Illness and culture in contemporary Japan

An anthropological view

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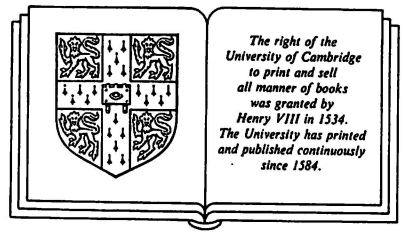

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9 Hospitalization: Biomedicine (II)

In this chapter I continue to examine the sociocultural aspects of biomedical health care in contemporary Japan by focusing on the process and experience of hospitalization. Many of the following generalizations, and the specific cases that illustrate them, pertain primarily to hospitalization either for the treatment of a physical illness or for an operation. They may therefore not apply to hospitalization for mental illness, to repeated hospitalization for a chronic illness, or to hospitalization at specialized *kanpō* clinics, only a few of which exist in Japan today. The description is not meant to be exhaustive, and its primary emphasis is perspectives from patients. Therefore, the role of a nurse, for example, is not included in the treatment and the role of a doctor is examined only insofar as it directly affects the patients.

The choice of a particular hospital is based on a number of factors. In the case of a company employee, for example, the firm may have insurance arrangements with certain hospitals. The most important factor in most cases, however, is the choice of a certain doctor who has shown expertise in a type of operation or the treatment of a particular disease. To receive care from such a doctor, some people are willing to choose hospitals a long distance from their homes. To supplement the family doctor's advice, people gather extensive information by word of mouth, although they rely most heavily on the advice of family members. Other things being equal, however, proximity is an important factor because family members continue to take care of patients after they are hospitalized, rather than relegating all this responsibility to the hospital staff.

Another factor, which I thought had totally disappeared, is the choice of a hospital that is in a favorable direction from one's house. I was reminded of this when I met a *futon* (bedding) dealer in hospital X, who had come to deliver a covering *futon* (*kakebuton*) to a patient. He and his customer were both from an area southeast of the hospital that was inhabited primarily by blue-collar workers. Although the hospital had once been fairly exclusive, catering only to the well-to-do, the insurance system had made it accessible to people with lower incomes. When this occurred, I was told, people in the southeastern area started to choose

the hospital because of its location, which was auspicious for them. This factor is no longer very important to most contemporary Japanese, who either do not think of it or ignore it in favor of the other factors discussed above. In nonemergency cases, many people used to choose a good day in the lunar calendar (see Chapter 3) to enter or leave a hospital. At present only a small number of people, usually the elderly, follow this practice, as Chiba (1981) observed during her hospitalization in Tokyo. As noted in Chapter 4, Taoistic beliefs in auspicious and inauspicious temporal units (certain days of the month or years in the cycle) and spatial directions still govern the conduct of at least some Japanese.

Introduction to a doctor

To many Japanese patients, a personal introduction to a doctor is very important in cases of hospitalization. One example, the case of Mr. A described in Chapter 6, will suffice as an illustration of the feeling about this practice. When he and his immediate superior at work decided that he should have his recurring ulcer treated surgically, the company doctor selected a municipal hospital in Osaka because of a particular surgeon there who was known for operations on the stomach. The company doctor himself made a special referral so that the man would be operated on by that surgeon, and not by another. When the selections of the hospital and surgeon had been made for the man, the husband of his wife's sister undertook to find someone who knew the doctor personally. He found that an old classmate at his high school, from which he had graduated some forty years earlier, had later become a classmate of the surgeon in medical school. His high school classmate telephoned the surgeon, and the personal "introduction" was successfully completed. Mr. A and his wife were profoundly grateful, and repeatedly talked about their brother-in-law's kind gesture. They expressed their gratitude when Mr. A was celebrating his recovery, and sent gifts to those who had visited him during his stay in the hospital. While the brother-in-law of Mr. A used his connections to secure an introduction to the doctor, Mr. A's brother took off from work in order to obtain an amulet from the Ishikiri Shrine.

Lest this description suggest merely the quaint habits of a strange people, or reinforce the stereotype of the Japanese emphasis on kinship and indebtedness, I must point out that the practice of securing a personal introduction to a doctor actually demonstrates the Japanese refusal to be passive recipients of institutionalized health care. These cultural institutions permit the Japanese to create, at least in their own minds, the optimal conditions for successful operations or treatment. They feel confident that they are the ones who have chosen their doctors, and not vice versa. They have the assurance that their doctors will pay personal attention to them and do their best, since they have established special relationships with them through proper introductions. Furthermore, the patients

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are reassured by the concern of others who have gone to shrines and temples to pray for them; and after all, a talisman does not hurt, and may even help, in ensuring the success of the operation or treatment. In short, the patients have done their best to personalize the situation, without becoming engulfed in a huge, impersonal institution.

On the other hand, this system can adversely affect people who cannot obtain an introduction. In fact, there has been a great deal of controversy about a related matter – that is, that "introductions" often are accompanied by a substantial gift, either in cash or in goods. Whether or not the system works against the less privileged, then, depends largely on the integrity of individual doctors. The National Center for Circulatory Diseases, for example, adopted a policy that forbade doctors to receive gifts. Some patients felt relieved about this policy, but others felt somewhat helpless at having their means for expressing gratitude eliminated.

Length of hospitalization

The average length of hospitalization in Japan is by far the longest in the world. A survey by the World Health Organization in 1977 (quoted in Kōseishō, ed. 1978:158) found that the average length of hospital stay for a patient was as follows: 42.9 days in Japan, 8.1 days in the United States, 16.7 days in West Germany, 13.5 days in Italy, 12.9 days in Sweden, 12.8 days in Denmark, and 13.1 days in England and Wales. In the case of Mr. A, he was hospitalized for a month and a half for an ulcer operation, and was on sick leave from his work for a total of two and a half months. Chiba (1981) was given an estimate of four weeks of hospitalization for her mastectomy, although this young woman journalist was determined to be discharged as soon as possible. She managed to be discharged after fifteen days, including one week of preoperative stay, setting a record for the shortest stay in the hospital. Another woman journalist, Nakazato (1981), was hospitalized for two months for a mastectomy.

