the laywoman Kisa Gotami whom the Buddha supported in her grieving over her dead child; by asking her to find a house that had not experienced death, the Buddha not only led her to a realization of the impermanence of life and the reality of death but also initiated her into a support community with all those others who had faced death.

Buddhism has many other ancient and contemporary examples of dedicated practitioners working to support both the dying and those who live on afterward in grief. The important point to make here is that many Buddhists today are drawing upon this long and deep tradition to find their own models for developing forms of Buddhist engagement that not only confront but also transform the many problems facing people dying in the world today. In this volume, we have culled some of the best and most inspired examples of Buddhist care for the dying and bereaved from all over the world, covering the entire Buddhist spectrum with essays from the Theravada tradition in Thailand and Cambodia; the Tibetan tradition in the Rigpa Spiritual Care Programme, which functions primarily in Europe and the United States; the East Asian Mahayana tradition in Taiwan; and the Lotus Sutra, Pure Land, and Zen traditions in both Japan and the United States.
Essential Themes in Buddhist Care for the Dying and Bereaved

While the founders and members of the initiatives presented in this volume have some mutual knowledge of and influence on each other, many have developed their work quite independently. For example, most of the authors from Japan have no knowledge of the initiatives going on outside of Japan. While the Tibetan Rigpa initiatives and the American Zen–based initiatives are knowledgeable of each other, they have both developed their own unique programs without direct collaboration. The initiative in Cambodia has had some direct influence from the Thai one, yet these two have distinctively different styles and have developed largely on their own. Finally, the initiatives in Taiwan, while being influenced by the modern British hospice model, have developed in total isolation from other Buddhist initiatives around the world. In this section, however, we will introduce many of the common and overlapping themes that emerge in the variety of essays in this volume. On the one hand, the diversity and cultural appropriateness of each initiative is an important part of their successes—as well as a warning to those who wish to replicate them in their own contexts. On the other hand, the points of congruency show an underlying, common wisdom implicit in the work that not only validates it empirically but also provides key elements for the adaptation of the work in a variety of social and cultural contexts.

Buddhist Spirituality for the Dying

As mentioned at the beginning of this introduction, Buddhism has a long and deep tradition of practices surrounding the time of death. The goal of all of the initiatives in this volume has been to revitalize and apply them to the modern world, specifically to modern medical contexts. For example, there is the original Buddhist emphasis on the importance of a calm and meditative mental state at the time of death. This is felt to be important not only in terms of the soteriological import of the future transmigration of the consciousness but also
more simply in terms of a “good death”: one that is filled with peace rather than struggle and angst. The Theravadan and Zen perspectives emphasize this point the most. On the other hand, the East Asian Buddhist tradition, specifically the Pure Land tradition, has developed the practice of chanting Amida Buddha’s name both by the dying and the bereaved in support of the dying to ensure a “good death” and the soteriological goal of rebirth in Amida Buddha’s Pure Land. Tibetan practice contains both these meditative and faith-oriented practices while adding further elements, such as the *tonglen* practice of voluntarily taking on the suffering of others as one’s own and seeing one’s illness as the fulfillment of this bodhisattva vow.

Across these basic Buddhist traditions, certain tensions exist concerning the dying process. One the one hand, there is a common, shared belief that the state of the mind at death is paramountly important, and thus open mourning and the disturbing or moving of the corpse for a period after death should not be done. Traditions that particularly emphasize this idea prescribe strict, disciplined, and formalized forms of dying where a religious professional, usually a monk or nun, is employed to support the dying as a guide and the achievement of a peaceful, “good death” is critical. In terms of the modern initiatives in this volume, this orientation expresses itself in the emphasis on highly trained religious professionals called chaplains who understand how to properly handle the issues that arise not only for the dying but for their families and caregivers as well. In this way, the modern-day Buddhist chaplain is akin to the traditional Buddhist deathbed counselor (*kalyanamitra*). This orientation may also express itself in more specifically Buddhist facilities, such as the special room for one’s last moments with a large painting of Amida Buddha and his Pure Land and the special morgue for chanting and keeping the body undisturbed at the National Taiwan University Hospital, or the construction of a care center alongside a retreat community of practitioners in the Rigpa Spiritual Care Programme in Ireland. This belief has also led certain Buddhists, especially in Japan, to shun organ donation as a violation of the dying person’s consciousness and subsequent transmigration.
On the other hand, the Buddhism views intention as the fulcrum for karmic action and the eventual transmigration of the consciousness. This belief has led certain Buddhists, in contrast to those mentioned above, to promote organ donation as an act of bodhisattvic compassion; they understand that an enlightened intention would override any disturbances to the consciousness of the deceased. This is an orientation that is strongly emphasized in the initiatives in modern Taiwanese Buddhism, even while they otherwise seek to maintain traditional Buddhist death practices. In terms of care for the dying and bereaved, this emphasis of intention over form dovetails with the modern hospice movement’s focus on presence and compassionate listening by the caregiver, including not imposing the caregiver’s religious vision on the patient but rather acting as a facilitator for the patient to discover his or her own spirituality. This orientation is perhaps best expressed by Issan Dorsey, the Soto Zen priest who founded Maitri Hospice in San Francisco in the late 1980s: “You need to meet people where there are and not where you want them to be.” This orientation also does not attach to the concept of a “good death,” although it may still hope for it. In practical terms, initiatives that emphasize this belief eschew the use of chaplains and instead rely on volunteers of varying levels of training. This model is prominent in the hospices of the large Tzu Chi denomination in Taiwan as well as the Maitri Hospice and the Zen Hospice Program in San Francisco.

This less formalistic orientation, as Rev. Mari Sengoku writes in her chapter, sees that “people die as they have lived” and that in most cases it is not possible and often counterproductive to try to teach new spiritual orientations or practices, especially meditation, to people who are dying. This has been a common experience for many groups in the volume, such as the Brahmavihara/Cambodia AIDS Project and the Kosei Vihara in Tokyo. On the other hand, many of the authors in this volume concur that those who have developed spiritual orientations before becoming ill seem to have better deaths. These experiences have led to a very significant movement by Buddhists within the scientific and medical communities to empirically...
verify the importance of spiritual care as part of a more comprehensive form of holistic care for the ill and dying. Jon Kabat-Zinn’s work in mindfulness therapy at the University of Massachusetts Medical School, Joan Halifax’s initiatives with the Dalai Lama and western scientists through the Mind and Life Institute, and Dr. Gian Borasio’s research team at the Interdisciplinary Center for Palliative Medicine (IZP) at Munich University Hospital are important such examples found in this volume.

These two tensions coexist among the initiatives in this volume; there is a sentiment that the patient should not be evangelized yet should still be offered spiritual pathways for actively moving into death and what lies beyond. In this way, one of the more surprising results of studying these initiatives is that we find an emphasis on developing a strong and committed Buddhist practice more for the caregiver than for the patient. That is, while these initiatives have varying levels of agreement on how much a patient should be offered Buddhist teachings and practices, they are in much more common agreement that Buddhist teachings and practices offer essential competencies for caregivers, whether they are actually Buddhist or not. From Zen volunteers in San Francisco who meditate together, to German and American medical professionals with Christian or secular orientations who learn Buddhist self-care methods from the Rigpa and Upaya programs, to ordained Buddhist chaplains in Taiwan and the United States who must internalize their seminary educations through practice as interns, a common perspective and point of emphasis is the need to properly train in spiritual competencies to sustainably carry on the intense work of “being with dying.”

**Informed Consent and Truth Telling**

“Informed consent” and “truth telling” are curious, specialist terms developed by the modern medical system. The former refers to the process of medical professionals, usually the head doctor, informing a patient of the particulars of their medical situation—in short, their diagnosis. The latter refers to the process of the doctor informing the
patient of the outlook for their improvement or perhaps the inevit-
tably of their death—their prognosis. One wonders what these two
processes looked like in the premodern era when people did not rely
on hospitalization and usually died in their own homes. Probably it
was a mix of the medical or care professional dealing directly with the
patient and also working in consultation with his or her family. In the
present era, a bias has developed that Asian societies, especially con-
servative Buddhist ones in East Asia that deeply value collectively, do
not agree with these two concepts and feel that they reflect Western
notions of individual autonomy. This claim is perhaps understandable
from an East Asian cultural standpoint, but not so much from a Bud-
dhist one. In fact, Buddhism has often been criticized for focusing
on individual salvation or enlightenment as well as for placing greater
emphasis on individual endeavor rather than divine intervention.

What the variety of chapters in this volume expose is that the kind
of denial of death that has lead to tragic forms of silence concerning
the informing of patients of their condition and impending death,
especially in Japan, appears to be more of the result of the culture of
modernism than an inherent predisposition in Asian culture to collect-
tivity and silence. Caroline Brazier shows in her chapter that a culture
of silence around death developed in Britain from the trauma of mass
death during the two world wars, the development of modern psy-
chology based on Freud’s admonition to “forget the dead,” and the
scientific materialism prevalent in modern medicine that sees death
as defeat. Various medical professionals in the chapter on Germany
attest to how they also had a culture of silence around death until
very recently and that it persists in their Eastern European immigrant
community. In his chapter, Carl Becker has not only pointed out how
the Japanese in a short period of fifty years have gone from a culture
comfortable with death to one in fear of it, but has also shown how
the Buddhist culture of venerating ancestors through regular and fre-
quent grave visits and memorial services kept death as a common
presence in the lives of traditional Japanese.

Most modern societies struggle with facing death, and, ironically,
modern physicians may struggle the most. In terms of the achieve-
ment of a good death and doing many of the meaningful Buddhist practices surrounding death as outlined above, the path toward this direction is completely shut off if the fundamental step of acknowledging death is not taken by caregivers, families, or patients. However, this is a very difficult and nuanced issue that precludes the simple conclusion that patients must simply be told point blank what is their diagnosis and prognosis without the interference of their families. Both Rev. Yoshiharu Tomatsu and Rev. Mari Sengoku, proponents of truth telling, have stated in their chapters that if patients are told of their terminal prognosis but then are left to cope by themselves without a supportive family or caregiver structure, then such “truth telling” can be devastating. Unfortunately, in many modern societies, where the dying are left in abandoned corners of hospitals with infrequent family visits and little team care from the institution, this could well be the result of the standardization of truth telling. In this way, many of the initiatives in this volume show how to build communities of care around patients and their families, whether it be a comprehensive team-care system of professionals in a hospital, a community of volunteers and fellow patients in a hospice, or a religious or local community in support of a patient dying at home or in a temple. Further, in the final chapters of the volume, we see the development of ethics committees in hospitals in the United States that are sensitive to the cultural differences of patients and the best way to handle the important work of informed consent and truth telling.

