

“This long heritage”

: Byun Sang hun (변상훈) and the Transformation of Korean Traditional Medicine (hanŭihak / 한의학), under the USAMGIK (United States Army Military Government in Korea (mikŭnjŏng / 미군정), 1945~1948

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This paper initiates an effort to look at “South Korean” medicine as perhaps distinct from “Korean” medicine, focusing specifically on the possibility of offering a post-colonial history of medicine.

As such, the paper looks at the formation of the NMC (National Medical Center) in Seoul in 1958 (1958-1963, 1963-1968, 1968-1971) by a consortium of European actors—Denmark, Sweden, and Norway—invested in developing new forms of international assistance after the Korean War.

Rather than take a firm stance, the paper ultimately suggests that the role of these actors in formative South Korean institutions was constitutive, and perhaps requires much more examination in the future.

Key Words : South Korean Medicine, post-colonial history, National Medical Center

“Herbs were prescribed chiefly to restore the balance between Yang and Yin, surgery was primitive, and modern medicine as brought in by the Americans and Japanese made slow headway against *this long heritage of the past*, presumably today it is still a potent influence.”¹⁾

Thomas B. Turner M.D., “Prewar Medical Influences in Korea,” 1976

1.1 Distinguishing between “Regular Doctors” and “Herb Medicine” (1947)

Issued in late March of 1947, the license provided to Byun Sang-Hun (변상훈)—here identified as “S.H. Byun”—representing the third generation in a family of traditional medical practitioners, certified his right to

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¹⁾ Thomas Turner, “Chapter XVIII, Japan and Korea,” p. 691. United States in World War II, Medical Department, United States Army. In Preventive Medicine in World War II, Volume VIII: Civil Affairs / Military Government, Public Health Activities, Col. John Lada, MSC, ed., 1976.

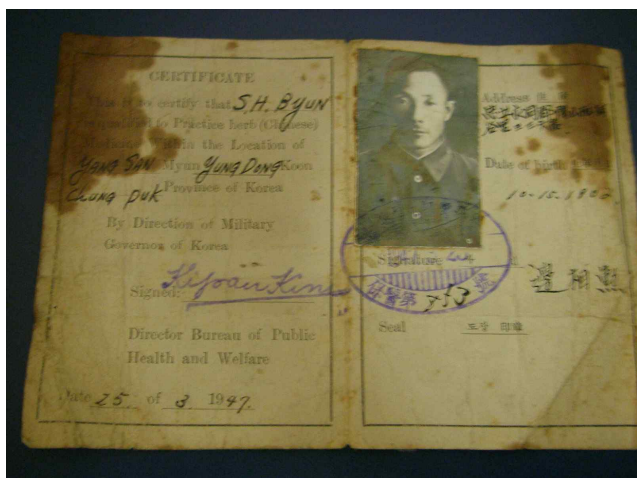


Figure One: USAMGIK ID card issued to Byun Sang Hun in March 1947; note that Byun’s practice is identified specifically as herb (Chinese) medicine (upper left). (Byun Family Papers)

continue operating his clinic at Yangsan, a small village located a short distance to the southeast of Taejeon in the southern half of the Korean peninsula.²⁾ The accompanying photograph, with the left side masked in shadow, offered a sober portrait of a middle-aged Korean

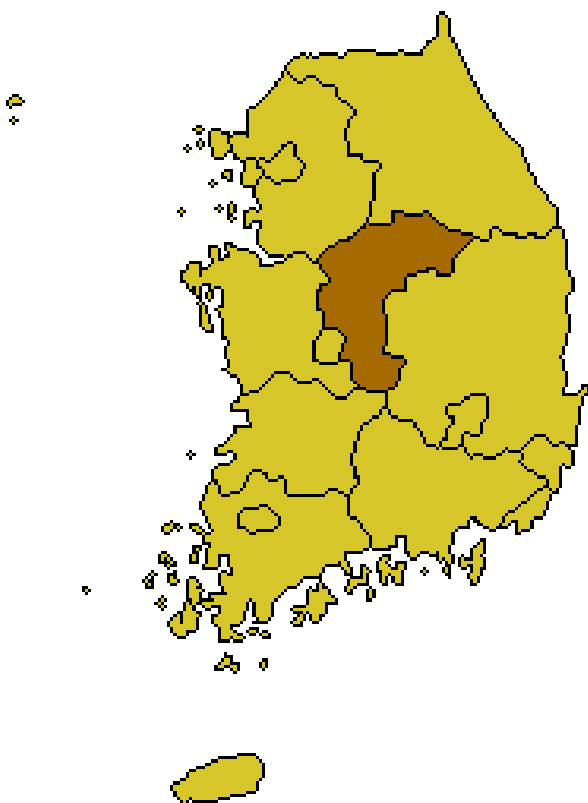


Figure Two: Chungbuk Province (shaded area), occupying the central portion of South Korea. Yangsan is located in the extreme SE corner of the region.