My observations of doctor's recommendations at the obstetric-gynecology clinic also revealed many cases of long hospitalization periods, and showed the readiness with which women were willing to be hospitalized on doctor's recommendations. One case involved a pregnant woman who had no major symptoms. She was recommended for hospitalization so that she could rest, because she had a history of miscarriages and had experienced some difficulty in becoming pregnant. Furthermore, as the case of Chiba (1981) illustrates, the preoperative period of hospitalization is long, especially in contrast to the procedure in the United States, where a patient is usually admitted the day before the operation. Doctors at the obstetric-gynecology clinic at hospital X often recommended hospitalization for childbirth well before the due date and before any sign of

labor, especially for women with a history of difficulty, or who were pregnant for the first time.

The length of hospital stays has been discussed in Japanese newspapers and other mass media. Some sources argue that in order to receive as much reimbursement as possible from the government and insurance companies, the hospitals take as many patients as they can and encourage long stays. This practice has been observed especially in treating the elderly, who are totally covered by the national health insurance plan. Some elderly patients, feeling as though they are suddenly left to care for themselves, prefer to stay in the hospital even after recovery. Opinions of doctors on treatment of the elderly remain divided. The director of hospital X said that he really did not have the heart to "kick out" old people if they wished to stay, provided the hospital had enough beds to accommodate them. Others argued that hospitals should not be old people's homes.

On the other hand, Okuyama (1976:50–2), a frequent and vocal critic of the Japanese medical system, argues that two factors are responsible for long hospitalization. First, in his view, patients in Japan are not hospitalized soon enough; they wait until they are very sick, and longer hospitalization is therefore required to treat them. Second, he says that the care provided by Japanese hospitals is so poor that recovery is slow, necessitating a long stay. He therefore suggests: "Perhaps patients should stay longer in a hospital, since too frequently they are discharged before complete recovery from their disease" (Okuyama 1976:52).

Okuyama's remarks are especially interesting in that, despite his consumer-advocacy approach, he argues for even longer hospitalization. His opinion provides additional evidence that one of the major factors behind the unusually long hospitalization period in Japan is a basic "pampering" attitude toward the sick, as we saw in previous sections of this book. The Japanese think of many more conditions as "illnesses" than biomedicine recognizes as "diseases." Even biomedically trained doctors recognize the presence of "illnesses" rather than just "diseases." In fact, contrary to Okuyama's interpretation, Japanese patients seem to be hospitalized longer and with much more minor symptoms than they would be in the United States.

Part and parcel of the Japanese attitude toward illness is the emphasis on *ansei* (peace and quiet, or bed rest) as the major treatment for virtually any illness, from a minor cold to a major disease. Exercise during pregnancy or after an operation has been effective in promoting speedy recovery in the United States. It has had a very limited success in Japan. One head nurse at university hospital Y told me that when they recommended exercise, many patients took offense and thought it inconsiderate; they insisted on *ansei*, "at least when I am sick." Biomedically, according to one doctor at university hospital Y, the practice of *ansei* has had little adverse effect on Japanese patients who, unlike Western

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peoples, have little problem with thrombosis. Lengthy hospitalization, then, may be seen as the official sanctioning of *ansei*, the most cherished treatment method in popular Japanese medicine. Long hospitalization periods thus affirm the legitimacy of, and provide institutional support for, sickness.

The definition of a wide range of ailments as illnesses, the "pampering" attitude toward the sick, and the belief in bed rest as a cure-all cannot completely explain the long hospital stays; some institutions, such as the insurance system, also are responsible. Another crucial factor in understanding the practice of lengthy hospitalization is the care of patients by the family and others – that is, hospital personnel are not the only ones who tend to the sick. Because of the substantial support by family and others, hospitalization is not nearly as costly as it is in the United States, where the sick are cared for exclusively by hospital personnel.

Another important characteristic of Japanese culture that facilitates long hospitalization is the way an individual worker's role is defined in Japanese organizations. A worker's job does not consist of tasks assigned exclusively to that particular individual. Instead, "diffuse job definitions" or "a lack of sharp jurisdictional definitions of job duties" (Cole 1979:200, 220) results in extensive job rotation. This practice enables co-workers to cover the tasks of the sick person with relative ease. There are few empty spots in the work allocation that no one else can fill. A long absence from work in Japan does not mean the inefficiency in production or execution of tasks that results in a society where individual work roles are more clearly delineated. In the case of a woman with a family, the period of hospitalization is often shorter, precisely because she is often the only one who can carry out all the tasks at home; she seldom has "co-workers" who can cover her job. Therefore, unless a woman has an adult offspring, usually a daughter, or other women who can help, she must go home as soon as possible. Even for women, however, hospitalization is much longer than in other societies.

For both men and women, there is an implicit and sometimes explicit expectation on the part of the patient, approved by family members and doctors, that hospitalization is a form of "vacation," a reward for hard work. This attitude may be linked to the limited use of paid vacation time by Japanese employees. Illness legitimizes the "vacation" Japanese workers otherwise feel pressured not to utilize (Cole 1979:231). Needless to say, the connection between these two phenomena is not always consciously recognized. This situation also applies to nonworking women, as we saw in Chapter 8. At hospital X I heard some women explicitly state that their hospital stay was a *kyūka* (vacation) from their families. On their vacation, patients expect to relax and be spoiled. It is predictable, then, that many Japanese patients resist postoperative exercise.

In the following sections, I will examine the role of the sick and patients

against the broader background of social relationships in Japanese society. Technically, the patient role begins only when a person is placed under the care of a hospital or doctor. The sick role, on the other hand, starts whenever a person becomes ill; that is, if his or her conditions are recognized as symptoms of an illness as defined in that particular culture. She or he is then relieved of some or all their normal roles, depending on the gravity of the illness. Numerous factors create intracultural variation in this pattern. People who are not well off are excused from their normal roles much less readily than those who are wealthy. In addition, certain roles for an individual may be relinquished more easily than others. For example, a woman may be able to give up her role as a professional, a homemaker, or even a wife, but may have to continue to fulfill her duties as a mother, depending on both the emphasis on the maternal role in her culture and the age of her children. Again, I will be stressing generalized Japanese patient roles, with some discussion of male-female variation at the expense of other types of intracultural and individual differences. In a Japanese hospital, people continue to carry out the sick role in their relationship with family members and visitors, but assume the patient role in dealing with the doctor and other hospital personnel. In the following description, I do not always make a distinction between the two.

The patient role

Retention of personal identity

In the United States, where the sovereignty of the individual is sacred, the patient role ironically denies individualism, at least symbolically. It begins with admission to a hospital, when an individual must discard such traces of personal identity as personal belongings, including clothes. People must change to nondescript sterile gowns and wear wristbands as identification, and assume a new identity as a "patient."