**Communication Skills in Medical and Religious Professionals**

These above issues of communication between caregivers and patients and their families lead directly into another common critical issue: the communication skills of both medical and religious professionals in the work of being with dying. Besides cultural issues, one of the causes of the lack of informed consent and especially truth telling is the fact that modern medical doctors are poorly trained in interpersonal communication skills. Rev. Yoshiharu Tomatsu’s chapter gives us an inside look into the way Japanese doctors are trained and his
attempts to support their development as compassionate communicators. In many of the chapters, the authors note how modern medical education drums out of students many of their initial idealistic motivations for becoming doctors, such as the desire to serve and to heal. In response, both the Upaya Being with Dying Program and the Rigpa Spiritual Care Programme have specific teaching components for developing the interpersonal communication skills of medical care professionals.

On the other hand, we find a perhaps more shocking revelation throughout the chapters of the equally poor communication skills of religious professionals. Indeed, the core motivation of Congregationalist minister Rev. Anton T. Boisen to create the first Clinical Pastoral Education (CPE) programs for developing chaplains in the United States in the 1920s was due to his own experience as a patient with a priest who could only spout back religious doctrine and not meet him as a person. Similar issues appear throughout the Buddhist world, most notably in the chapters on Japan where many priests reluctantly succeed their fathers into a vocation they view more as a business than a calling. In general, monastic education across the Buddhist world often makes monks into preachers more than listeners and compassionate companions—the root meaning of the term *kalyanamitra*.

*Buddhist Chaplains and the Team-Care System*

The cultivation of the Buddhist chaplain is thus an important theme running through many of the chapters in this volume. While we have seen that there are varying emphases on the need for certified religious professionals—that is, ordained monks and nuns as opposed to volunteers—the development of chaplain training is a significant response to the marginalized role of religious professionals in many modern societies and the need to find ways to reengage with society. Rev. Julie Hanada points out in her article that ideally there would be no need for chaplains if the typical monk or nun would receive the proper type of training in his or her seminary to engage with common people in a variety of environments, not just within the temple
environment. However, in so many Buddhist countries, monastic education has become confined to the rote memorization of texts, sectarian interpretations of doctrine, the study of ritual minutiae, and the management of the religious institution—in many ways not very different from the style of education for medical doctors.

Clinical Pastoral Education (CPE), as Rev. Thomas Kilts, a Tibetan Buddhist CPE supervisor in the United States, notes, is “about dealing with relationships and crises and not just a temple congregation. One has to learn that in being out in the world with people in crisis, not just in a temple, when to use Buddhism and when to not.” This is one of the first important competencies of chaplaincy. As part of the emphasis on deep listening and presence over preaching, chaplains must learn how to speak in a variety of ways so that, as Issan Dorsey said, they can meet people where they actually are. Many of the authors in this volume note the great challenges experienced by chaplains in such training: first, in terms of adapting to the intense demands of medical environments, and second, in terms of learning how to bring their intellectual knowledge of spirituality into the heart as a practical and engaged way of relating to people. In this way, Clinical Pastoral Education (CPE) in the United States has a mandatory emphasis on ecumenical and nondenominational competencies; that is, chaplains must be able to work equally well with patients from other faiths as with ones from their own denominations. This is one of the greatest challenges in the cultivation of chaplains, because, as we will see in certain chapters, when religious denominations train and remunerate their own chaplains, there may be a reluctance to cultivate them fully in an ecumenical manner. The key in the US system is that chaplains are remunerated by the hospitals and are considered a part of the medical team, and so they must practice with a professional nonbias toward patients.

This is one significant difference from the chaplaincy model over the volunteer model. Chaplains work as paid professionals in medical institutions that are often publicly funded. In this way, they have a wider range of skilled responsibilities, such as ethics work as part of a team of professional clinicians in the hospital, work with the
community, and nurturing the spiritual health of the medical organization itself. This first aspect of being part of an interdisciplinary care team is a critical new development in modern medical systems around the world. Modern medical care has been structured exclusively around the control of medical care professionals—that is, doctors—with little to no decision-making roles for nurses, social workers, psychiatrists (often reduced to pharmacologists), various types of therapists, and chaplains. However, over the past twenty to thirty years, considerable developments in the understanding of holistic care, led by pioneers like Jon Kabat-Zinn, have helped create a mandate for spiritual care. These developments have not only shown the efficacy of spiritual care but also how it can save expenses for medical institutions and governments through preventative medicine as well as hastened healing. Rev. Julie Hanada sums up the role of the chaplain in this way: “Chaplains can help shorten length of stay in the hospital, communicate with the medical team, and help patients and families feel heard—all of which can reduce complaints and lawsuits, and facilitate end-of-life and medical ethical discussions.”

Another key aspect of this mandate for chaplains is not only working with patients and families but also with the other caregivers and professionals in the medical institution. Rev. Julie Hanada has remarked that in her experience chaplains may spend up to 50 percent of their time working with the care team itself, dealing with a whole host of issues that plague medical professionals in their demanding work—as explained in detail by Rev. Joan Halifax in her chapter. On this level, the chaplain becomes much more than a compassionate companion to a dying individual or consoler to a grieving family. As a number of authors have noted, the role of a chaplain also involves overseeing and nurturing the spiritual culture of the entire professional care team and in some places the entire medical institution in which they work. This is indeed a huge and complex type of work that includes special skills and competencies. The Upaya Being with Dying Program established and run by Rev. Joan Halifax is perhaps the most compelling example in this volume of a cultivation system for chaplains that offers such knowledge and skills in this area of com-
munity and institutional transformation—most of it amazingly based on adaptations and interpretations of core Buddhist teachings.

**Institutions: Hospitals vs. Hospices vs. Home Care**

These above points lead us into one of the final major issues of the volume, which is two pronged: the reform of existing medical institutions and the development of holistic medical care environments in which spiritual care is integral. As seen throughout the volume, the first front is incredibly difficult and challenging work since modern medical institutions are built around cultural concepts of denial of death, death as defeat, and scientific materialism, which are the antithesis of the values in the holistic care movement to which Buddhist care belongs. While we have seen a number of different initiatives to try to influence this culture, specifically the work to scientifically prove the efficacy of spiritual care, the personal power of a sympathetic chief doctor or medical administrator has often been the key for driving change. In the chapters on Taiwan and Germany, it was high-level doctors with strong Buddhist leanings who paved the way for progressive holistic care to be introduced in their hospitals. Ironically, Japan, a supposedly predominantly Buddhist country, seems to have the greatest lack of such medical professionals and government bureaucrats sympathetic to Buddhist or other forms of spiritual care. Yet the existence in Japan of Buddhist priests who are also medical doctors, almost always working incognito, may serve as a ray of hope that social attitudes toward Buddhism and religion can start to change.

On the other front, we can see in the volume numerous ground-breaking and radical initiatives for Buddhist-based care beginning as grassroots activities, particularly with the marginalized. In Thailand, Cambodia, and the United States, Buddhist-based care for the dying and bereaved began in the AIDS communities, with Maitri Hospice and the Zen Hospice Project in San Francisco, the Dhammarak Niwet Hospice on the grounds of Phrabat Nampu Temple in Thailand, and the Brahmavihara/Cambodia AIDS project. These projects
are deeply meaningful for their realization of the true religious ideals of compassionate caring. As Caroline Brazier sums up in her chapter, “The quality and character of a culture is reflected in its care and concern for its weakest members.” While these initiatives have faced huge obstacles in serving a community in which the patients have so few of their own resources—such as family, money, and a sense of personal self-worth—they also have benefitted from the creativity afforded in serving a constituency that no one else took an interest in. Unlike hospitals and medical systems that have entrenched power systems and vested interests, working with marginalized communities can offer a certain freedom of creativity to develop programs in line with the ideals and values of these Buddhist practitioners.

In this way, much of the hospice movement, both Eastern and Western, Christian and Buddhist, has developed from home hospice care by volunteer groups. It is at this level that perhaps the most radical visions in this volume are presented. The reform of modern medical institutions through the development of holistic care teams, which include chaplains, is certainly a heartening development. However, when looking at the economic difficulties behind maintaining massive, centralized medical systems, as seen in Carl Becker’s chapter, one wonders whether there is any future in such systems and whether we would be better served with more localized, community-based holistic care. This is the vision of a number of the authors from Japan. Rev. Yozo Taniyama in his chapter envisions the Vihara Movement as expanding the scope of its work beyond caring for the dying and into community social welfare. Both he and Rev. Tomatsu see the meaningful care for the dying and bereaved and its extension into greater community participation as keys for reviving Japan’s “Funeral Buddhism”—a pejorative term denoting the narrow focus of priests and temples on performing funeral and memorial rituals for financial remuneration. Perhaps the closest manifestation of this ideal is the work of the Maitri Hospice embedded in and nurtured by the community it serves in San Francisco. There is also the developing vision of the Rigpa Spiritual Care Programme, which is building religious communities and spiritual care centers side by side.
They seek to go beyond simply caring for people to building a community or society where encountering the Buddha’s first noble truth of suffering—in birth, aging, sickness, and death—is part of the very fabric of daily life.

**Grieving**

The common issue that we have left for last to discuss is what happens after death. This is an area where many of the initiatives discussed in this book are actually somewhat undeveloped. Perhaps this is the natural outcome of working within the compartmentalized field of death and dying in the modern world. Rev. Tomatsu in his chapter speaks at length about the separation between premortem and postmortem worlds in Japan; that is, the medical world of dying and the religious world of death. Many of the chapters discuss how the culture of death as defeat leads to the abandonment of the dying within medical institutions, pushed off into the back of wards. The holistic health and chaplain movements have sought to bring the dying back out of exile and to care for them as an integral part of hospital work. Still, the work of grieving that comes after death is not something that hospitals or palliative care wards are mandated to do, so the wall persists between pre- and postmortem worlds with grieving families moving on to try to find new communities to support them in the postmortem process.

