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Examination of Common Concepts in Hospitals with Catholic Ideals in Japan

Hiroko Shimizu*, Hoshina Uehara, Shinji Ishimaru and Emiko Wada
[1]*Japan Catholic Nursing Association, Yawatahama-shi, Ehime, 796-0033, Japan*
[2]*Tokyo Metropolitan University, Graduate School Doctoral Program, Tokyo, 192-0397, Japan*
[3]*Japan Catholic Medical Facilities Association, Tokyo, 135-8585, Japan*
[4]*Japan Catholic Medical Association, Tokyo 113-8621, Japan*

Abstract

The purpose was to examine how Catholic philosophy influences staff activities. To achieve the objective, a free-form survey was conducted and analyzed among senior staff at the facility.

The subjects were 33 people in total, including senior staff who had participated in training sessions related to Catholic medical care, Catholic doctors, and nurses, 11 men and 22 women. Among the subjects, 6 were clergy, 4 were officials, 2 were consultants, and 8 were department heads. In terms of occupation, 18 were medical professionals, and 4 were spiritual care workers. 80% of the subjects were of Catholic faith. The written text was analyzed using qualitative analysis software, and a cluster analysis was performed using frequent language analysis. Correlation tests were conducted based on linguistic similarity.

As a result, 104 frequently occurring words were collected, with “Christ” appearing 20 times, “love” 19 times, “heart” 13 times, “person” 10 times, and “religion” and “spirit” appearing 8 times each. Next were “suffer,” “reverence, ” “spiritual, ” “heal, ” “love, ” “respect, ” and “cherish. ” The four clustered categories were: “Emotional care with compassion and kindness," which includes “Calling out and accepting” and “Respecting and loving people," “Based on the spirit of love," which includes “Medical care based on love," and “Farewell care," “Companionship and prayer” which includes “Farewell prayers” and “Companionate end-of-life care," “Compassionate hearts living with the weak” which includes “Good relationships between staff” and “Together with the weak."

In Japan, there are an extremely small number of Catholic nurses, doctors, and staff members. However, the descriptions of staff activities that are thought to be influenced by Catholic ideals include content that contributes to quality assurance in medical care.

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Introduction

The World Health Organization Charter states that “everyone has the fundamental right to the highest standard of health, without discrimination because of race, religion, political belief, or economic or social condition.” To achieve this, efforts are expected not only from the state but also from ordinary citizens. Moreover, people with religious backgrounds also contribute to this goal.

Christianity activities in Japan began on August 15, 1549, when Jesuit St. Francis Xavier arrived in Kagoshima prefecture and began spreading Catholicism. Despite the extremely inconvenient transportation at the time, members of the Society of Jesus, Franciscans, Dominicans, Augustinians, and other orders came to Japan one after another. They came from diverse regions like India, the Philippines, and other places and are said to have enthusiastically engaged in missionary work, establishing churches, monasteries, schools, hospitals, and other facilities in various places). However, Catholic medical care did not develop due to the ban on Christianity imposed by the government in 1587. It lasted for about 270 years until the Meiji government, a civilian government, lifted the isolationist order in 1857.

Even in 2023, the number of Catholics in Japan is only about 430,000, or just 0.3% of the population [1]. In an actual survey of medical workers [2,3], the vast majority of medical workers considered both Shinto and Buddhism to be their own religion. In this situation, there are 27 Catholic medical facilities registered in Japan, 20 of which are hospitals [4]. Although these hospitals uphold the ideals of Catholicism, it is believed that the medical staff who hold the Catholic faith are an extremely small minority.

On the other hand, a survey by Aoyama et al. [5] reported that in palliative care wards in facilities with a religious background, the environment for bereaved family care, seasonal events, and religious care was well-established. Furthermore, patients were highly evaluated on the Good Death Index (GDI). In a report titled “Religious Background and Activities of Religious Persons in Medical Facilities: A Survey Using Questionnaires,” Taniyama et al. [6] conducted an interview survey on the activities of religious persons in medical facilities. It involved the examination of the religious care and specialized work of religious persons such as hospital chaplains, clinical religious priests, and Vihara monks.

They stated that religious persons were seen to refrain from forcing their faith on patients and to deal with patients and their families with care, supporting the results of Aoyama et al. It has been said that care by religious persons has a beneficial effect on terminally ill patients in palliative care wards that provide care for such patients. However, it is necessary to consider the impact it has on Japanese patients, many of whom are non-believers. In “Care by Religious People for Deceased Non-Believers and Their Families in Religious Hospitals” by Yamamoto et al. [7], a survey was conducted on the significance and of

***Corresponding Author:** Dr. Hiroko Shimizu, Japan Catholic Nursing Association, Yawatahama-shi, Ehime prefecture, 796-0033, Japan.