In sharp contrast, the patient role in Japan reinforces individual identity, as well as each patient's identity as a social persona. This is indeed ironic, since Japanese culture is not known for its emphasis on the individual. In Japan, where one must usually wear a uniform from kindergarten all the way through high school, and formerly through the university, hospital patients use their own nightwear. The use of personal nightwear may seem trivial. However, its symbolic significance in the retention of the patient's individual identity becomes clear with increased understanding of the patient role in the Japanese medical system. Nightwear is one of the most welcome gifts to a patient, chosen especially by those who know the patient well. Attractive nightwear is thought to cheer the patient. The patient must change this clothing often, since it gets soiled, or symbolically polluted, by the sick body more quickly than usual. Extra night-

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I casually mentioned the American custom of wearing a sterile gown to a group of young women part-time workers at the National Museum of Ethnology, and was taken aback by their emphatic expressions of distaste, which I attributed to their young age – the age when appearance is very important, especially when one has only recently been released from school uniforms. This incident happened at the beginning of my fieldwork, and I had not thoroughly analyzed the differences in the patient role between the two cultures. Also, because I had been hospitalized only twice in Japan, when I was very young, but several times more recently in the United States, I had become accustomed to the American practice. Later, I discussed the American admission process with a colleague who had spent several years in the United States when she was a graduate student. She recalled the discomfort she felt when she was forced to change to a sterile paper gown at the university infirmary. She explained that it was an important incident, in that she became sharply aware of the alien nature of American society, in which she would never really feel at home. In other words, the gown was an epitome of what she perceived as the essence of American culture, with which she felt incompatible.

To ascertain the feelings of health professionals on this matter, I described the American admission process and the use of hospital gowns to a group of eight doctors. Their negative reaction was just as strong as that of nonprofessionals. One doctor in his mid-fifties, who was once the head of a medium-sized hospital but was now in private practice, said that if a Japanese hospital decided to enforce such a rule, people would bring suit against this abrogation of human rights, and it would be all over the front pages of the newspapers. All of them stated that they would let even very ill patients wear not only their own nightwear, but also their own underwear, precisely because they are so ill, and should be made as comfortable as possible. They then pointed out that the practice was indeed inconvenient in cases of bedridden patients, especially since most Japanese use Western style underwear, rather than the traditional underwear, similar to a wraparound skirt, which would be much easier to handle.

I introduced the subject again when I visited doctors and nurses at university hospital Y. There, according to a head nurse, some hospital personnel had recently brought up the idea of instituting the use of hospital gowns. The idea met with immediate and strong objections at a meeting. Some then suggested using gowns of several different colors, with lace for women; even then the proposal was quickly dismissed. The head nurse added that people feel that "at least when they are ill," they should be able to choose their personal attire.

Retention of kinship identity

Continued care by the family and others. Not only do patients remain individuals after hospitalization, but they also remain part of the basic social unit, which in

most cases is the family. Care of the sick is not transferred completely to the hospital. Instead, the people closest to the patients continue to care for them, often day and night, in important ways. This care begins at the time of admission. For example, the internal medicine ward of the National Center for Circulatory Diseases allows families and other people close to patients, including children, to wait in the hospital rooms when the patients are brought in for an operation or treatment at the intensive care unit. The doctor at this facility pointed out the importance of the *seishin ian* (psychological comfort) provided by the family. A nurse added that patients feel they must share a nurse, but they can expect exclusive attention and care from their *miuchi* (inside people), families and other closely related people (see Chapter 2). She also pointed out that this practice is beneficial for the family, since they would become restless at home, not knowing what is happening to the patient.

At this hospital, where regulations are much more strict than at most other hospitals, the family must receive permission to care for the patient first from the head nurse and then from the hospital. These rules are made by the head nurse of each ward, so some wards have more stringent rules about family care than others. In fact, at the ward for infant heart surgery, families are not allowed to attend to the patients because of their critical condition. According to a nurse in this ward, some families arrange for their infants to stay in another pediatrics ward so that they can be with them.

Most other hospitals, however, almost expect the continued participation of the family in patient care. The director of hospital X, in fact, told me that he often relied heavily on the observations of family members about the patient's changing condition; he assumed that they would have better knowledge of the patient's condition, and therefore would make sharper observations, than could a nurse who would see the patient only occasionally and might not feel the same concern. A doctor in his late thirties at a municipal hospital near Osaka told me of his dismay when he visited hospitals in France. He observed that family members there would not bother taking care of "the functions of the lower part of the body"; instead, they watched as the nurses did so and went home in the afternoon rather than staying through the night. He felt quite disappointed, as he put it, especially since the French were so demonstrative toward the patients in kissing and other bodily contact. To him, it was incongruous that their expressed feelings were not supported by what he considered to be devoted care for their loved ones. In contrast, he noted that Italians were similar to the Japanese in terms of family care for the patient.

If circumstances permit, one family member will stay with a Japanese patient in the hospital room. Unless the family hires a *tsukisoi* (a round-the-clock attendant), someone stays even at night. There are three major functions for the people attending the patient. First, they attend to all personal needs, unless that

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The third major duty of the family is to provide meals for the patient. Families used to bring bedding as well as cooking equipment to the hospital, and cooked for the patients right there. Although this is rarely done now, some hospitals still allow patients to bring their own bedding. Some Japanese feel that the Western-style blankets provided by the hospital are uncomfortably thin, and bring their own quiltlike traditional bedding. Although the custom of bringing cooking and eating equipment is no longer practiced, contemporary Japanese use the system of *sashiire* extensively. The original meaning of the term *sashiire* refers to goods, including food, brought to imprisoned defendants awaiting verdicts. Japanese use this term figuratively in referring to the custom of bringing cooked food for the patient, implying that the patient is "imprisoned." Between *sashiire* and the food brought by visitors, some patients never taste the food served by the hospital kitchen, although hospitals now provide three meals a day, with government funds. Patients, family members, and even doctors all have a ready explanation for the practice – the food at hospitals is very poor in taste and quality. One doctor stated emphatically: "We certainly cannot expect a sick person to eat the hospital food, which is not edible even for a healthy person; the money provided by the government for hospital food is not enough to prepare tasty and nutritious food."