Many of the initiatives in this volume attempt to support these grieving persons, but most grief-care programs are not highly developed, perhaps due to these initiatives’ heavy emphasis on dying and offering a specific alternative to the functions of a hospital. The Rigpa Spiritual Programme’s wider vision of a religious community embedded in birth, aging, sickness, and death shows the potential for a community that can support people through the pre- and postmortem worlds and link them together as one total process. This is where Japanese Buddhism in particular has critical potential for the ongoing Buddhist hospice movement. As many of the Japanese authors discuss, the Japanese Buddhist practice of regular memorial services
for the dead has served for hundreds of years as a highly developed grief care system uniting spiritual values with the regular practice of remembrance, all connected to a community of support. The ironic point is that the power of these Eastern practices is being shown to the world in a roundabout fashion—by Western researchers, such as renowned suicidologist and thanatologist Edwin S. Shneidman and his concept of “postvention” and Dennis Klass and his notion of “continuing bonds.” This is one major area of endeavor that many of the Buddhist hospice movements could further develop and which makes potential Japanese Buddhist contributions to this field highly significant. The spirit of holistic care that runs throughout the hospice movement could invite the extension of hospice care into regular grief care work, thus building a bridge to not only a more holistic culture of living with death but also the subsequent birth of institutions and communities that reflect this culture.

Conclusion

This volume is the second major publication of the Jodo Shu Research Institute’s (JSRI) project “Ojo and Death: Its Meaning for Pure Land Buddhism, Japanese Buddhism, and Contemporary Society.” The project was initiated in 2006 by the chief of the JSRI International Relations Section, Rev. Yoshiharu Tomatsu, who had been active in the Institute’s bio-ethics study group, grappling with Buddhist positions on brain death, organ transplants, stem cell research, and so forth. The Ojo and Death Project has sought to confront a variety of practical issues that directly impact the average Japanese: Japan’s rapidly aging society, coupled with its low birth rate, and the subsequent financial crisis in the ability to take care of the elderly and dying; and the Japanese medical establishment’s outdated approach to patient care. The project has also, of course, tried to confront the crisis of the growing irrelevancy of Buddhist priests and temples in the lives of their lay followers. It has also sought to bridge various divides in Japan, such as (1) the gap between parochial academic teachings and practical medical approaches to bio-ethics; (2) the gap
between a medical system that neglects the spiritual needs of the
dying and a ritualistic Buddhist temple system that neglects the spiri-
tual needs of the living; and (3) the gap between classical Buddhist
ritual practices and their application to modern living and dying. In
this way, the project has sought to bring together care profession-
als across the spectrum from within Japan to cooperate on bringing
comprehensive transformation to the way the critically ill, dying, and
bereaved are cared for.

By 2011, the project had held two international roundtable dis-
cussion conferences, four special seminars with foreign and domestic
specialists in the field, four complete panels as parts of international
academic symposia, and one large public symposium and work-
shop, while conducting research trips to Taiwan, Southeast Asia, the
United States, and Europe, and completing our first major publica-
tion, Never Die Alone: Death as Birth in Pure Land Buddhism (Jodo
Shu Press, 2008). To address these critical issues within Japan, the
project has studied the growing number of Buddhist-based hospice,
spiritual care, and bereavement care activities around the world as
well as within Japan. The wide variety of encounters we have had
through this research is presented in this volume with grateful appre-
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The Evolution of Funeral Buddhism in Japan

Funeral Buddhism (soshiki bukkyo) is an important keyword in considering Japanese Buddhism. In the Japanese religious tradition, ancestor worship was syncretized with Buddhist rituals by the Middle Ages, and the form was further fixed by the time of the Edo Shogunate (from the seventeenth to the nineteenth centuries). In this system, more than 90 percent of funeral services were carried out in a Buddhist style at home or at a temple until the twentieth century. The income from funerals eventually became the basis for temple management. However, Funeral Buddhism has faced a turning point in recent years. The number of funerals now held at funeral homes and performed in a non-Buddhist style has increased, as well as the performing of a chokuso, a simple cremation without rituals. The Buddhist temple was traditionally one of the centers of the community; priests carried out funerals in cooperation with the local community. However, now some of the roles of priests have been taken over by undertakers and the many different kinds of funeral homes.

As part of the customs of Funeral Buddhism, people automatically participate in the weekly, monthly, and yearly memorial services after the funeral—that is, every seventh day until the seventh week or forty-ninth day; the hundredth day; every month on the date of death; the first anniversary; and the anniversaries of third, seventh, thirteenth, seventeenth, twenty-third, twenty-seventh, thirty-third,
and fiftieth years. The monthly memorial service was an especially important function to develop the relationship between the priest and his parishioners. In this system, a priest would visit the parishioner’s house to chant sutras in front of the home Buddhist altar (*but-sudan*) in which mortuary tablets (*ihai*) of deceased family members are installed. However, this custom, and thus also the relationship, has become weaker, principally because many people have relocated to other regions and do not know the name of the temple to which their parents belonged. Consequently, when a new death in the family occurs and they are introduced to an unknown priest through the intermediation of an undertaker, they may not ask for such extended memorial services after the funeral. Thus, the relationship between Buddhism and funerals is changing.

Many priests have not been able to find concrete solutions to this crisis. According to a questionnaire of Buddhist priests that the Japan Young Buddhist Association carried out in 2003, about half of the respondents criticized Funeral Buddhism, making remarks like, “I am not actively concerned with living people,” and “My activities incline toward funeral services.” Of these respondents, 85 percent were priests less than forty years old. They feel more a sense of impending crisis in comparison to elderly priests. Their reflections that rituals are heavy and human relationships are thin is the focal point of the criticism. Before modern times, priests were concerned with the deathbed process of common people. Deathbed rituals had been required by devoted laypeople. Priests also gave the certificate of death and executed the funeral. In the twentieth century, the number of people who die at hospitals has increased so that now 78 percent meet their end there. On the other hand, the role of the priest at the deathbed has declined. When a priest enters a hospital in black robes, he is evaded. He is only called in after the death of the believer to chant sutras. This indicates why priests in the questionnaire said they are not “actively concerned with living people.”

The main purpose of this chapter is not to deny Funeral Buddhism itself, but rather to introduce the Vihara Movement as a response by some priests to the criticisms from society. The idea of the vihara priest
or Buddhist chaplain has been an indispensable part of the development of the Vihara Movement, and therefore, a training program for chaplains was necessarily created. However, I feel their field of work should not be limited to only medical settings. If an organization could be established that is linked with local temples, such chaplains could play an active role as health care specialists, not only at hospitals but also in the local community.

What Is the Vihara Movement?

Vihara is both a Sanskrit and Pali term that means “temple,” “monastery,” or “place of the rest.” Rev. Masashi Tamiya, a priest of the Higashi Honganji or Otani branch of the Jodo Shin Pure Land denomination, proposed it in the early 1980s as a substitute word for “Buddhist hospice,” and the term came to indicate “terminal care based on Buddhism and the institution that provides it.” Since vihara usually means just a “temple” or “monastery,” especially in Theravada Buddhist countries, some of the readers might feel some incongruity. However, monasteries in ancient India had lodgings for pilgrims, and large ones had facilities for medical care, social welfare, and education for local people. The Jetavana Vihara was established during the lifetime of the Buddha, and after centuries, it came to house medical facilities, including a “house for the dying” or “abbey of impermanence” (mujo-in) for terminal nursing care. This background of the term vihara reminds us of the history of hospice in Buddhism. Hospices in Europe during the Middle Ages also started as lodging places for pilgrims and then developed into medical and social welfare facilities. Therefore, hospice and vihara have a common point in their development and function. Japanese Buddhists who first participated in the hospice movement here were reluctant to use the word “hospice” as it is derived from Christianity. Therefore, they chose the Buddhist term as a banner for their movement.

Although the Vihara Movement is not a complete response to the criticism of Funeral Buddhism, its concept includes the reformation and the reactivation of Japanese Buddhism. Rev. Tamiya was affected
by the hospital sermons started in 1984 by the Kyoto Young Buddhist Association (now called Bhagavan Kyoto), which is an ecumenical Buddhist group. He then began to promote the Vihara Movement as an ecumenical activity in 1985. After him, the Nishi Honganji or Honpa Hongwanji branch of the Jodo Shin denomination created vihara activities in 1986. Rev. Shunko Tashiro of the Higashi branch then started vihara activities at the Nagoya Higashi Betsuin headquarters temple as a foothold in 1988. The Nichiren denomination started their vihara activities in 1994. Additionally, volunteer organizations of the Vihara Movement were formed in many cities. Some are denominationally based while others are ecumenical. There is no particular difference between the terms “Vihara Movement” and “vihara activities.”

The starting point of the Vihara Movement was terminal care. In total, there are 208 certified palliative care units in Japan as of December 2010, yet only two of these are Buddhist based. The first one was created at the Nagaoka Nishi Hospital in Niigata in 1993 and is non-sectarian. The second was created at Kosei Hospital in Tokyo in 2004 and is run by the Rissho Kosei-kai denomination. The third will be the Asoka Vihara Clinic in Kyoto, which was established in 2008 by the Nishi branch of Jodo Shin, but is not yet certified as not enough of the patients have cancer or are terminal. However, besides palliative care units, there are several vihara institutions and organizations for the welfare of the elderly, disabled persons, and children, as well as for counseling. Most of them are grassroots based.

In this way, I have defined vihara in three ways:

Narrow Definition: Terminal care based on Buddhism and the institutions that provide it.

Wider Definition: Activities and institutions managed by Buddhists that are focused on aging, sickness, and death in the fields of medical and social welfare.

Widest Definition: Social activities managed by Buddhists and non-Buddhists that support the lives of people and pro-
vide opportunities for the contemplation of “life,” such as disaster aid, education for children and youth, and cultural programs.  

Although many Buddhists and concerned people use both the narrow and the wider definitions, my investigation has shown that the actual activities of vihara institutions fit the wider and the widest definitions. Therefore, we will mainly use the wider definition in this chapter; in the future, it may be possible that the widest one will be mainly used. In the development of the Vihara Movement, it is the chaplain who forms the core. In the next section, I will describe the situation, surroundings, and education programs of chaplains in Japan.

**The Role of the Vihara Priest**

At vihara institutions, the Buddhist chaplain is called a “vihara priest.” Unfortunately, at most such institutions, most of the staff are not believers of the related religious group; thus, the religious idea is not thoroughly understood, and the chaplains do not always have a role of authority. However, chaplains can show the characteristics of Buddhism through their actions just as much as they might show someone the Buddha hall. Their role is thus very important.