male in Western dress, wearing a shirt of a dark hue. The individual in question, born in 1902, had chosen to continue the practice handed down by his two predecessors, his father and grandfather; and the licensing procedure likely carried with it a certain degree of anxiety, as it was not yet clear how American military authorities, or USAMGIK, would treat local medical practitioners.³⁾ Certainly Byun was hardly alone in submitting to this procedure, as the reverse side of the same document assigned him #853, thereby placing him among a larger group of individuals who had already registered with the USAMGIK Bureau of Public Health and Welfare. Within less than two years, this act of registration would be recognized by an independent South Korean state, which would mobilize Byun’s practice as part of its national story, celebrating his embrace of the “traditional,” even while marginalizing his form of practice.

2) Licensing and Registration Certificate, 1947, Byun Family Papers, Dr. Byun Kil-Won. Byun Sang-hun (1902-1989) continued the practice started by his grandfather, Byun Seok-hong (1846-1926) and father, Byun Yeong-mok (1878-1923), in 1902. The current Dr. Byun, Byun Kil-Won, represents the fifth generation of practitioners in the family. Similar examples of USAMGIK license certificates may be found in the Dong-Eun Medical Museum at Yonsei University. See “A Modern Doctor Takes up a Traditional Business,” *Joongang Daily*, January 27, 2006, for a brief introduction to the Byun family story. The family story can also be located on several other Korean websites. In addition to maintaining the two clinics at Seoul and Yangsan, the family now runs its own enterprise devoted to the sale of organic health foods: their website can be found at: <http://www.jwfood.com>.

3) The USAMGIK (*mikūnjōng* / 미군정), or United States Army Military Government in Korea, represented the governing authority on the southern half of the peninsula from 1945 to 1948, with powers gradually transferred to a South Korean provisional government beginning in 1947. The term *hanbang* (한방) connotes Korean traditional medical practice in rural areas, while *hanūihak* (한의학) corresponds to similar practices within the context of the central Korean government at the end of the nineteenth century. I have used *hanūihak* in this story to capture the transformation from court practice to local practice. The transformation of *hanūihak*, by which Chinese practice became designated as “Korean,” is the subject of a recent dissertation (2006) by Soyoung Suh of UCLA.

The area assigned to Mr. Byun's clinic encompassed the township (myun / 면) of "Yang San," located in the "Yung Dong" district (kun / 군) of the "Chung Puk" province of Korea, specifying the area in which he would be permitted to practice.⁴⁾ Comprising a region occupying the south-central portion of the Korean peninsula, the only province lacking access to the sea, Chungbuk (North Chung) was then, as it is now, primarily a rural area, encompassing low-lying mountains as well as agriculture.

The town of Yangsan, located in the southeastern portion of the province, was situated toward the center of the peninsula, placing it in proximity to the border with neighboring Chungnam (South Chung). The specificity of Mr. Byun's site was significant not simply as a matter of administrative record-keeping, but also because USAMGIK was becoming increasingly conscious of the need to account for the geographical distribution of local medical personnel—including both those trained in Western medicine and Korean traditional medicine—in the aftermath of a series of minor epidemics—including an outbreak of cholera—the preceding year.

The spring 1947 survey of "herb medicine" and its associated practitioners was only one in a series of activities conducted over a period of roughly sixty years (1885-1945) devoted to identifying, classifying, and transforming the practices of Korean traditional medicine, or hanuihak (한의학). The arrival of Western missionaries in the late 19th century had witnessed initial contact between the different medical traditions, with Horace Allen winning influence at the Korean court through his ability to treat a variety of ailments.⁵⁾ Still later, Japanese colonial authorities (1910-1945) had attempted to categorize local practices in terms of their own familiarity with German academic medicine adopted during the Meiji period. Byun Sang-hun had previously undergone a similar registration procedure during the period of Japanese colonial rule on more than one occasion, providing a detailed explanation of his prior training in order to secure for himself the right to

continue with his practice as a *uisaeng* (의생), or herb doctor.⁶⁾ This latest intervention by American military authorities thus needs to be seen in its proper context, representing another in a series of challenges to the authority of traditional doctors.