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care by clergy for non-believer patients and their families in hospitals. Based on the interviews involving 23 Buddhist and Christian clergies, it was reported that for many Japanese who identify as "non-religious," the thing that is needed to connect to the afterlife and the souls of the deceased is "clergy" and not "religion." This was due to the expectation of support for "care for the dead" by clergy, which was carried out in local communities in old Japan, and "care for the dead" by bereaved families. From these facts, it is thought that although there are many non-believer people in Japan due to oppression in the old days and the influence of cults in recent years, people facing death expect clergy to ease their fear of death, regardless of the type of clergy.

However, there are few clergy members in Japanese medical institutions, and although Interreligious Clinical Clergy training is being conducted, there are still few who can provide religious care. In medical facilities that have a religious philosophy and raise awareness of religious care throughout the entire medical facility, an important thing to consider is the impact of philosophy on the activities of staff. If the quality of care can be improved by teaching religious philosophy, even if the clergy is not employed full-time or is absent, then the significance of teaching religious philosophy is considered to be increased. Therefore, in Japan in 2024, we have examined how the Catholic philosophy influences the activities of staff members.

Purpose

The purpose of this study was to examine how Catholic ideals influence the medical activities of staff at medical facilities that uphold Catholic ideals.

Subjects

The participants were 33 senior staff, Catholic doctors, and nurses who participated in a training session organized by the Japan Catholic Medical Facilities Association. There were 11 men and 22 women, of which 1 Catholic priest and 5 Catholic nuns were clergy. The positions held by each facility included 4 business managers as c, a chairman, a facility director, and hospital manager, 2 advisors, and 8 department heads, such as the nursing director and administrative director. The occupations of the participants were 1 doctor, 1 midwife, 15 nurses, 1 physical therapist, and 4 spiritual care workers such as chaplains and pastoral care workers. In terms of religion, 80% of the participants were Catholic.

Survey Method

Data was collected by dividing 33 participants into six groups and conducting a training session organized by the Japan Catholic Medical Facility Association. Each group was asked the question, "Do you think your colleagues have been influenced by the philosophy or environment of Catholic medical facilities?" Each group wrote down their answers anonymously. The sentences written by the six groups were entered into the qualitative analysis software NVivo (QSR International Co. Ltd., USACO, Tokyo). Particles and adverbs were removed from the sentences, leaving only verbs and nouns. A frequency analysis was performed based on the frequency of occurrence of verbs and nouns. Next, NVivo mechanically performed a cluster analysis using Pearson's correlation test on the sentence codes and group codes. On the basis of word similarity, subcategories and categories were formed from the clustering. Then, the researchers named each of the subcategories and categories.

Ethical Consideration

Data were collected as anonymous data through group work. After the training session, the data was provided to the researchers as anonymized data and ethical considerations were observed.

Results

The "things that seem to have influenced the philosophy and environment of Catholic medical facilities" written in the group work were expressed in 55 sentences.

When the 55 sentences were analyzed for frequency of occurrence, 104 words were found, each counted 1 to 20 times, with weighted percentages ranging from 0.44% to 8.73%. The most frequently counted words were "Christ" (20 times), "love" (19 times), "heart" (13 times), "people" (10 times), "teachings," and "spirit" (8 times each), "Catholic" and "cherish" (6 times each), "have" and "medical care" (5 times each), "weak" (4 times), "care," "love," "based on, "go," "live," "...-oriented", and "ethics" (3 times each), 16 words including "reverence," "heal," "spiritual," and "needs" (2 times each), and 69 words including "spiritual care," "pastoral care," and "die" (1 time each).

In addition, a cluster analysis based on similarity was performed, and 17 small categories consisting of one or two words were narrowed down to eight subcategories. The subcategories were then narrowed down to four categories. Then, the categories and subcategories were named. The categories and subcategories were: "Mental care with compassion and kindness," consisting of the subcategories "Calling out and accepting" and "Respecting and loving people"; "Based on the spirit of love," consisting of the subcategories "Medical care based on love" and "Farewell care"; and "Companionship and prayer" consisting of the subcategories "Farewell prayer" and "Compassionate end-of-life care"; and "Compassionate heart living with the weak" consisting of the subcategories "Good relationships between staff" and "Together with the weak."

Discussion

The process leading to category naming is explained as follows.

One subcategory included in the first category, "Emotional care through compassion and kindness," includes verbalized scenes of cherry blossom viewing and greetings with patients and their families. It has been named "Calling and accepting" because it is an expression of heartfelt care. The subcategory that included the expressions "laughter" and "respect and love others" was named "respect and love others" because it expressed an attitude of respecting others and their personalities. Based on the above, we named this category because the act of respecting the individuality of patients and their families and speaking out to everyone represents "emotional care based on compassion and kindness."

The second category, "Based on the spirit of love," expresses situations in which medical care is performed based on love, such as "based on love," "medical practice," and "the spirit of justice," so the subcategory was named "medical care based on love." In addition, the subcategory was named "Farewell care," which expressed actions such as "holding a farewell party," "care for those left behind," and "memorial mass." These are considered to be interactions based on the spirit of love in caring for the grief of family members left behind by the death of a patient, and so the category was named "Based on the spirit of love."