Rev. Masashi Tamiya’s brother manages the Nagaoka Nishi Hospital, which serves as a symbol and exemplar of the Vihara Movement. Local priests have been cooperating with the activities there even before the establishment of the Vihara Ward, a Buddhist hospice. One chaplain is a full-time employee, and ten to twenty volunteer chaplains also play active roles. They have a volunteer group that is financially supported by over one hundred priests and laypeople from several denominations. At the hospital, 27 out of a total of 240 beds are used for the Vihara Ward, and the chaplain belongs to only this ward. There is not a chaplain for the other wards. The roles of the vihara priests at Nagaoka Nishi Hospital are as follows:
(1) Religious Services: A chaplain will chant sutras every morning and evening as well as holding seasonal religious events. When a patient wants a chaplain to chant a sutra for him or her or to have a religious talk, the chaplain is available to do so at any time at the Buddha hall or at their bedside. I remember an extraordinary patient who had a small Buddhist altar (butsudan) in her room to worship and to communicate with her late daughter. She welcomed any chaplain to chant in front of the altar. There are volunteer chaplains from several different denominations, so that if a patient wants to see a priest from a specific denomination, the full-time chaplain will arrange for that. Unfortunately, at almost all hospitals in Japan, patients’ daily religious activity, like chanting Amida Buddha’s name, is kept private and hidden by the patients themselves, even though chaplains can help with many kinds of religious services. As I mention below, it is a Japanese custom to hide religious matters in public places.

When a patient dies, a chaplain is called on at any time of day. If the full-time chaplain is out, a volunteer one will come to the hospital. The dead patient is given a bath by the hands of their primary nurse and the bereaved family, which is similar to a Buddhist ritual called yukan. After the deceased is dressed, the bereaved and staff gather at the Buddha hall. A chaplain will do sutra chanting and give a sermon, after which all participants will offer incense in turn. The deceased is then taken away, usually by undertakers, but sometimes by the bereaved family itself. The staff sees them off at the door of the hospital.

(2) Spiritual Care: A chaplain provides spiritual care for patients and family members. When a patient wants a chaplain to provide spiritual care, the chaplain does so according to the patient’s faith and not his or her own. A nurse may also come to talk with a chaplain, when he or she gets very tired with his or her job or daily life. A physician may seek advice from the chaplain on sedation, intravenous control, notification of the limit of lifetime, and other ethical matters.

I had one interesting and impressive case with a patient who was born into a Catholic family. At one point, she became devoted to a
new Christian denomination, but she eventually left the sect after several years. She continued to believe in many of the sect’s teachings, however, and this lead her to fear that she might cease to exist after her death. I wondered why she did not believe in heaven, even though she appeared to believe in Christianity. I asked her, “You said that you will cease to exist after your death. Don’t you believe in the Resurrection and Judgment Day?” She answered, “I was instructed that we must wait for the Resurrection, but that 13,000 chosen people have already been resurrected soon after their death, so I don’t know what will happen to me if I’m not one of the chosen.” I said, “Well, some resurrect quickly, while others take a rest for some time.” She said, “Yes.” I said, “I see. The chosen people will resurrect and work for this world. That’s great. But those who want to take a rest can do so in another world for some time.” She said with a smile, “Wow, this is the first time I’ve heard such an interpretation. So I can take a rest for some time then, can’t I?” I said, “Yes, you can.” Then she seemed relieved and thanked me by putting her hands together. While the content of the conversation was religious, our faiths were different from each other. It was an ecumenical experience for both of us.

(3) Grief Care: Days after a patient passes away, some of the bereaved family may come to the ward to have a talk with the staff, including a chaplain. Some of them may stay hours there with the chaplain. The Vihara Ward also hosts gatherings of bereaved families. One gathering is for the bereaved of less than one year. Another is for those over one year and is managed by people concerned for the bereaved members of the group. Both meetings have sutra chanting and incense offering at the Buddha hall as well as a tea party on another floor of the hospital. Former Vihara staff members are also invited to these meetings. The tea party is not structured like a self-help group, and the attendants talk freely.

(4) Cultural Events: Chaplains and staff plan and prepare seasonal events: cherry-blossom viewing in the spring, fireworks shows in the summer, colored-leaves viewing in the autumn, and an end-of-year
party in the winter. Each of the volunteers, and sometimes patients and their family members as well, play strong roles in these events—acting as drivers, cooks, waiters, builders, wheelchair attendants, and so on. For example, Nagaoka city is well known for its fireworks show, which serves as not only a cultural festival but also a memorial service for the victims of the air bombing in 1945 and of the earthquake in 2004. The Vihara Ward has a good roof from which to see the show where several beds can be set up. During this event, patients can forget their pain. In this way, patients aim to survive until such seasonal events.

(5) Team-Care Approach: A chaplain attends meetings for daily and weekly updates, for reviewing recent deaths, and for the multidisciplinary team. He provides new information about patients if needed. When a meeting with a patient, family members, nurses, and the presiding doctor is held, a chaplain will also attend. Sometimes a chaplain will help patients with decision making. For example, in the case of an old man with terminal cancer, the patient asked to stop his intravenous fluids. The doctor and the nurse in charge called for his wife, his relatives, and a chaplain (myself in this case). The patient said in a calm voice, “I don’t want to prolong my life anymore. I want my intravenous fluids stopped now.” His relationship with his family was not so good and his attitude was strong, so there was a tense and unpleasant atmosphere in the room. Then I said to him, “Life is not only for you. Life is shared by everyone. Shall we talk about it more? After talking more, we can make a decision.” After a while his niece said, “We want you to live as long as possible.” He in turn softened his attitude, and at last concluded, “Okay, I understand all of you want me to live more. I will prolong my life ten more days,” after which he decided to reduce his fluids by half.

(6) Troubleshooting (between family members, staff members, and so on): Here I will show three cases of dealing with a patient’s family, a chaplain in training, and the medical staff.
There was a case of the grandson of an old patient. He was a young adult aged twenty and emotionally unstable because of overlapping stresses, including anticipation of his grandmother’s death. He began squealing in the ward, picking fights with staff members, and stalking a nurse. I confronted him, and fortunately we could develop a good relationship. He then began come to my room every day to talk about many issues and never made any more trouble. I did nothing more than act as his sitter for some weeks.

Another time, a monk came to our hospital from South Korea. He wanted to train as chaplain at the Vihara Ward, so we arranged everything for him. When I met him, we encountered some problems: first, he could speak little Japanese and only some English; second, he was overly aggressive and compulsive in attending to patients so that we worried he would become a bother to them; third, he told me that he wanted to preach to the patients. I became upset, especially with this last point. I explained that, in the concept of vihara, our aim is not to spread faith. However, he was too stubborn to understand our concept, so I actually had to ask him to leave. In Korea, it seems priests are respected and allowed to preach anywhere. The religious environment in Japan, however, is far different. He could not understand the simple maxim: “When in Rome, do as the Romans do.”

Looking back on my three years at Nagaoka Nishi Hospital, one of my important failures as a chaplain is that I could not have good relationships with all the doctors, nurses, and volunteers. When I was employed as a chaplain, I did not understand what chaplaincy was really about. There were few notes and instructions at that time about being a full-time vihara priest. The role of the chaplain was vague among all of the staff, except for some routine work. I had to begin by clarifying the role of a chaplain as part of the medical team. I managed to clarify the nature of chaplaincy and reform its role. In short, I tried to increase the time spent seeing patients and their families, while skipping some of the routine work the medical staff expected of me. From the view of medical staff, it seemed that I was negligent and perhaps arrogant, since I did not share enough time to talk with them about my intentions to clarify and reform the role of the vihara priest.
Such misunderstandings seemed to have come from both my immaturity as a coworker and by the lack of understanding of chaplaincy.

**The Working Environment of Chaplains in Japan**

The term “chaplain” is not well known in Japan; it is generally only known to Christians—who only constitute 1 percent of the population. The chaplains at Christian medical, social welfare, and educational facilities are often given the title “director of religion.” There are some examples of those with the title “vihara priest” at some Buddhist palliative care units. There are very few “chaplains” at non-religious medical and welfare facilities. The other kinds of terms used are “spiritual care worker,” “pastoral care worker,” “counselor,” or “clinical spiritual care counselor.” There have been prison chaplains in Japan since the nineteenth century, but they are not called “chaplains,” rather they are called *kyokaishi*, which literally means “clergy who provides instruction and preaches.” Since the name *vihara* is new even for Buddhists, few know that both vihara priests and *kyokai-shi* are “chaplains.”

Apart from the problem of the name, Japanese medical facilities are not an easy place for chaplains to work. An understanding of the roles of a chaplain is not shared among either medical staff or patients. A chaplain’s work is not counted in the point system of public medical insurance, so the merits are not clear from the viewpoint of financial management.

Furthermore, most Japanese are not conscious about their own religion, although they are influenced by it. In a public opinion poll by the national *Yomiuri Shimbun* newspaper from May 30, 2008, about the outlook toward religion, responses to the question “Do you believe in any religion?” were 26.1 percent “yes” and 71.9 percent “no.” However, to the question about participating in religious activities, most people said that they visit their family graves (78.3 percent), pray at Shinto shrines (73.1 percent), and pray before Buddhist and Shinto altars at home (56.7 percent). Only 3.9 percent answered that they do not engage in any religious activities. About three-quarters
of the respondents were not active members of a specific religious community, yet most of them do worship ancestors or pray in a Buddhist or Shinto manner. In contemporary Japanese society, which has been heavily secularized, we refrain from talking about religious and spiritual matters in public places. It is the same in hospitals, where it is extremely rare for patients to appeal to medical staff about their own religious needs. In addition, the hospitals with no religious affiliation do not have chapels or a place to pray calmly. On the other hand, some patients do wear Buddhist rosaries, have sutra texts or the Bible at their bedside, and pray under the glancing eyes of medical staff.

Once in my experience as chaplain at Nagaoka Nishi Hospital, there was a terminal patient at the vihara ward who, although he did want to have a conversation, was always counting numbers under his breath like, “245, 246, 247 . . .” I asked the reason for this of his family, and they answered, “When he was at the other hospital before, he recited Amida Buddha’s name, Namu Amida Butsu. However, this was not appreciated by the other patients around him, so he began to recite numbers instead.” In this way, patients will hide religious practices at hospitals in Japan in the same way they might hide alcohol or cigarettes.

One way that chaplains in Japanese hospitals can create a good working environment and perform their duties well is to be mindful of aggressive religiosity. People hate a pushy priest, and I have heard that some priests were forced to leave certain hospitals since they had given unexpected, unwelcome sermons to patients. We should think carefully about what it means to “save” a person. When we face a suffering girl, how can we answer her? It may be arrogant to answer, “I will save you.” It is easy to answer, “The Lord will.” It is difficult to answer, “I cannot.” However, we can answer not just in words but with actual actions. If there is something we can do, we just do it. If not, we just listen to her, pray in silence, or seek the help of others.