The family usually emphasizes the patient's favorite food as well as food that is good for sick people. Mr. A's wife commuted every day with food from their home in Kobe to the hospital in Osaka, roughly a four-hour round trip. Prior to his hospitalization, in order to ease the man's ulcer, his wife kept a number of aloe plants, the popularity of which as a health food had once swept through Japan; she made every conceivable dish that could be made with aloe leaves, often in unrecognizable form. Now that her husband was in the hospital, she brought a dish of clams whenever she could; clams are a traditional *byōnin shoku* (food for the sick).

In accordance with this emphasis on family care of the sick, doctors often urge terminal patients to go home to die. When they observe that death is near, they usually tell the families to take patients home, so that they can breathe their last there.

Family members and others who take care of patients. So far I have referred to the family and family members without specifying exactly who participates in patient care. When a patient is someone other than the woman of the house (*shufu*), there is little question of who takes care of the patient – the woman takes care of her husband and children. This is the ideal pattern, and when possible, it is closely followed.

The role of women as caretakers of the sick overrides other roles dictated by

the formal kinship structure. Japanese society used to emphasize patrilineal descent. Until the end of World War II, the law required that the oldest son inherit the major part of the property, in return for assuming the responsibility for taking care of the parents. Upon marriage, a daughter would leave her natal family and join the family of her husband. Not only did she acquire his family name, but she was also entered in his family registry and buried in his family plot. Ties with her own family remained secondary to ties with her husband's family. Even at that time, there were culturally sanctioned occasions when a married woman returned to her natal home; these occasions included childbirth and the times when her parents became sick.

Some of these traditional kinship rules still prevail, although the spirit has waned considerably. The emphasis now is the nuclear family and a stronger conjugal bond. There is much less pressure for younger women to give their primary allegiance to their husbands' families. Of the changes in kinship structure installed by the new constitution after World War II, the elimination of the primogeniture rule, accompanied by the institution of equal inheritance among offspring, has resulted in an unexpected problem for the aged in Japan: There is now no cultural rule that specifies who must take care of parents in their old age.

My own observations of case studies point to an increase in daughters taking care of their own parents, although a government survey in 1977 (quoted in *Asahi* April 1, 1979) reported more involvement of son's wives in care of the elderly. According to this survey, of the persons responsible for care of the aged, 37% were son's wives, 24.7% their own wives, 17.8% daughters, 5.7% their own husbands; daughter's husbands or sons were not involved. Whatever their kinship roles, then, women are in charge of the sick, and often they must care not only for their own elderly parents, but also for their husband's parents.

What if, then, the woman herself becomes sick? As noted earlier, the sick role or patient role assumed by women is somewhat attenuated. Pampering of the sick, long hospitalization periods, and all the other features discussed in this section apply in the case of women, but with considerable modification. Just as in the United States, a woman can ill afford to stay in bed all day, and must be hospitalized only as a last resort. "What do we do if mother gets sick?" was the title of a newspaper article published by the Kobe Municipal Government (*Kōbe* March 15, 1979). The article urged women to go for regular checkups to avoid becoming ill; the message is that women cannot "afford" to become sick.

When women do get sick, as the statistics above show, care is not always provided by male kin. In the case of the care by husbands, regardless of generation, the decision seems to depend on the individual; the role of a husband does not formally include the care of his wife (see *Asahi* May 16, 1979). I have seen many cases in which either a daughter or a mother came to help, even from

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a long distance. For example, when the wife of a physician at university hospital Y was hospitalized, her mother came all the way from the island of Shikoku, bringing an amulet from their community shrine, and took care of her grandchildren. One woman in her late forties at the obstetric-gynecology clinic at hospital X asked for immediate admission to the hospital for a partial hysterectomy; she had taken ''a leave of absence'' from her family for one month in order to undergo surgery at the hospital near her mother's house so that her mother could take care of her. Her own family resided in Kyūshū, indeed a very long distance from Kobe. In general, women choose hospitals with more nurses and other personnel to care for them, and rely less on family members.

Retention of identity as a social persona

Visitation (mimai). If the use of personal nightwear and other belongings signals the retention of the patient's individual identity, and if continued care by the family symbolizes maintenance of kinship identity, then the custom of *mimai* (visits to the patient) sustains the identity of the patient as a social persona. The patient role in Japan does not override these other three roles, which are the most basic as well as the most meaningful to the individual in most societies.

Mimai, or visitation, is a well-established cultural tradition with a long history. The term refers to visits during critical or uneasy times for an individual, such as during a serious illness. Visits are also made during seasonal rites of passage, such as midsummer or the end of the year. Offering a gift is such an integral part of *mimai* that the term is sometimes used to refer to the gift itself. In the past this gift was always food, and even now it is usually food. The food brought in to the patient is commonly called *sashiire*, as noted earlier. Traditionally, the visitor must share the food with the patient, with the idea that the vitality of the healthy visitor is transferred to the patient, aiding the process of recovery. Contemporary Japanese think of food as the source of energy in the literal sense, although food has always been considered the source of symbolic power (*chikara*) (Yanagita 1962).

I asked the doctors about damage done by food brought in by families or visitors to patients on special diets. They had all encountered cases in which food brought in did have negative effects on their patients. They also pointed out that even though the person to whom the food was brought might not be on a special diet, another occupant of the room might be. Because food is customarily shared by all those in the same room, it could cause harm to those on special diets. These doctors were quite convinced, however, that the benefits of providing good food to *chikara zukeru* (cheer up) the patient far outweighed the possible danger. Even though these doctors, thoroughly steeped in biomedical

knowledge, do not believe in the literal interpretation of the traditional *mimai* custom, they acknowledge its psychological effect on the patient and, even though unconsciously, the symbolic meaning of food. This is the basis for their extreme lenience toward this custom; they did not seem to be offended by such violations of their instructions.

Shortly before I started to visit university hospital Y, the administration had moved up the starting time of visiting hours so that they would include both lunch and dinner. The sole purpose of this change was to accommodate feeding of the patients by families and visitors. One young doctor, however, suggested to me that, by allowing these practices, Japanese doctors showed too little concern about the entire body of the patient, and instead were concerned only about the ailing body part. This opinion was certainly in the minority, although some wards of larger hospitals, such as at university hospital Y or the National Center for Circulatory Diseases, where patients are on special diets, do have stricter rules. Most patients I talked to welcomed the food from outside. The extent to which patients cherish *sashiire* is vividly illustrated in the diary-report of two women journalists (Chiba 1981; Nakazato 1981). I might point out that this practice works quite well with Japanese foods, most of which are served at room temperature, unlike most Western main dishes, which must be served hot.