And, at the same time, this activity needs to be addressed in terms of USAMGIK's project during the nearly three year period of occupation (September 1945-August 1948), a legacy of the unexpected collapse of Japanese forces in August 1945. Caught off guard by

4) Licensing and Registration Certificate (see **Figure One**), Byun Family Papers. I have followed USAMGIK's terminology of the time; the province is more commonly designated as *Ch'ungch'ongnamdo* (충청남도) or Chungnam.

5) *Seoul Taehakkyo Ūikwahaksa Charyo Chip I* (서울대학교 의과학사 자료집) I contains the terms of Allen's original agreement with the Korean government. See also Hyung Woo Park et al., *Chaetong Chechungwŏn Kyumowa Hwakdae Kwachŏng* (재동 제증원의 규모와 확대 과정) (A Study on the Location and Function of the Jaedong Jejoongwon), *Korean Journal Medical History*, June 2000, pp. 29-53, for a discussion of the design and function of Allen's hospital site; and Hyung Woo Park's *Jejoongwon: The First Westernized Hospital in Korea* (Seoul: Body and Mind Books, 2002) for the full Allen story. Prior to Allen's arrival, the import of Western medical techniques, especially inoculation for smallpox, was already beginning to take place. See Chang Duk Lee's *Chosŏn sidaemal kŭpmansŏngchŏnyŏmpyŏng kwa ūiryokikwan* (조선시대말의 급만성전염병과 의료기관) (Infectious Diseases and Medical Institutions in the late Choson Dynasty), *Korean Journal of Medical History*, December 1995, pp. 165-174. While Allen's story is typically cited as the origin of Western medical institutions in Korea, this earlier story (Lee's version) likely represents the first contact between the two traditions, initiated by a Chi Suk-Young, a Korean who had studied abroad, in 1879. There is also evidence of the transmission of Jenner's vaccination technique from China earlier in the nineteenth century.

6) *Resumè / ilyŏksŏ* (이력서) and Self-Introduction, 1947, Byun Family Papers. The term *uisaeng* (의생), assigned to traditional practitioners beginning with the 1913 licensing regulation (see **Section 1.4**), implies a trainee or student of lesser status, in contrast to those trained in Western medicine. In effect, the licensing procedure contributed to the marginalization of traditional practice.

Japan’s offer of surrender on August 15th, the U.S. Eighth Army did not arrive in Korea until early September, nearly three weeks after the conclusion of combat.⁷⁾ Moreover, the Civil Affairs personnel accompanying the Eighth Army had been trained at American Civil Affairs Training Schools (CATS) sites primarily for the occupation of Japan, meaning that there was a conspicuous lack of expertise regarding the local context.⁸⁾ Under the circumstances, the practice in most cases was to continue to rely on Japanese personnel and bureaucratic procedures until suitable replacements could be found.⁹⁾ The request that Mr. Byun register his presence with local authorities may therefore be seen as part of an exhaustive survey of not only trained medical personnel, but also an inventory of social resources as a whole. As the American military hoped to hand over its authority to an independent Korean government, a prospect that was looking increasingly likely by spring 1947, there needed to be a thorough accounting of all available facilities and personnel.¹⁰⁾

This effort to survey local resources was framed in terms of public health concerns that had been raised during previous campaigns in Europe, and much closer to the Korean peninsula, the conquest of various island groups held by Japanese forces.¹¹⁾ In pragmatic terms, this meant that the major concern—even above the welfare of the local population—was that of maintaining the health of the occupying forces. The need to survey encompassed those elements that could potentially contribute to the spread of disease—including the availability of clean water and sanitation facilities, contact with animal populations, and the regulation of refugee movements—and required the presence of American personnel trained to handle such contingencies.¹²⁾ Koreans, on the other hand, had a lengthy tradition of relying on traditional practitioners to satisfy the basic requirements of daily health, and were not always certain about the utility of Western biomedicine, especially as it had been heavily promoted by Japanese public health personnel.