In this way, chaplains must distinguish between religious care and spiritual care. Only when a patient asks for a religious need can we respond to it. This is a very simple but important motivation in the Vihara Movement.
Another way is in their relationships with nurses and doctors. Who will call in a chaplain if he does not have any relationship with the medical staff? A basic relationship as a coworker with other medical staff members is very important. Chaplains must show other staff members that they can play a positive role for the whole hospital, especially in taking care of the stressed-out staff. Healing the staff can help the patients to heal.

Another thing to remember is that a well-trained priest has many skills to help people, but he is never almighty. When he faces a difficult case, he might become burned out. Who can help this priest? I feel a support network can help him before he becomes exhausted. We need a safety net for suffering priests in order to help suffering people.

Education and Training for Chaplains

Some Japanese clergy are developing a system for the training of chaplains. Although Clinical Pastoral Education (CPE) is a common mandatory course at Christian theological schools in the West, unfortunately, it is offered at only a few schools in Japan. From the 1960s to 1980s, Protestant clergy played a key role in establishing a few institutions for CPE in Japan, but their work did not spread through the country. Rev. Tsugikazu Nishigaki, who is one of the pioneers of this work in Japan, emphasized that it is important to introduce CPE in theological education.\(^5\) The Clinical Pastoral Education and Research Center of Japan directed by Rev. Fr. Waldemar Kippes has provided some courses and developed pastoral counselors since 1998. Led by the Catholic Church, it has made a large contribution toward pastoral care and counseling, but it is still not widely accepted among the medical community in Japan.

Some kinds of programs that are distinct from CPE are provided by Buddhists. Both the Nishi branch of the Jodo Shin denomination and the Nichiren denomination have training programs for volunteers of their vihara activities. The Nishi branch started their program in 1987, which includes clinical experience at elderly homes. Ryukoku University, which was established by the Nishi branch, cooperates
with this program. Ryukoku University also established the Graduate School of Practical Shin Buddhism in 2009 and aims to educate priests as experts in social activities, including vihara activities.

In 1993, Rev. Tamiya played a key role in establishing a one-year graduate course in Buddhist nursing at Bukkyo University, which is affiliated with the Jodo Pure Land denomination. It aimed to train vihara priests. However, it was closed down in 2006, because they could not attract enough students. I surmise that the program offered insufficient clinical experience and that the image of the vihara priest, of Buddhist nursing, was too obscure for many. Furthermore, the university did not seem to have a full understanding of this course, and they seemed to switch their policy away from a Buddhist approach.

In 2002, the Koyasan branch of the Shingon denomination opened courses for counselors and spiritual care workers under the direction of Rev. Daien Oshita. This served as an opportunity to establish the Department of Spiritual Care at Koyasan University in 2006. However, prospective students found attending the course in the remote mountain area of Mt. Koya unappealing, and student recruitment was stopped in 2009. In this brief period, although they did attract some adult students as well as teenagers, I think that an undergraduate course is not appropriate for training chaplains, which is a specialized and intensive field. The program could also not bring in compelling specialists as instructors. Rev. Oshita has since left the university, continuing on with the Japan Spiritual Care Worker Association. Many of the students at this association are medical staff while some are priests and lay Buddhists.

The Japan Association for Buddhist Nursing and Vihara Studies was established in 2004 by Rev. Tamiya, Akiko Hujihara, and some scholars, including myself. The name of this association shows its aim. The field of endeavor is not necessary limited to medicine and nursing; social welfare and education are also included.

The Professional Association for Spiritual Care and Health (PASCH) was established in 2005 and carries out the Program for Spiritual Care Chaplains, which can be said to be a Japanese version of CPE. PASCH is a unique association as it is managed by
Christians, Buddhists, and nonreligious persons; its supervisors are Rev. Toshiyuki Kubotera of the Free Methodist denomination, Rev. Taka-aki David Ito of the Anglican Church, and myself, of the Higashi Jodo Shin denomination. Rev. Kubotera and Rev. Ito were the second generation of Japanese chaplains developed by CPE who followed the lead of Rev. Nishigaki and others. As they are conscious of the problems in the spread of CPE in Japan, they have the following goals: to be ecumenical and multifaith, to have cooperation with public hospitals, and to join hands with Buddhists, since they comprise the majority among Japanese religions. In addition, because changing jobs and leaves of absence are not easy to obtain in Japan and the scholarship system is not well developed, full-time programs that last a month or a year like those in the United States are not appropriate. Therefore, they have developed short programs that attempt to condense fifty hours of instruction into one week.

The Grief Care Institute of Japan was established in 2009 at St. Thomas University and funded by the West Japan Railway Foundation. It was then transferred to Sophia University in April 2010, because St. Thomas University was in financial difficulty and stopped student recruitment in 2010. This institute has opened a Grief Care Worker training program under the direction of Rev. Sr. Yoshiko Takaki, who is one of the pioneers in grief care in Japan. I have also been invited to join the institute for this program. We train facilitators for self-help grief care groups and chaplains for professional grief care and spiritual care. We also provide continuing education for health care professionals. Our courses include PASCH’s one-week short program and a four-month extended program. More than twice as many students as available openings took the entrance examination in 2009 and 2010. About one-third of the students are nurses, a few are Buddhist priests, and some are Catholic and Protestant laity. However, most of them have “no religion.”

The task of chaplain training in Japan is to be ecumenical and to form a consensus about the role of spiritual care in health care, to create a place where religious persons and health care professionals can make a sincere connection to the spiritual needs of people, especially
ones in suffering. The Japan Society for Spiritual Care was established in 2007 to take on such a role. Most of the members are medical professionals and experts in social welfare, psychology, and education. Christian, Buddhist, and Shinto clergy also participate.

What is the turning point between success and failure in these projects? I think the key points are market analysis, accessibility to the program, and clinical experience. For instance, Rev. Kippes has a large market for Catholic pastoral care; Rev. Kubotera and Rev. Ito have a good discernment of Japanese society. These groups are small nonprofit organizations, target working adults, and provide short-term programs. In addition, the trainers are clinically experienced. In contrast, Bukkyo University and Koyasan University failed to gather students because they are incorporated educational institutions concerned with profit making, were targeting young students, and provided long-term programs in which students had to resign from their jobs before entering the school. Furthermore, few of the trainers/teachers were clinically experienced, and many were rather academic.

THE FUTURE OF THE VIHARA MOVEMENT

As seen in the chapter by Joan Halifax, the concept of Buddhist chaplaincy is beginning to transcend the field of terminal care. In Japan, the Vihara Movement is growing and is linked to the wider field of social welfare. However, the recognition and understanding of the role of the chaplain is still quite narrow. Therefore, I will not consider the future of Japanese Buddhism from the concept of chaplaincy; I would rather like to start from a wider view by considering it from the daily practice of a priest participating in the suffering of the people.

Funeral Buddhism Becomes Grief Care

In early Buddhist scriptures, the Buddha instructed the monks not to busy themselves with arranging and conducting his funeral, but to leave it to qualified laypeople and to continue on diligently with
their practice.\textsuperscript{6} However, even Theravada Buddhist monks, who are seen to follow early Buddhism more closely than Mahayana ones, do involve themselves with such funeral services. Of course, in Japanese Buddhism, the syncretization with ancestor worship since the Middle Ages has developed the performance of funeral services. As such, we should recognize that there is an inconsistency in the significance of funerals between Buddhist doctrine and folk religion. Rev. Kokan Sasaki, a Soto Zen priest, comments on this issue from the viewpoint of religious anthropology:

Japanese society is beginning to cope with the significance and the role of funerals, which has been considered just as a tradition and custom. Now, people are asking these questions: Why is a funeral necessary? Why is a priest necessary for it? Buddhist denominations and priests must answer them. They should revise their doctrines and practice sincerely. This can answer the criticism of “Funeral Buddhism.”\textsuperscript{7}

When we consider grief care, we may also answer this question. As Carl Becker describes in his chapter, in the psychoanalytic view of Freud, attachment with the deceased is considered to be a pathological attitude; Freud advised that one should forget the dead. However, recent studies show that it is better to reconstruct the “bond” with the deceased. Dennis Klass took notice of the Japanese prescriptions for ancestor care:

- Take good care of a Buddhist altar and a mortuary tablet, and talk with the deceased as if he or she exists there.
- Do so in front of a grave as well.
- Invite the souls of those who have died to one’s house during the Bon Festival, and see them off after hosting them for a few days.\textsuperscript{8}

Klass went on to argue that such practices eased the grief of the bereaved, and that Buddhist death rituals, which maintain the “continuing bonds” with the bereaved, could be a form of grief care. Such
a reconceptualization of traditional practices coming from an overseas researcher is a powerful call to Japanese Buddhist priests to not just blindly continue funeral rituals simply because they have always done so. Each denomination must reexamine its doctrine and rituals, while considering the grieving process. Although Funeral Buddhism is often used in the context of criticizing contemporary Japanese Buddhism, there are some priests, like Rev. Yoshiharu Tomatsu in his chapter, who have a positive way to look at their funeral work. It is, therefore, more constructive to reform Funeral Buddhism in line with real social needs rather than to seek to get rid of it.

The Temple as a Social Welfare Center

In the study of Buddhist social welfare in Japan, it has been shown that a temple has several social resources and that it can be a center for community welfare, nursery schools, and elderly homes. On the other hand, the research on Buddhist temples done in 1992–93 by Kairyu Shimizu and Tei-ichiro Hoshino reported that only 15 percent of the respondents, who were associated with temples but may not have been the chief priest, “engaged in social work.” Concerning “problems when a temple performs social work,” the following frequent answers were given:

- There is not enough manpower or funds.
- All of Buddhist society should engage in social work.
- There is not an incentive system offered by the denomination.
- Efforts by at least some temples / parish units are necessary.
- Operations adopted with a stronger Buddhist mind are necessary.  

A typical chief priest is very busy with religious services, duties as a member of the community, and his family; priests can only be active in vihara activities after having fulfilled these duties. Because most temples are managed by only one or two priests, when various new functions are added at a temple, like vihara activities, the burden is
shouldered by them, and this never turns out well. In this way, one wonders, “Can we lighten the duties of priests to make their social work more active?”