The importance of visitation to the retention of the social identity of the patient cannot be overemphasized. In addition to close family members, other people are expected to visit patients, including more distant relatives, friends, and people at work. Neglect of this custom is usually interpreted as a sign of unwillingness to associate with the patient, or even worse, of negative feelings toward the patient. Although some ignorance or neglect of social manners is tolerated, negligence by those who must pay a visit may bring grave social consequences.

In general, these rules are also applicable in the United States, where hospital visitation is increasingly less emphasized; however, the practice is assigned a great deal more importance in Japan. In the case of one elementary school boy, cited as an example by a doctor at university hospital Y, the teacher and the entire class came to see him after his surgery. The hospital has since adopted the policy of warning the family in order to prevent such occurrences. Usually, the higher the social status of the patients, the more visitors they receive. Mr. A's case again serves as an example. During his two-and-a-half-month stay in the hospital, he received a total of 114 visitors, the majority of whom were from his company. Some, like his immediate superior, visited him regularly, bringing news about the company and also about international trade and the stock market so that Mr. A, who had always worked in the export-import section of the company, would be kept abreast. Because he had taken good care of the men who worked for him, many of them also made repeated visits.

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position of the husband or father is often reflected. For example, a nurse in the pediatric ward at university hospital Y recalled a recent incident involving the grandson of a well-known person in Osaka. On the first day of the boy's hospitalization, 36 visitors, most of whom did not know the boy himself, came to his room, leaving gifts and name cards to inform the grandfather of the visits.

As noted above, university hospital Y recently extended its visiting hours to accommodate carry-in food at lunch; the hours are now from 12 noon to 7 P.M. for all the wards. At hospital X, the hours are from 3 to 8 P.M. on weekdays and from 10 A.M. to 8 P.M. on Sundays and holidays – although the hospital was very lax, so that one could actually visit patients at almost any time. The National Center for Circulatory Diseases had the shortest hours: from 3 to 6:30 P.M. on weekdays and from 1 to 6:30 P.M. on Sundays and holidays. The enforcement of the rule was also more strict at this hospital. In the Keihanshin area there are a few hospitals operated by foreigners or Western religious organizations. These hospitals tend to follow the non-Japanese tradition of strict hours for visits. One such hospital, a Baptist hospital in Kyoto, has experienced a number of cases in which women come for prenatal care but choose another hospital for childbirth that has longer visiting hours.

The frequent presence of visitors in hospital rooms certainly generates ambivalent feelings on the part of doctors, patients, and their families. The possible harm done by the demands of visitors to a patient in need of rest has often been argued among people and in newspapers (*Asahi* March 25, 1979). Many people advocate a change in this custom. Indeed, the *mimai* custom runs contrary to the Japanese emphasis on the peace and quiet, or bed rest, that is recommended for almost all illnesses and for postpartum recovery. An apparent contradiction exists, then, between the medical value of bed rest and the value of social relationships. The predicament created by this contradiction was expressed by the director of hospital X: "It is indeed hard for us to refuse visitors when they come from far away or when their visits might cheer up the patient, even though most patients need a lot of rest."

The dilemma is worse when the patient becomes critically ill, because of yet another social custom. As a young doctor once explained to me, it is the duty of the doctor treating the patient to notify the family when death is approaching, and he or she often urges the family to take the patient home to die. In turn, it is the duty of the family to notify certain people who are expected to come and bid their last farewells. If the patient cannot be moved from the hospital, the doctor can put up a sign saying "No visitors" on the door. Ironically, this sign is read that the patient is in critical condition; consequently, it often increases the number of visitors. A doctor recalled one painful incident in which the medical staff set up an oxygen tent in the room of a critically ill patient and many visitors rushed to see him, defeating the purpose of the treatment and endangering the

patient's life. One method sometimes employed by patients who are well known is to place another name on the outside wall of the room in the hope that most visitors will not be able to find the correct room. One large hospital discontinued posting the patient's name on the wall outside the room for the same reason.

The seemingly excessive lenience in allowing hospital visitors, however, must be analyzed in the context of Japanese society and Japanese views of human and social relationships. There is no question that in critical cases, the harm caused by visitors can be serious and sometimes devastating. On the other hand, in many cases the visits, although they tire patients in many ways, do have positive psychological effects. Most important, visitors enable patients to maintain their social identities, by reassuring patients that not only their friends and families, but also their co-workers perceive them as important. For people to whom work is important, and whose own self-images are derived largely from their identities as social personae, a flow of visitors prevents a sudden void in their own self-perception; otherwise, they might experience a feeling similar to the one at the time of retirement, when a person may go from "President Frank Smith of X Company" to simply "Frank."

The beneficial psychological effect of visitors was quite clear in the case of Mr. A. His immediate superior's daily visit not only kept him informed about happenings at his company and in world trade, but also reassured him that he was in good standing with his boss. His wife occasionally chided him, after his boss left, asking how her husband's condition could be expected to improve after hearing about the stock market, and so on. Given Mr. A's devotion to his work, however, and his personality, which is very sociable, the positive psychological effects seemed far to outweigh any adverse physical effects.

The involvement of the entire social group in Japanese hospitalization is curiously similar to the shamanistic healing process of so-called primitive or folk peoples. Many scholars point out that shamanistic healing is a communal event and that community involvement is a major source of moral encouragement for the patient, who can see and feel that others are concerned about his or her well-being (Ohnuki-Tierney 1981a:168–9). Thus hospitalization in industrialized Japan and shamanistic healing both emphasize the importance of involvement by the entire social group – the members of the community in shamanistic healing in a folk society, and the members of the social network in Japan.

The Japanese system, in which hospital patients are cared for by family and friends, has protected Japanese patients from the encroachment of the increasingly impersonal nature of modern life. However, the practice does exact a toll, especially on women, especially now that more women are working outside the home. In the cafeteria of hospital X, I met a woman who came every day to take care of her husband and spent a great deal of time at the hospital. She and her husband jointly operated a gas station, and she continued to supervise their

employees and take care of the financial end of the business. A woman's perception of this system is described vividly in *Onna ga Shokuba o Saru Hi* (The Day When a Woman Leaves Her Work), by Okifuji (1979), who describes her final decision to quit work in order to care for her father, who became a victim of cancer. The system also works against individuals without families, although many do have friends and others who extend care as family members would do, as described in Chiba (1981) and Nakazato (1981).