Unlike other military occupations taking place at about the same time—Germany, Japan, and Austria—the occupation of Korea did not require the removal of a particular ideology or political party, but instead, the members of a specific national group.¹³⁾ What was deemed necessary in the Korean case involved the replacement of Japanese medical personnel by local trainees so that members of the former group could be repatriated to their home islands. In the course of undertaking this task, however, American soldiers recognized that there simply were not enough Koreans

⁷⁾ The CATS sites (Civil Affairs Training Schools), based at twelve universities distributed throughout the U.S., offered language and cultural training (1942-1945) to American military personnel preparing for the projected occupations of Europe (Italy, Germany) and Japan. See Ada Leeke, When Americans Came to Korea, Freeman, S.D.: Pine Hill Press, 1991 for an account of an American officer who underwent this training at Stanford before serving in Korea. Also see Records of the School of Military Government, 1943-1945, U.S. Army School of Military Government, Special Collections, University of Virginia Library. The chaos associated with the occupation of the Korean peninsula also extended to the comparable occupations of Japan, which also saw late troop arrivals.

⁸⁾ Leeke, 1991.

⁹⁾ Jin Kyu Robertson (Suh), Legacy of Empire: Japanese Influence on the United States Military Government in Korean 1945, Ph.D. dissertation, Harvard University, 2006

¹⁰⁾ SKIG (South Korean Interim Government) would begin to assume a portion of the governing functions by 1947.

¹¹⁾ Chapter XVI, “Philippines and Okinawa.” in Lada(ed.), 1976.

¹²⁾ Turner, Chapter XVIII, in Lada (ed.), 1976.

¹³⁾ While there is a rich literature in English regarding the occupations of Germany and Japan, Austria and Korea have received far less attention. For Austria, see James Carafano, Waltzing into the Cold War: the Struggle for Occupied Austria, College Station: Texas A & M Press, 2002; for Korea, E. Grant Meade, American Military Government in Korea, New York: King’s Crown Press, 1951. There is no recent study of USAMGIK, with the exception of its treatment in numerous volumes concerning the prelude to the Korean War.

possessing the requisite training, meaning that Japanese police, professors, teachers, and physicians maintained their positions well into 1946, and sometimes even beyond.¹⁴⁾ In those cases where replacements could be found, new staff members tended to be Koreans who had previously found favor with colonial authorities, and were sometimes viewed as compromised by their peers. With respect to medicine specifically, this claim has been made by Korean scholars, arguing that departing Japanese personnel were simply replaced by a similar group of Korean physicians.¹⁵⁾

Contributing to the sense of urgency from the American perspective was the added contingency of disease control, a problem complicated by the movement of new populations on the peninsula.¹⁶⁾ Horace H. Underwood, a senior figure and a member of a prominent missionary family, was among the American missionaries who returned to Korea to assist with the task of rebuilding. Taking a position with the Education Bureau of USAMGIK, Underwood was ideally situated as an observer, and wrote numerous reports regarding the problem of refurbishing an education system that had been largely neglected during colonial rule. In emphasizing a general expansion of access to education, Underwood called for not only an increase in the number of educators, but also for the training of “doctors, nurses, [and] veterinarians” willing to work in the outlying areas of Korea.¹⁷⁾ In making this appeal, Underwood reinforced the link between two related perceptions, a shortage of medical doctors to serve the local population, as well as the tendency of existing medical personnel to be heavily concentrated in urban centers.¹⁸⁾

With this appeal, Underwood backed a proposal that would dominate the USAMGIK approach to the problem of maintaining public health, a desire to rely almost exclusively on physicians trained in the Western medical tradition. If practitioners such as Mr. Byun merited attention; and were included in the survey, their skills and expertise were nonetheless considered only marginally effective. This chapter will address the

motivations informing the gap between the American military approach to this new set of problems and the resource base of traditional Korean medical practitioners. Ultimately, Byun Sang-hun’s story does not represent one of elision; but rather, the complicated story of a set of skills which began to adapt and transform beginning in the late nineteenth century, facing a succession of challenges to its authority. The issue of increasingly sophisticated forms of surgical intervention and the emerging problem of disease control—particularly typhus and cholera—were only two of the claims put forward to question the value of traditional practice, which nonetheless succeeded in reinventing itself, both as an independent approach and as a necessary complement to Western medical practice in the newly formed ROK after 1948.