Traditionally, priests have given advice or consultation to local people and members of the temple. This is a kind of social work or coordination work. When the matter is beyond the ability of a priest, he introduces an appropriate expert from his own connections. If every priest can share such connections at the local temple or parish level, he can cope with these problems more effectively. Temples can be more effective windows to care than other types of social work facilities; through the close relationships between priest and parishioner that Funeral Buddhism has promoted for hundreds of years, a priest can access a temple member and connect him or her to care more easily. A priest can intervene in various domestic problems that are hard for other social workers to do. In this way, more people will be helped without increasing the burden on a priest if such particular social resources are connected to a network of services.

I would like to suggest that we establish regional centers of Buddhist social welfare, so that each temple can become a window to a social welfare network. Social workers, health nurses, lawyers, and chaplains can be posted at a regional center, which links to a network of many priests and public resources as well as providing direct support for temple members in trouble. The types of services that could be offered are (1) counseling on psychosocial, spiritual, religious, economic, and legal issues; (2) self-help groups of the elderly, disabled, bereaved, abused, alcoholic, and so on; (3) dispatch of chaplains to medical and welfare institutions; and (4) referrals to outside specialized agencies. In this way, we could realize the aim of the Vihara Movement and activities as well as Buddhist social welfare. Such a network can help with spreading this movement, and the inheritance of Funeral Buddhism can be turned into practical use in the present age.
Conclusion

A quarter of century has passed since the Vihara Movement began. Meanwhile, Funeral Buddhism has changed greatly, and Japanese Buddhism has been driven into a corner. The result of the Vihara Movement has appeared at the grassroots level. However, it cannot be said that the whole of Japanese Buddhism has been influenced and reformed by this movement. An understanding of chaplaincy, which should form the core of the Vihara Movement, is not yet shared. Concerning the education of chaplains, some clergy are continuing efforts in multifaith cooperation. It may be a long path, but it is an important contribution to Japanese society. Change will happen gradually, but I feel more priests are now engaged in social action. While many people are still unconscious about their own religion, they are seeking something spiritual. Buddhism has unique resources that can meet the psychosocial and spiritual needs of suffering people.
I have worked in the area of contemplative care of the dying for forty years, beginning my professional work in 1970 at the University of Miami School of Medicine as a medical anthropologist. There was a significant amount of cultural diversity in the hospital, so it was important to have an anthropologist on hand to help be a bridge between cultural and medical perspectives. There, I realized that the most marginalized people in the hospital system were those who were dying. My interest in the work with dying people, however, opened for me with the death of my grandmother, who took care of dying people. There were other factors that led me to this work, like becoming a Buddhist practitioner in the mid 1960s.

After I left medical school in 1972, I worked with psychiatrist Stanislav Grof, who was involved with a major project using LSD as an adjunct to psychotherapy with people dying of cancer. This work was profound, as most of our dying patients had the opportunity through the therapy to go through a contemporary rite of passage. This changed their experience of dying, benefited their quality of life and relationships, and transformed their view of death as they lived their final days.¹

After this work with Grof, I received the Buddhist precepts in 1975, became a teacher in the Kwan Um Korean Zen School in 1980, and subsequently took Japanese Zen ordination from Rev. Bernie Tetsugen Glassman. This deeper step into the practice of Buddhism brought
me in touch with the profound perspective that Buddhism offers to those who are dying, a perspective that normalizes death and sanctifies it as well. These three forces opened me to the work with the dying: my grandmother, my experiences with Grof, and Buddhist practice.

**CLINICIAN BURNOUT AND TRAUMA IN THE UNITED STATES**

The hallmark of compassionate and contemplative-based end-of-life care is relationship-centered care of people living and dying with life-threatening conditions and their families. A number of curricula using different teaching methods have been developed to give health care professionals the knowledge and skills to care for dying people. Despite the development of these curricula, health care professionals report a lack of skills in psychosocial and spiritual care of dying people. They also report difficulties in caring for the dying, with high levels of moral distress, grief, and burnout.

There is increasing research on the deficit of empathy and compassion among health care professionals. This compassion deficit often begins during the medical and nursing training experience. This suggests that health care professionals need more than technical skills to care compassionately for others and to sustain themselves in their caregiving roles. Clinicians are typically not given the tools to address their stress.

There are five “syndromes” that clinicians suffer from, in terms of encountering the challenge of their vocation.

1. **Burnout**: cumulative work demands and stress.
2. **Secondary trauma**: dysfunction that arises from prolonged exposure to the suffering of others.
3. **Moral distress**: moral conflicts when the clinician knows what is right to do but cannot do it.
4. **Horizontal hostility**: disrespect among members of a peer group.
5. **Structural violence**: violence in the system.
Burnout

There are specific symptoms and signs of burnout on the individual level. These are the kinds of things that we see often in clinicians here in the United States:

- complete emotional and physical exhaustion
- cynicism and being very detached from the job
- deep inadequacy about lack of effectiveness in being able to do the job
- overidentification or involvement, and an almost addictive relationship to the job
- hypervigilance and neurotic alertness that lead to a state of chronic irritability
- increasing social withdrawal from family and social relationships
- poor judgment and personal and professional boundary violations
- perfectionism and rigidity
- existential crisis in which the meaning of life and spiritual and religious beliefs are questioned
- increase in interpersonal conflicts
- avoidance of emotionally difficult situations
- issues with addiction, detachment, and an increasing sense of numbness
- difficulties in concentrating and various psychosomatic illnesses like headaches and immune system impairments

Secondary Trauma

This is very close to posttraumatic stress syndrome and involves hyperarousal, burnout, disturbed sleep patterns, irritability and anger outbursts, hypervigilance, avoidance, and reliving disturbing encounters. On the team level, when there is a diminution of morale because of burnout, secondary trauma, moral distress, horizontal hostility in the institution, or structural violence, you see the morale of the institution
drop. The result is impaired job performance, increased absenteeism, staff conflict, and high job turnover. It is a pretty dramatic situation that clinicians are facing in the United States. I am not saying that everyone is in this dilemma, but many clinicians are. A statistic that demonstrates this situation is the suicide rate among clinicians. A male clinician is 1.41 times more likely to commit suicide than the average American male, and the female clinician is 2.27 times more likely to commit suicide. The incidences of depression, addiction, and so forth because of stress are also very high among clinicians.

*Moral Distress*

These stresses are actions, dimensions, and experiences that we find common in many different clinical settings in the United States.

- **Resources:** There are a number of small hospitals that simply do not have the resources for patients to be supported in specialized intensive care situations. There can also be a shortage of nurses to take care of patients. As a result, the few nurses can easily burn out. This inadequate access to resources can thus cause the nurses serious ethical challenges, when they see their patients suffering and can do little to help.

- **Informed consent:** Another stress is a lack of adequate informed consent. For example, a patient may arrive at a hospital who is comatose, but there is no paperwork indicating an agreement with regards to resuscitation or nonresuscitation, intubation, and so forth. In other words, the advance directives have not been articulated.

- **Conflicts in care:** In other situations, the clinician, patient, and patient’s family often have different goals in terms of care. The patient wants to live as long as possible; the family is running out of patience or economic resources and feels like nothing should be done, or that everything should be done; the hospital mandates that it can only keep the patient in the hospital for a certain amount of time.
• Causing pain and feeling guilt: Clinicians often experience a tremendous amount of stress when engaging in interventions that cause pain and suffering. It is also not uncommon for a clinician to make a mistake, so clinical errors cause a feeling of guilt among clinicians.

• Futility: Clinicians also encounter a sense of futility with, for example, patients’ demands, clinical errors they have committed, feelings of inadequacy of not being able to really help a patient adequately, seeing that many interventions do not really benefit the patient, and demands made by the institution.

• Death and quality of life: Often clinicians encounter deep disputes about life-sustaining therapies related to hastening death. What is the merciful thing to do with someone who is in a persistent vegetative state—keep the body alive or help death happen? What does a patient need to have quality of life? Is another intervention going to compromise the quality of life—will it make patients more miserable or hurt them physically? What if the patient’s family insists that the patient wants to be kept alive no matter what? There is also the issue that a small increase in the morphine dosage will both make the patient more comfortable and help him or her die more easily and more quickly. However, is this legal or right? How does the family feel about it? How does the nurse feel carrying out the doctor’s orders? Does she feel like she’s engaging in homicide? There are quite a number of issues that come up.

• Denial of death: These issues are compounded by Western clinicians’ training to save lives at any cost. This leads them to a kind of denial of death. Clinicians may feel angst being in the presence of someone who is suffering from intractable pain, is in a state of extreme mental suffering, or is terribly afraid of death.

• Relational inabilities: Another issue is that many clinicians simply do not have the ability to discuss interventions with patients and families concerning death and dying. They may also not have the capacity or interest to discuss stresses at
work. In this way, they do not have the opportunity to work out issues, such as ones related to workaholism, perfectionism, or self-neglect.

**Horizontal Hostility**

This issue was brought to my attention by a nurse and student of mine, Jan Jahner, who has done a powerful presentation on this challenge in the medical setting. She has defined horizontal hostility as disrespectful behavior among peers, bullying between clinicians, and hazing that frequently occurs in medical training. Lateral violence or horizontal hostility is the consistent and often hidden patterns of behavior designed to control, diminish, or devalue another peer or group that creates a risk to health and/or safety. Horizontal hostility shares three elements common to racial and sexual harassments laws: (1) it is defined in terms of the effect on the recipient; (2) it must have a negative effect on the recipient; and (3) the bullying behavior must be consistent. Signs include two domains: (1) overt—name-calling, sarcasm, bickering, fault-finding, back-stabbing, criticism, intimidation, gossip, shouting, blaming, put-downs, raising eyebrows, etc.; and (2) covert—unfair assignments, eye-rolling, ignoring, making faces behind someone’s back, refusal to help, sighing, whining, sarcasm, refusal to work with someone, sabotage, isolation, exclusion, fabrication, etc.

The prevalence of horizontal hostility in the United States has been documented: 33 percent of nurses leave their jobs due to horizontal hostility; 44 percent report bullying; 33 percent intend to leave because of verbal abuse. Bullied staff members have lower job satisfaction and higher stress, depression, and anxiety and higher intent to leave. In the United States, 90–97 percent of nurses experience verbal abuse from physicians, 60 percent of newly registered nurses leave their first position within six months because of some form of horizontal hostility, and verbal abuse is often cited as the reason nurses leave their jobs.²
**Structural Violence**

This is the discrimination against groups within an institutional setting causing suffering. The term “structural violence,” first used in the 1960s, has been attributed to Johan Galtung and his book *Peace by Peaceful Means: Peace and Conflict, Development and Civilization*. It is a type of violence that corresponds to the systematic ways in which a social structure or institution discriminates and causes suffering to others by preventing them from meeting their basic needs. Structural violence is attributed to the specific organizations of society that injure or harm individuals or masses of individuals. In medicine, structural violence occurs in relation to the uninsured, ethnic minorities or people of color, women, people with AIDS, and so forth. It involves not only the denial of medical services to marginalized groups but also the use of interventions that are suppressive or harmful. Structural violence is also meted out toward those employed by the medical system who are perceived to be lower in status.