Gifts. Hospital visits are almost always accompanied by gifts. Although the function of any gift is social, the choice of a specific gift derives almost exclusively from the symbolic meaning assigned to the item chosen, thereby rendering the immediate goal of the gift-giving not pragmatic or economic in nature. Based on my observation of Mr. A's case and several others, discussions with other people, and consultations at the gift departments of three large department stores, one in Osaka and two in Kobe, I see roughly four types of gifts that are considered appropriate for the occasion: food, items for personal cleanliness, flowers, and money.

In the past, food was the only gift item for the sick, and it is still the most common. Traditionally, uncooked fresh foods are chosen; because of their freshness (*nama, shinsen*), their vitality is supposed to be transferred from nature, via the healthy person, to the patients to invigorate them. Eggs used to be one of the most welcome presents for the sick (Embree 1958:214) and continue to be a health food among contemporary Japanese. However, eggs are no longer used as gifts, at least in urban areas. At present, fruits are chosen most often. Cantaloupe-type melons, originally an imported fruit, are one of the most prized gift items. Each melon comes in a gift box wrapped in soft white paper and is fairly expensive, ranging from ¥ 2,000 ($9) to ¥ 4,000 ($18). It seems luxurious, with its Western origin, and very different from more "mundane" apples or tangerines. Canned fruit juice, often packed in a gift box of two or three, is another popular present today, although it is not "fresh" fruit. The choice of fresh, natural food, and of such fruit as cantaloupes, which are of Western origin, reveals the link between the symbolic nature of the food selected for the patient and the clear-cut "outside," represented by nature and foreigners, both of which are associated with healing power (Chapter 2).

In urban areas today, visitors – especially those who know the patient well – often bring cooked food, either sweets or main dishes. They try to bring the patient's favorites. Extreme care is taken in choosing the food from a store known for that particular type of food. This concern reflects the Japanese emphasis on *shinise* (stores operating for generations, and known for certain kinds of food). In addition to regular dining halls, most department stores have a *meitengai*, which houses well-known restaurants, and in the basement they also

feature famous manufacturers of food. The choice of the right food from the right store indicates not only refined taste on the part of the visitor, but also eagerness to please the patient. The selection of cheese or wine in many Western societies is somewhat similar, but in Japan the range of foods is quite remarkable; careful selection applies not only to some main dishes such as *sushi*, but also to seaweed, pickles, and almost every other food item.

The second major category of gifts includes *nemaki* (nightwear, either Western-style pajamas or the traditional kimono made of cotton or gauze), cakes of soap, and colognes. Common to all three items is their symbolic relationship to pollution and purification. Nightwear, as noted earlier, touches the sick body and thus must be changed frequently in order to get rid of the pollution. Relatives and friends who are fairly close to the patient sometimes give nightwear to facilitate these frequent changes. The symbolic association of soap and colognes to purification of the sick body is obvious. The popularity of soap as a gift item is illustrated by the 1979 spring-summer catalog from the gift section of the Daimaru department store in Kobe. The catalog lists thirty-one kinds of cake soap, all in gift boxes, and fourteen kinds of cakes of soap in different shapes (lemon, eggplant, cucumber, golf ball) in boxes and baskets, plus five kinds of laundry detergent in gift boxes. The price ranges from ¥ 500 ($2.30) to ¥ 3,000 ($13.60). In addition, it displays eighteen different combinations of imported cakes of soap and colognes, including the Chanels. The prices for these assortments are the highest, and range between ¥ 1,000 ($4.50) and ¥ 7,000 ($31.80). First introduced by the Portuguese, soap is a popular gift item for other occasions as well. However, when used as a gift for patients, its meaning as a purifying agent is perceived even by Japanese who describe their perception only in "scientific" terms.

The third type of gift is flowers. Flowers are pleasing to a bedridden patient, and the flowering process suggests growth and the vigor of nature. However, there are a number of taboos in choosing flowers. The most important is to avoid giving potted flowers, since the roots suggest a metaphor for the patient having roots in the hospital and never being discharged. Some Japanese, especially the young, are not fully aware of this taboo, and sometimes bring potted flowers; these are usually given to nurses and other hospital personnel. The choice of a particular flower also follows certain rules. Camellias must be avoided, since when the flower withers, the entire "head" falls off – an all-too-obvious analogy with death. The hydrangea is also taboo, since its flower changes color, suggesting a change for the worse in the patient's skin color. The Japanese are very sensitive about skin color, and the absence of luster and paleness are interpreted as symptoms of ill health. Lilies are also unwelcome, since their smell is too pungent. At present, according to nurses at university hospital Y, the two most

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welcomed flowers are roses and carnations, which were originally imported. Their symbolic implication is akin to that of the cantaloupes of Western origin.

The last type of gift is money. Many Japanese frown upon cash as a present, but it is used especially by distant friends and relatives who do not feel obliged to visit, but would rather ask another visitor to deliver a gift for them. The use of money as a gift has not been uncommon among the Japanese; money has always been used for *otoshidama* (New Year's gifts to children) and *kōden* (gifts at a funeral). However, one must be careful in choosing money as a gift lest it be interpreted as a sign of lack of thoughtfulness.

Since gifts express the wish for a speedy recovery, and not for "taking root," a feature common to all four types of gifts is their perishability. This idea is most conspicuous in fresh food and cut flowers, neither of which last very long. The pragmatic or economical nature of the gifts is secondary. In fact, the family of a patient with many visitors often experiences difficulty in disposing of all the perishable food. In Mr. A's case and in others I heard of, the family received so many expensive melons that they ran out of people to whom to give them. The choice of gifts, in summary, rests heavily on the symbolic meaning of the items chosen. Their function is social in nature; their economic or utilitarian value is secondary.

Return gifts. Just as certain people are obliged to visit a patient and to bring a gift with them, the patient usually is also obliged to give gifts in return. Because gifts of food are intended to transmit energy from the healthy person to the sick, return gifts must not be given until the sick person recovers completely; otherwise, the illness might be given to the healthy visitor. Although no formal ritual is usually involved today, the Japanese still mark the day when a person formally returns to health. The event is called *tokoage* (lifting of the bedding). As noted in Chapter 2, the beginning of the day for healthy Japanese is marked by folding the *futon* (bedding) and putting it in a closet. To have the *futon* laid out day and night is a sign of sickness; thus, the return to health is symbolically stated as the "lifting of the bed."