Far from a static set of traditions handed down from time immemorial, hanŭihak underwent numerous changes over a period of more than three hundred years—a period spanning the late 16th century to 1945—selecting elements of Chinese practice and adapting them to meet the needs of the local community. To

¹⁴⁾ The original USAMGIK projection had called for the transfer of these positions to Korean hands by January 1946. Cf. Note 9.

¹⁵⁾ Shin Jwa Sup (신좌섭), “Kunchŏngki ŭi bokŏnŭiryŏngchŏngch’aek (군정기의 보건의료정책), “Policy of USAMGIK toward Public Health and Medicine in Occupied South Korea,” *Korean Journal of the History of Medicine*, December 2000, (9.2), pp. 212-232. Dr. Shin’s Master’s thesis, which concerns medical education under the USAMGIK, also takes up this topic

¹⁶⁾ “Typhus, Small Pox Control Health Bureau’s Big Task, RG 554, Box 20, “Public Health & Welfare, Health of Troops.” Also see “Misc. Typed Materials,” Public Health & Welfare, RG 554, Box 19. Nara II, College Park, MD.

¹⁷⁾ “Education in Korea: The Situation and Some of the Problems,” Horace H. Underwood, Report to SKIG (South Korean Interim Government), August 28th, 1947, p. 3. File 14.160, Underwood Family Materials, Yonsei University.

¹⁸⁾ Turner, “Chapter XVIII, Japan and Korea,” p. 692, in Lada (ed.) 1976. According to Turner, USAMGIK estimated that about 30% of the trained physicians resided in Seoul, administering to only about 5% of the population.

administer this gradual process of knowledge transmission, a set of local institutions (see Section 1.3) were established to educate and authorize the training of Korean court physicians, and these sites would continue to function until prior to the onset of colonial rule. Moreover, many of the elements described in USAMGIK materials—local variations of surgery and inoculation, practices which were perceived as remnants from the past—had actually been introduced in response to the encounter with Western biomedicine in the 19th century; and thus, *hanŭihak* already represented a hybrid set of practices by mid-20th century. Narrating this series of transformations through the collective story of five male generations of the Byun family, this chapter outlines the series of changes taking place within a sinicized Korean culture that would encounter the transforming effects of Japanese colonial rule, followed by American occupation.¹⁹⁾

If traditional medicine has not always received its due, moreover, this development needs to be examined not by looking at these practitioners in isolation, but by looking at the rapid emergence of newer biomedical institutions which came to dominate the South Korean scene. Missionary families like the Underwoods provided a means to guide funding and resources from Western donors to local institutions, first during the colonial period, and subsequently, with independence and the Korean War. These resources went almost exclusively to promoting the growth of biomedical practice, and in particular, Severance Hospital and Seoul National University Hospital would represent two of the most influential institutions in terms of training significant numbers of Korean doctors and nurses, along with subsequently promoting the practice of public health.²⁰⁾ In choosing to focus on Byun Sang-Hun and his personal story, this chapter argues specifically that this second story, the prominence of which has tended to dominate the historiography, is contingent: biomedicine’s appeal lay precisely in its ability to highlight the artificial contrast with *hanŭihak*, the dynamic modern posed against the static past.

Ultimately perceived as part of the latter, Byun Sang-hun would be celebrated as a heroic figure near the end of his life, a bearer of traditional practices through difficult times (see Section 1.7).

1.2 TKM (Traditional Korean Medicine) and the Appeal of Local Physicians

Scholars focusing on the role of Korean traditional medicine typically base their periodization according to the governing power, focusing on one of three periods, either late Chosŏn (1876-1910), colonial rule (1910-1945), or the period of independence following the occupation (1948-present), marking the beginning of the ROK. While this approach has produced a growing body of literature, especially for the complex intersection between the first two periods, it has often treated the post-1945 story as one marked exclusively by the emergence of Western biomedicine.²¹⁾ In fact, Korean traditional medicine underwent enormous changes during this period, particularly after the Korean War, when it

¹⁹⁾ Andre Schmid, *Korea Between Empires, 1885-1919*, New York: Columbia University Press, 2002. See especially Chapters 1 & 2, “Decentering the Middle Kingdom and Realigning the East” and “Engaging a Civilizing Japan” respectively, for the Korean court’s changing attitude toward Chinese culture in its official discourse at the end of the 19th century. Schmid argues that many Koreans consciously rejected Chinese models in favor of more “modern” Japanese practices.