The third category, "prayer," "time of farewell," and "prayer of remembrance," expresses "parting care," and we named the subcategory "prayer of farewell" because the focus is on prayers that are distinct from the actions of caregivers, including "caregiving" and "pastor's prayer time." "End-of-life care" and "Staying close to people" were given the subcategory of "Staying close to people at the end of their lives." These were combined into the category of "Staying close to people and praying."

The fourth category was thought to express good relationships between staff members with compassion, such as "good relationships between staff members" and "compassionate hearts," and so was given the subcategory "Good relationships between staff members." "Practicing the philosophy" and "Way of life" were not adopted as subcategories because they do not express a meaning or situation. "Going to people," "Together with the weak," and "Improving the environment" were given subcategories because they were considered to be situations represented by "Together with the weak." These were included in the category of "Compassionate hearts living with the weak."

The four categories that expressed the activities of senior staff members expressed how staff members treat others with a kind attitude and how they maintain relationships with other staff members as well as with patients and their families. By not only viewing patients and their families as objects of care but also viewing the daily relationships between staff members as relationships of care communication, it can be inferred that care for patients and their families can arise from a more everyday attitude. Regardless of the personal beliefs and thoughts of each staff member, such acts of closeness and consideration in the workplace can create an overall atmosphere if the facility's ideals drive the activities. Furthermore, since the employees are said to take the image of the clergy praying as a model and participate in the prayers themselves, it is inferred that the modeling behavior of the clergy encourages the behavior of the employees. The prayer, in this case, is not a religious, ritual, or formalized prayer. Instead, it is a prayer that means deep thoughts and thoughts expressed as "existential prayer" and can be said to involve a request to a being that transcends one's own human powers. Praying for the well-being of patients and colleagues is a sincere communication with others, a joint act of mutual trust and sincerity [8]. This is an expression of ethical conscience that arises from the awareness of one's responsibility to "pray" within relationships with others and personal relationships [9].

This attitude allows medical personnel to be aware of their own powerlessness, find humility, and empathize with the weaknesses of patients and their families. The category name "A compassionate heart living with the weak" suggests that medical staff should consider the weak or vulnerable positions of patients and their families and respect and cooperate with each other by overcoming personal differences such as differences in experience and knowledge. It is believed that transcending the differences in qualifications and abilities of facility staff and cooperating with and complementing each other will lead to the creation of a comfortable work environment. In other words, it can be said that the ethics of collective action are being fostered. Caring for patients and their families can easily place a heavy burden on nurses and doctors, but cooperative relationships throughout the facility and among all staff members can help reduce that burden, foster experiential value, and prevent staff turnover [9].

Based on these findings, it is possible that in hospitals and other medical facilities that advocate Catholic ideals, a cooperative environment is cultivated throughout the facility through the modeling and activities of clergy to spread the philosophy. It helps to create a kind of medical environment that is close to patients and their families. In other words, it is possible that religious people have a modeling effect on staff, leading to high-quality mutual relationships among staff and being a factor in providing high-quality care to patients and their families. For this reason, it is expected that medical facilities with a religious background will benefit by focusing on ideological education.

The data obtained this time were mainly from senior staff members, and the majority of them were people of Catholic faith, so while the answers were focused on the purpose, it cannot be denied that there was a bias.

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Author Contributions

Hiroko Shimizu: Study design, data collection, manuscript writing
Hoshina Uehara: Data analysis,
Shinji Ishimaru: Data collection
Emiko Wada: Data collection

Conflict of Interest

The authors declare no conflict of interest regarding the publication of the article.

References

1. Japan Catholic Central Council (2024) accessed December 10 2024.
2. Current Status of the Catholic Church (2023) accessed December 10 2024.
3. Shimizu H, Frick E, Büssing A, Uehara H, Tsuji A, et al. (2023) Validation of the Japanese Version of the Spiritual Care Competence Questionnaire, International Journal of Nursing and Health Care Research 6: 1-12.
4. Japan Catholic Medical Association (2024) accessed December 10 2024.
5. Aoyama M, Saito A, Sugai M, Morita T, Kizawa Y, et al. (2017) Why religiously-based facilities are more likely to achieve a desirable death for patients: Results of a survey of bereaved families of 127 hospice palliative care wards nationwide. Palliative Care Research 12: 211-220.
6. Taniyama Y, Yamamoto K, Morita T, Shibata M, Kasai K, et al. (2020) Religious background and activities of religious practitioners in medical facilities: A survey using questionnaires. Tohoku Studies of Religion 16: 29-42.
7. Yamamoto K, Kasai K, Uchimoto H (2021) Care by religious practitioners for deceased non-believers and their families in religious hospitals, Tenri University of Health Sciences Bulletin 9: 13-23.
8. Shimizu T (2000) Ethics of Collaborative Action. Philosophy in the Medical Field II: We who are involved with words. pp136-139, Keiso Shobo, Tokyo
9. Yoshitaka Hamaguchi (2005) The meaning of life, illness and suffering. Christian medical ethics of life and death. pp104-109, Toshindo, Tokyo.