As custom requires, at the time of his *tokoage* Mr. A went to the gift section of a department store and chose return gifts for 114 of his visitors. For this purpose, he and his wife had kept a meticulous list of gifts throughout his entire hospital stay. He decided on three categories of return gifts based on the value of each gift received and the social relationship between himself and the visitor. He sat for over two hours on each of his two visits to the gift section of a large department store in Kobe and wrote his name on *noshi*, a covering specially made from rice paper that is always placed on a gift. This task of sending return gifts is often done by a woman, although in this case Mr. A undertook the task

himself. Although all the gifts were delivered by the department store, he made an exception for his immediate superior, whom he and his wife visited with an expensive and carefully chosen gift in order to express their gratitude personally.

It should be noted here that anthropologists have assumed that gift exchange is an important characteristic of "primitive" societies (Mauss 1966; Lévi-Strauss 1969). Their studies also indicate that the items exchanged are usually of symbolic or nonutilitarian value (Ohnuki-Tierney 1976:317). The Japanese again share with the "primitives" both the importance of gift exchange and its symbolic nature.

Tsukisoi: Round-the-clock attendants

Tsukisoi refers to the practice in which an attendant, not a medical specialist, is hired to look after a patient around the clock (see Caudill 1961 for a discussion of this practice). These attendants are usually middle-aged or older women whose children are grown, widows, or women who are otherwise free from household duties. Although their official duty is to meet the basic physical needs of their patients, these women also provide psychological comfort to the patients, who are reassured that there is always someone beside them to provide exclusive attention. Although the job is demanding, it does not pay well.

In some cases, a family member staying with a patient will relieve the attendant during the day so that the latter can take care of the patient during the night. The *tsukisoi* system also works well for patients who do not have families or friends to care for them.

Until recently, the *tsukisoi* system had been an integral part of the Japanese system of hospitalization. It also operated informally; that is, the women were hired by the patients and their families and were paid directly by them. Hospitals willingly accommodated the women without establishing any formal relationship with them. Although the *tsukisoi* system has not changed a great deal in practice, recently a new regulation has been instituted by the Ministry of Health and Welfare which specifies that those hospitals with at least one nurse for every four patients may be certified as *kanzen kango* or *kijun byōin* (hospitals that provide complete care, or that meet the standard), but may not permit the employment of *tsukisoi* by patients. These certified hospitals, on the other hand, receive from the government an additional ¥ 2,240 ($10.20) to ¥ 2,360 ($10.70) per patient, depending on the gravity of the patient's condition. Patients who enter hospitals that are not certified in this manner are allowed to hire their own attendants, and the payment of these attendants may be reimbursed from the insurance if the doctor verifies the need for them. In 1979, the average payment to an attendant was between ¥ 7,000 and ¥ 10,000 per day (twenty-four hours). (The information on the new regulation is taken from *Asahi* February 21, 1979.)

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In practice, as long as the patient or the family can afford it, an attendant can be hired even in a complete-care hospital by being disguised as a family member, since even at these hospitals family members can attend a patient, provided the doctor approves of their presence. The new regulation, however, has created a problem. The care provided by hospital personnel at the complete-care hospitals may be inadequate for some patients who are totally disabled, and yet the patients must pay out of their own pockets in order to have an attendant.

Doctor-patient relationships

In this final section on the patient role, I will review briefly some of the material presented earlier on the doctor's role, since the patient role cannot be fully understood without examining the ways in which doctors interact with patients.

The custom of "introduction," as I explained previously, is a means by which patients and their families choose the doctors, rather than being chosen by them. It also helps to establish a personal relationship between the two, since a doctor is chosen not by a simple match between the doctor's specialty and the patient's ailment, but because of a "vote of confidence" the patient has somehow given that particular doctor. At the time of hospitalization, each patient is assigned a *shujii* (the doctor primarily responsible for the patient). Both the doctor's and the patient's names are written on a tag and posted on the bed as well as in front of the patient's room. This custom institutionalizes a symbolic expression of the personal tie between the doctor and the patient.

Granted, there are many doctors who do not respond to the confidence and trust of the patient, and there are many patients who question the competence and sincerity of the doctor. There have been a number of observations that many Japanese patients entrust the doctor not only with their medical problems, but with their entire welfare. Caudill and Doi (1963:381) observed how patients with neuroses entrusted themselves completely to their doctors (*Sensei ni omakase shimasu*; I entrust everything to you, Doctor). This attitude is also found among patients with physical problems. Shortly after the spring *renkyū* (successive holidays, a long holiday weekend) one woman patient at the obstetric-gynecology clinic at hospital X told her doctor: "I tried my best not to move about during the holidays, since you might be gone for a vacation and I did not want to give birth during your absence." When the doctor told her he was going to Kyūshū for the weekend and suggested that he admit her the following day and artificially stimulate labor, she agreed to do so most readily.

The nature of the doctor-patient relationship also helps to explain why diagnoses of cancer are not given to patients. Long and Long (1980:15) observe :

> To discuss a fatal prognosis not only depresses the patient, but would be asking the patient to accept part of the burden which has been assumed by the physician. It is an

admission that the doctor, and scientific medicine, ultimately will fail. Many doctors sit up all night with a dying patient. Whatever they could do medically has been done, but other aspects of their role remain. One doctor drinks a final cup of *sake* with his dying patients.

Equally revealing is a statement made by Dr. Kajihara during the twentieth annual meeting of the Japanese Medical Association (quoted in *Asahi* April 19, 1979). He notes: "Human beings react indeed very strongly to the notion of death. We should let the patients spend the rest of their short lives without anxiety; we therefore should not inform the patient of the cancer verdict." He explains the need for announcing the cancer verdict in the United States in terms of the greater possibility of a malpractice suit if the information is not given to the patient.

Entrusted with such responsibility, then, the doctor is expected to take care of the patient not only as a patient, but also as a human being. Medical judgment is weighed against the psychological needs of the patient as an individual, and as a social being embedded in a network of kinship and social relationships. The doctor's tolerance or often encouragement of *sashiire* (food brought in for the patient), *mimai* (visiting), and patient care by a family member or even a *tsukisoi* (a round-the-clock professional attendant) are all mechanisms through which nonmedical aspects of the patient's needs are accommodated. The *satogaeri* custom, whereby a woman returns to her natal home for childbirth, often necessitating the change of a doctor, is another example along this line. These are, however, institutionalized as customs, so that not only are doctors exempt from making individual decisions, other than in critical cases, but they are also often unconscious of the implications of these customs for their roles as doctors. On the other hand, many Japanese doctors make a conscious effort to take the psychological needs of their patients into consideration.