**Being with Dying: Professional Training Program in Contemplative End-of-Life Care**

To address the concerns explained in detail above, the “Being with Dying: Professional Training Program in Contemplative End-of-Life Care” (BWD) course was created in 1996. The premise of BWD is that in order for clinicians to provide compassionate end-of-life care, it is necessary for them to (1) become self-aware and recognize their own suffering, (2) make a commitment to addressing their own suffering, and (3) develop receptivity, compassion, and resilience through nurturing physical, emotional, mental, spiritual, and social dimensions in their own lives and in relationships with others.

We feel that cultivating stability of mind and emotions enables clinicians to respond to others and themselves with compassion. BWD provides an opportunity for participants to discover wisdom and insight from their peers and an interdisciplinary team of facilitators.
that includes contemplative practitioners, clinicians, and educators. BWD is for clinicians who have been through extensive medical training. These include physicians, nurses, and the interdisciplinary team of social workers, psychologists, and chaplains.

We establish a fixed quota in the program to ensure that one quarter of the participants are doctors, one quarter are nurses, and the other half are individuals from the interdisciplinary team. The eight-day residential program uses many learning modalities (e.g. didactic teaching, self-directed learning, inquiry, and creative processes) to enhance awareness of the importance of the inner life and professional responsibility.

The training has four components that center respectively on the transformation of the clinician, the patient, the community, and the institution.

**Transformation of the Clinician**

(1) **Worldview**
Our first step in this work is to identify and clarify the worldviews, values, priorities, and knowledge of the clinicians. This gives the clinician a functional base from which he or she can work. The worldview of clinicians actually influences how they deliver care. The worldview includes their values, which influence their priorities, which influence their knowledge—so we sequence it in that way.

(2) **Contemplative Interventions**
The second area we work with in exploring how we can transform the clinician is related to contemplative interventions—in other words, we teach them meditation. We call them “contemplative interventions” as a skillful means, because when you say “meditation,” it produces resistance in most medical settings. Our focus in these reflective practices or contemplative interventions is on the cultivation of insight, mental stability, and compassion. We work with a number of different contemplative interventions during the eight-day training program.

Let’s look at what we mean by “contemplative” dimensions since
we use that term to precede the term “end-of-life care.” This work has come out of my relationship with the formation of the Mind and Life Institute, which sponsors neuroscience research and dialogues with His Holiness the Dalai Lama. For many years, we needed the neuroscientific evidence to prove that these interventions were trackable and traceable and that the benefits could be clearly mapped. As mentioned in previous chapters in this volume, Jon Kabat-Zinn is one of the pioneers in this field and is also a board member of the Institute. The work in this area has increased exponentially over the past decade in large part due to the work that the Mind and Life Institute has done—much of which has been published.

When we say “contemplative,” we mean traditions that encompass moral and ethical virtues and values and that also engage in reflective practices that cultivate the mind. We are now learning from contemporary neuroscience that these practices provide deep benefits in emotional regulation and improved skills of attention. Meditation, specifically, assists with creating greater resiliency for individuals, inducing greater calm, reducing stress, and enhancing coping skills. These practices also cultivate prosocial mental qualities, like empathy, compassion, and so forth. We have also learned that these practices have a profound effect on the well-being of health care providers. This in turn has an effect on how the clinician interacts with the patient and how the patient perceives his or her own experience of dying.

In this context, we feel it is very important to teach clinicians how to develop a metacognitive perspective, which is the capacity to be self-aware, to be resilient or pliant, to develop intentional balance, to be compassionate, and to discover meaning in their work. We endeavor to help clinicians understand that there are beneficial outcomes to these contemplative strategies, including attentional and emotional balance, cognitive control, and resilience. Attentional balance, for example, means having an attention that is sustained, vivid, stable, effortless, and nonjudgmental. We also explore emotional balance and the psychosocial impact and neural substrates of empathy, compassion, and altruism. We point out the benefits of cognitive control and how you can guide your thoughts and behavior according
to your intention. We teach how to override habitual responses and
down-regulate aroused emotional reactivity. Through these contem-
plative interventions, one can develop mental flexibility, insight, and
metacognition, which means you are able to reframe experiences in
ways that are prosocial. There has also been important work in the
area of resilience, which involves not only stress reduction and relax-
ation but also enhanced immune response and other health benefits.

• Physiological practices: We employ a number of different con-
templative interventions to help people learn the very basic
mental state of focused attention: learning how to have a
narrow attention aimed at an object. For example, practices
include mindfulness on the breath, body-scan meditation,
and walking meditation. We also use yoga and chi-gong as a
means for enhancing embodied concentration. Through these
concentration practices, people begin to stabilize the mental
continuum.

• Compassion practices: Connected to these basic physiologi-
cal practices, I would like to also address the relationship
between the clinician’s ability to be aware of his or her visceral
processes, which is called interoceptivity, and its relation to
compassion. This interoceptivity involves experiencing one’s
digestive processes or cardiovascular or respiratory systems.
It is basically mindfulness of the body, which is one of the
Four Foundations of Mindfulness taught by the Buddha in
the Satipattana Sutta of the Pali Canon. What we have learned
is that people who are numbed out or autistic do not have the
ability to be interoceptive and to track their internal visceral
processes. If you do not have this capacity, you will lack the
capacity to actually sense into the feelings of another. Your
capacity to be interoceptive is a building block in the experi-
ence of empathy. Without empathy, which is the ability to
recognize and feel the suffering of another, there is no capac-
ity for compassion.
In this way, compassion is comprised of a number of different features. The first is its progression in stages from the ability to recognize suffering, then to feel suffering, then to develop the aspiration to transform it (either directly or indirectly), and finally to not be attached to the outcome. There are also two basic forms of compassion: biased or referential compassion and unbiased or nonreferential compassion. Referential compassion has an object, and nonreferential compassion has no object; it is universal compassion. We ultimately train clinicians in nonreferential compassion, but we begin by using referential compassion as a base. Finally, it is important that clinicians learn that compassion along with empathy and presence are not a one-way street. They are bidirectional; that is, experiences of mutuality. This means that in the moment, the individual is present, attuned, sincere, and well boundaried so that he/she does not go into a state of “empathic overarousal.” Authenticity is very important in such a situation.

In this way, we teach the four brahmaviharas (“boundless abodes”) of loving kindness, compassion, sympathetic joy, and equanimity, as well as a very long teaching on the Tibetan practice of tonglen (“giving and receiving”) in which one visualizes taking on the suffering of others and giving back to them well-being—a practice that we have seen the Rigpa Spiritual Care Programme develop highly elsewhere in this volume.

- Investigative practices: The next domain in mental training that we feel is important to address is the investigative faculty. We have set practices that develop insight, focusing on values, altruism, pain, suffering, death, and violence. These are existential dimensions. We do this through the practice of classical vipassana insight meditation from the Theravada Buddhist tradition, the Nine Contemplations of Atisha that come from the Tibetan Buddhist tradition, and the Contemplation of Priorities developed by Lama Yeshe.

For the subjective familiarization of the experience of the moment of death, we teach the meditation on the dissolution
of the body after death, as also explained in the Satipattana Sutta, and also the dissolution of the elements from the Tibetan tradition. We also do writing meditation that explores death and lead a process called “sandtray” that uses symbols based in Jungian psychology.

In addition, we address how to be present with pain and suffering without consoling or personalizing. One meditation we use for this is an adapatation from the Lotus Sutra. First, we do an exercise called “Seeing Purely,” which is to perceive an individual from his or her most unconditioned self. Then we do a complimentary practice called “Bearing Witness” in which people learn how to be simply present with the truth of individual suffering. Another practice that we teach is comeditation practice. This is a breath and visualization practice done with a caregiver and a dying person. We also train people in Council Process in which people sit in a circle and speak of their experience while not seeking consensus. This process helps one to learn to bear witness to an individual’s experience as it is.

- Nondual Practices: The final area that we teach is called Open Presence, which is the developing of panoramic, receptive, nonjudgmental attention. This is basically a reflective practice of choiceless awareness.

(3) Moral Character
The third area that we address has to do with the development of moral character. We explore the moral and ethical basis of what it is to not only cure but to care. We look at how one of the biggest challenges that clinicians encounter is moral distress. Thus, we teach people how to deal with moral dilemmas and moral conflicts.

We also have developed contemplative interventions to support relationship-centered care. When one has emotional balance, for example, one can be in better relationship with people, have better interpersonal communication, be emotionally intelligent, have an easier time communicating difficult news, be more sensitive on the
social and cultural level, and be a better facilitator of community. We find that having intentional and emotional balance and a metacognitive perspective assist with insight into ethical reasoning.

In this regard, we use the work of James Rest in terms of moral development. We think his ideas help develop increased moral sensitivity with which one is better able to empathize with another person’s distress. Because of intentional balance, you are better able to (1) discern the most ethical action; (2) have a deeper moral motivation, which means putting moral values ahead of other values; (3) develop moral character, which is to become a person who manifests strength in their convictions; and finally (4) engage in moral actions. To learn how to take action that is consistent with an ethical perspective is a big piece of training that we do.

As important as the development of compassion is, we feel becoming a wise clinician is equally important. In this area of training, we use the work of Thomas Meeks on the neurobiology of wisdom. Meeks looks at how wisdom is comprised of a number of different features including what we have already addressed in prosocial states of mind and behaviors; in other words, how do you actually value the promotion of the common good? We see how one rises above self-interest and engages in empathy, compassion, social cooperation, and altruism as a function of wisdom.

When the mind is truly stable and deep, one’s capacity to engage in wise decision-making is heightened. Such decision-making takes place on the social level based on having lived a life in which one has been self-aware and not just operating out of an automatic perspective. This means one is able to learn from one’s own life experience. This capacity is very important in the domain of wisdom.

Meeks also talks about how emotional balance and stability are essential in terms of the cultivation of wisdom and in the capacity to be self-reflective, to have self-understanding, and to not only be tolerant but to value altruism. From the point of view of tolerance, this means that one is able to see things from multiple perspectives and to be in a situation where there is an absence of projections. Meeks sees having a metacognitive perspective as essential in terms of the domain.
of wisdom, because it enables you to more easily deal with ambiguity. He talks about the capacity of the wise person to be open to new experiences and to act in the face of uncertainty.