Paradoxical though it may sound, doctors in Japan assume total responsibility for their patients, and yet remain nonauthoritative by accommodating "human factors," instead of adhering strictly to a more narrowly defined medical judgment.

Hospitalization as a "human drama"

The description so far has concentrated primarily on Japanese hospitalization as a cultural system comprised of various customary institutions, such as visitation, gift exchange, carry-in food, family care, professional attendants, and roles assigned to patients and doctors.

But hospitalization is also a serious, or even a crisis, situation not only for patients themselves, but also for all those close to them. It is a situation in which even the most rigorously suppressed emotions are revealed by the intensified interaction among the people involved. An interpretation of hospitalization, there-

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fore, would be incomplete without an examination of the process from the perspectives of all the people, or, to put it in an anthropological framework, from the perspective of the actors in a social drama (see Turner 1975b). In this section, I will present such an interpretation of the case of Mr. A.

Mr. A certainly occupied center stage in the drama surrounding his hospitalization. Because of Mr. A's intense involvement with his work, the most prominent interactions during his illness were with the people with whom he worked. He was reassured of his good standing at work by the visits of his immediate superior and was flattered by the concern of those who worked for him, whom he and his wife referred to as *buka* (subordinates). On the other hand, if we examine the other people with whom he was interacting, it becomes immediately apparent that there was a second drama taking place simultaneously, centering on his wife. Mr. A, as noted earlier, was a college-educated middle-aged man who has followed, quite successfully, an upwardly mobile life style. In many ways, he fits all too well the stereotype of a category of men (and increasing numbers of women), both in Japan and elsewhere, who are married to their work. As a typical Japanese male "workaholic," he came home very late every day and spent weekends on the golf course with his business associates. Also, he had been overseas a number of times, often for extended periods of time.

In Japanese society, where traditionally there has been a sharp division of labor between husband and wife in terms of both activities and roles, many women take Mrs. A's type of life for granted. They develop their own network of friends, and do not rely on their husbands for socialization or various other psychological needs. This pattern helps when their husbands are assigned duties elsewhere in Japan or overseas, since the family does not always accompany the husband, especially when the move disrupts the children's schooling. Without a network of women friends, Mrs. A had had problems coping with her husband's absences. However, during his last tour of duty in an English-speaking country, his family had joined him. There Mr. A came home every evening, and his social engagements included Mrs. A, in contrast to the Japanese pattern, in which men's social activities often exclude wives. Mrs. A's superb command of English, coupled with her sophisticated knowledge of Western cultures and her remarkable ability as a hostess, in turn enhanced Mr. A's image among his associates, both Japanese and Western. His appreciation of his wife increased, and the couple's relationship was strengthened enormously.

To Mrs. A, then, Mr. A's hospitalization was a chance to relive that enjoyable overseas stay. She received all Mr. A's superiors and co-workers as they visited him in his hospital room. She was publicly recognized as the wife of a successful and well-liked executive. Her self-image not only was enhanced in her own view, but also was socially affirmed. In addition, the situation provided her with the greatest amount of time with her husband in their entire married life.

In almost any society, the status of a husband is also given to his wife. A conspicuous example of this pattern is the First Lady in the United States; the minute that a man becomes president, his wife automatically receives a greatly elevated status as First Lady. In the case of Mrs. A, this practice reveals an additional aspect peculiar to Japanese society. Mrs. A's daily presence at the hospital signified that her husband's work life had come under the domestic sphere, over which his wife had complete control, because tending to the sick is a woman's job.

Discussion

Through the crisis situation of hospitalization, the patient's entire social network becomes activated and reaches a new height of intensity, both positively and negatively. All the participants in the "drama" are forced to reexamine their human relationships. During the hospitalization, every fiber of the patient's social network is tested. Many relationships are strongly reinforced, while others prove too frail and are discontinued.

As patients, doctors, family members, relatives, and friends, all the actors in the drama act out their prescribed roles within the constraints of certain cultural rules. Sometimes the rules are manipulated or bent somewhat – or even purposely ignored. Hospitalization thus provides a setting in which individuals directly confront cultural rules. The dynamic relationship between them creates an intense human drama in which past experiences become extremely important in directing current behavior; past interactions with the patient determine an individual's decision about whether or not to visit, how to visit, or how to care for the patient. The decision on visitation or care, in turn, shapes the future relationship with the patient.

An analysis of hospitalization thus reveals norms in the value system and the formal Japanese social organization. In addition, it also uncovers the nonformalized power allocated to women and the nonformalized social network. It is important to point out that the nonformalized social network has seldom been given prominence in analyses of Japanese society – yet, as we have seen in this chapter, it is quite significant in understanding how Japanese society operates.

Being a microcosm of Japanese culture and society, hospitalization also presents rich intracultural variations. Thus, the ideal of generous sanctioning of illness and indulgent care of the sick must be modified when the patient is a woman or someone who cannot afford to take off from work. Intracultural variations are found not only along sex and socioeconomic lines, but also among individuals.

Individual variations are greatest when we consider how individuals perceive their own behavior and how they are motivated to act. Then we see a range of

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variation underneath the seemingly same overt patterns. For example, some people are aware of the symbolic meaning of the gifts, as well as reacting to them on an emotional level; they feel good about appropriately chosen gifts, and show a strong aversion to tabooed items, such as a potted flower. Some people react only at the emotional level, without realizing why; others understand the practice only intellectually, without accompanying feelings. Many people, in fact, follow the rules simply because it is customary, without any understanding, either intellecutal or emotional, of the nature of the gifts they choose or receive.

Individual variation is also apparent in the motivations of people who use the cultural systems. For example, some patients make a strenuous effort to be introduced to a doctor and give expensive gifts in order to "bribe" the doctor, whose acceptance of the gifts also may be based on a wide range of motivations, depending on the individual. To other people, a gift is a genuine expression of gratitude. As Dore (1973:262) concludes, "Only a hair-line separates the 'mere token' of gratitude from the bribe.... "

By studying the hospitalization process, we can learn a great deal about Japanese culture and society and about the actual interactions of individuals involved in the process. Conversely, we can never really interpret the hospitalization process without a thorough understanding of Japanese culture and society. Hospitalization in Japan is by no means a universal experience involving simply the biomedical treatment of a disease. Rather, it is a Japanese experience, *mutatis mutandis*.