(4) Self-Care
The fourth and last area for clinicians that we feel is very important is to train them in strategies for self-care and how they can actually support their well-being in a high-stress profession. Many professional caregivers experience burnout because the system—particularly conventional medical institutions or hospices that are fiscally driven—pushes them so hard. It may even be that these institutions benefit little from caregivers’ taking care of themselves. Often professional caregivers are financially rewarded for working overtime or taking on the night shift, and the overwork can produce stress that results in numbness. Numbness makes it difficult for a caregiver to feel what is really going on. It may make it difficult for him/her to perceive dysfunctional work patterns that the institution is perhaps encouraging. In the meantime, it is easy to become weary and gray with despair, sick from overwork and stress. We ask caregivers to assess nine areas of self-care: physical, emotional, intellectual, social, spiritual, cultural, relational, fun, and vocational.

These are four very large areas, but it basically comes down to the fundamentals of Buddhism; that is, how can we assist clinicians to be wise and compassionate? The training from many different perspectives opens up the values of wisdom and compassion, which are fundamental qualities to be developed for a sane and good person in the world today. We look at wisdom and compassion not only from the point of view of the individual but also in terms of helping institutions become wise and compassionate.

Transformation of the Patient
This focus on the clinician personally is not separate from the clinician’s work in an area that we call transformation of the patient.
Here we again have four major areas with a large curriculum behind each one.

(1) Patient Issues
We train the clinician to use various interventions to ascertain the social, cultural, and psycho-spiritual issues from which patients suffer. Cultural issues could be, for example, if they are from Japan or certain other Asian countries where denial of death is common and speaking about death actually induces fear within the patient. This is the kind of thing—that it is actually not appropriate to speak about death in front of the patient—that is important for a clinician, especially a Western doctor, to identify and understand.

(2) Pain and Suffering
We address the distinction between pain and suffering by looking at physiological and psychological changes. Pain is acute physical stress, and suffering is the story around it, the perception of pain. If a clinician asks patients whether they are more afraid of pain or death, many will say pain and the issues around pain control that interfere with physiological or mental function. This is something that has to be worked with. In the program, we feel that humans have enough pain just being in their bodies and that there is nothing redemptive about pain. Thus, we feel it is important to relieve pain in the most skillful way possible and to try to make that relief spiritually relevant.

(3) The Moment of Death
We deal with peri-death phenomena, which are all the processes around the moment of death. This includes what we call “active dying” (the final stage of the dying process), the actual moment of death, what happens for and around the patient at the moment of death, and then care of the body after death.

(4) Grief
We then focus on grief, in which we address issues related to anticipatory grief. This part also relates to clinicians and family members,
because anticipating the death of a person affects people deeply and leads to grief. The anticipation of one’s own death and the loss of capacity is also often accompanied by feelings of deep grief. Finally, there is, of course, the grieving experience for the patient’s family and for the clinical team. One of the questions we ask our clinicians is, “How do you mark the death of a patient?” Many clinicians do not mark it, and, of course, there are consequences to this.

Transformation of the Community

We have a deep emphasis on the profound value of relationship, relationship-centered care, and the development of the interdisciplinary team. The relational dimension could be clinician-patient, clinician-family, clinician-community, clinician-institution; patient-clinician, patient-family, patient-community, patient-institution; and so forth. In these terms, we try to teach clinicians about presence, how to not personalize, and how to not devalue the relationships of other people who are offering care within the wider community system. We also have a deep emphasis on the development of respect. This leads us into techniques in community development and cultural sensitivity. This work helps clinicians to ascertain the culture of the community and become sensitive to the cultural dimensions within the community in their caregiving process. In terms of our training process, we frequently use role-playing, particularly for culturally complex situations. Another issue that we work with in terms of community development is interprofessional relationships, such as respecting other members on the interdisciplinary team and teaching doctors to listen to chaplains. Here we address issues related to horizontal hostility and the profound importance of respect.

Transformation of the Institution

This area addresses the ethical issues that arise in an end-of-life care situation and the way that the institution responds to them. This
area deals with everything from having patient advocates, to advance directives, to how patients are communicating with family members about do-not-resuscitate orders, and so forth. There is also increasing inquiry into the spirituality of clinicians, which asks, “Where does our sense of meaning come from?” The contemplative dimension looks at what practices actually open up our capacity. The challenge is how to input this content in clinician training and then how to actually apply it to clinical settings. In this way, we are strongly advocating increased research initiatives in the medical field, such as with the Fetzer Institute in Kalamazoo, Michigan. Due to the diminishment of empathy and compassion in the clinical setting, Fetzer is very interested in us developing compassion-based training for clinicians. For our training to be effective, it very much depends on the clinician learning how to value well-being, insight, and compassion—and to basically have self-respect.

There is more and more interest today in spiritual care that is being mandated in very important ways in conventional medicine. For example, the Mayo Clinic in Rochester, New York, one of the most renowned medical institutions in the United States, says spirituality is an integral dimension of compassionate care and an important aid to healing for patients, their families, and their caregivers. The University of Virginia Medical School, where an academic chair in contemplative end-of-life care is now funded, says the good practice of medicine depends upon physicians’ awareness of both their patients’ and their own spirituality.

This major shift by many medical institutions in the United States to embrace the complete care of patients, their families, clinicians, and their communities has come about from the increasing suffering on the part of patients and clinicians. It has also come about because the efforts of some people in the field have begun to influence medical policy in this country. For instance, Christina Puchalski’s commitment to introducing spiritual inquiry into medicine by taking spiritual histories has sparked change; policy now mandates that, during the intake of the patient, there must be a spiritual interview.\(^6\)
The Buddhist Chaplaincy Program and Total System Change

In our Buddhist Chaplaincy Program, not only do we address suffering on a person-to-person level but, like the BWD program, we also look at whole systems that are suffering. Many clinicians have gone into medicine because of a calling. What is fascinating is that many clinicians are coming into our Buddhist Chaplaincy Program because their calling is not being fulfilled in medicine. All they want to do is what a chaplain does: address the spiritual dimensions in health care. We also have lawyers in our chaplaincy program who in a similar way changed fields because their desire for justice was not being realized in a dysfunctional legal system. We have people who are doing specializations in environmental chaplaincy, youth chaplaincy, and chaplaincy in businesses and government, in addition to prison and hospital chaplaincy. We have people now who are engaged in projects related to gender minorities, working with people who have gender identities that are not the two most common ones. We have people in human rights organizations and legal organizations that have become chaplains, because they are trying to understand justice in terms of compassion.

Our training program does not provide certification from the Association of Professional Chaplains, but you do not need this to sit with dying people or work in a legal institution. As a religious person, I think the kind of certification that is required in this country is useful, but I do not think it is necessary at all. If you are a minister, then you go and minister—but if you are a good person, then you step in and you care. We have a chaplaincy program that is very powerful. However, I really think this is about the human heart and about compassion, not certification. In those environments and countries where there is resistance to compassion, you have to be skillful; certification alone is not going to help get you into a system that is not interested in caring for people. As seen in the following chapter on Buddhist hospice care in San Francisco, hospice volunteers do tremendous work in this country, and they do not have psychological credentials. They do a brief hospice training, have good supervision, and serve
dying people. Ultimately, I think the idea of certification makes it harder for people to do something that is only human. We would not even need a system of certification if our communities were inspired to take care of the dying.

I feel that there is not much that separates the trained from the untrained, that aspiration is really the key. If you truly care, you can do the work. If this is not your work to do, then you won’t do the work. You won’t do the service. You won’t be engaged in compassionate care. It is not everybody’s job. I think it is fine that people want to create systems and standards, but I think it can prevent more good from happening and does not stop so much of the bad. For example, I know many people who are certified at the highest level as religious personages, professional psychologists, and psychiatrists but who are unsympathetic and unable to do this work. They have spent so much time getting certification that their own hearts have not awakened. You can try to train people in presence, but this is not how it works. Meditation is helpful in this regard. There are all kinds of games and techniques, but it is in a way a natural gift. Moreover, one’s aspiration really matters in this kind of vocation.

Our vision of chaplaincy operates on many different levels. Because you cannot separate the patient from the clinician, the clinician from the community, or beings from the institutions themselves, we have used a systems-theory approach for both our Buddhist Chaplaincy Training and Being with Dying training programs. Joanna Macy, the well-known Buddhism-and-systems theorist, is a teacher for us. Merle Lefkoff, who worked with Jimmy Carter in his White House administration as a diplomat and is a systems theorist, is on our faculty. We feel that a systems perspective is the only viable one. Individual clinicians can go through a deep change in how they approach their work, but the institutional demands create a moral conflict within them and within how they can approach their work. Therefore, you cannot look at things in isolation. Everything is interconnected—as Buddhism teaches. We also have a very strong emphasis on neuroscience, direct and structural violence, and ethics, relationship, and communication. In this way, our training, especially the chaplaincy program, is basically on socially engaged Buddhism.
After participants leave the chaplaincy training, they are supported by a cohort system of around twelve to twenty-four people. These cohorts are broken into smaller groups that are mentored by students from the preceding cohort. Students who have already been through the program mentor four to five people. They form a mindful community, a mini-cohort. They use email, the phone, and the Ning social networking website. They are a complete support and learning group. It has been a powerful process, overseeing these micro-communities as they have developed. We also have another network based on the participant’s chosen discipline; many people who come into the program are very interested and committed to end-of-life care, so there is a learning group on end-of-life care.

We do not use this cohort model with the Being with Dying program; it’s not necessary because BWD program attracts people from the same institution. For example, we have a large group of people from the University of Virginia who train every year, as well as clinicians from Duke University and San Diego Hospice, which is the largest hospice in the US. These are regional groups who then ask our faculty to continue the training process in those venues. This is necessary because isolated individual training does not work. You cannot sustain it.

I think that our model is a powerful one, because it has Buddhism, systems theory, neuroscience, and finally community development, all sitting on a contemplative base. I think we have been successful in introducing this work into the culture, because we see more and more of our curriculum appearing out there in the landscape. We are not proprietary about our curriculum or about our faculty, so people have a chance to develop the curriculum in their own terms and make it appropriate to who they are and the institution that they serve. Our work at Upaya is a model of a possibility in bringing Buddhism into Western culture in a very pragmatic way. As time passes, we have seen more programs around the country that are following our model. This bodes well for an engaged and applied Buddhism that is not only national but global.