²⁰⁾ *Activities of Severance Union Medical College and Severance Hospital, 1927-28*. Seoul: Severance Union Medical College. Rare and Older Books reading Room, Yonsei University Library.

²¹⁾ Don Baker, offers one of the best surveys of **TKM**: Don Baker, “Oriental Medicine in Korea,” in Helaine Sellin (ed.), *Medicine Across Cultures: History and Practice of Medicine in Non-Western Cultures*, Dordrecht, Boston & London: Kluwer Academic Publishers, 2003, pp. 133-154. Annette H. K. Son provides one of the few modern surveys covering all three periods: “Modernization of Medical Care in Korea, 1876-1990,” *Social Science & Medicine* 49 (1999), pp. 543-550. Gil-Soo Han’s “The Rise of Western Medicine and Revival of Traditional Medicine in Korea: A Brief History,” looks primarily at the return of interest in traditional medicine corresponding with recent economic growth in the 1980’s. *Korean Studies* 21, 1997: pp. 96-121.

began to be taught in university degree programs for the first time.²²⁾ This process of accommodation represents an extremely valuable activity in itself, especially as it took place at a time when the ROK was in the process of refashioning its own independent institutions and practices. In this refurbished form, Traditional Korean Medicine (or TKM) forms a critical component of the South Korean national story.

In arguing for the adoption of this terminology, I am following in the tradition of recent scholars of China, many of whom have argued that traditional medical practices reorganized under the PRC have to be treated as a distinct field, comprising a set of practices designated under the rubric of Traditional Chinese Medicine or TCM.²³⁾ For the comparable Korean case, I adopt the label TKM, aiming to encompass both (1) the revised forms of practice emerging in late Chosŏn and colonial rule (1876-1945), as well as the new university degree programs which subsequently appeared in an independent South Korea. Moreover, the analogy between the Korean and Chinese cases is a useful one, as the transformation of local medical practices was common to the nations of East Asia.²⁴⁾ Once an elite set of practices catering almost exclusively to the court, TKM, in contrast, became associated with the Korean countryside, thereby making it available to the average person. In contemporary South Korea, the use of herbal remedies and TKM now stands alongside Western biomedicine as a legitimate form of practice, with many Koreans choosing according to their particular ailment.²⁵⁾

Reinventing Byun Family Tradition

The use of this new terminology, TKM, goes a long way toward accounting for the positive image of traditional practitioners. Within the Byun family, there is a lengthy oral tradition filled with such stories: at his clinic, Byun Sang-hun would periodically receive visits from Japanese soldiers on leave from nearby camps, seeking treatment for a variety of complaints.²⁶⁾ A number of these ailments—digestive trouble, back pain, and minor diarrhea—were fairly common, typical of those plaguing local residents; and in this case, Byun

felt obligated to assist to the best of his ability.²⁷⁾ The notion of the practitioner reaching out to the population, even going so far as to assist Japanese soldiers, fits with the popular image of the practitioner as benevolent caregiver. In a culture where written records were maintained by only a few, however, there was little incentive to record these transactions in the form of individual patient records, especially with the onset of the early 1930's and the coming mobilization for war with China.²⁸⁾ In placing traditional medicine in dialogue with Western medicine, first under colonial rule, and subsequently, the USAMGIK, this chapter provides an explanatory context for the process of transformation—including changes in both the practice and the social

²²⁾ See Baker, pp. 150-152.

²³⁾ I am referring here in particular to a number of M. Phil and D. Phil theses which have emerged from Cambridge University and the Needham Research Institute. Bridie J. Andrews, *The Making of Modern Chinese Medicine, 1895-1937*, D. Phil, Cambridge University, 1996. Kim Taylor, *The History of the Barefoot Doctors*, M. Phil, Cambridge University, 1994. Kim Taylor, *Medicine of Revolution: Chinese Medicine in Early Communist China (1945-1963)*, D. Phil, Cambridge University, 2000. Hilary Smith, *To Revise and to Improve: Historical Narrative in Traditional Chinese Medicine Textbooks in the PRC*, M. Phil, Cambridge University, 2000. **TKM** also carries with it an ideological flavor, as South Korean **TKM** bears a particular image of the nation as both Korean and modern, in contrast to corresponding medical practice in the North.

²⁴⁾ Sellin (ed.) 2003. This anthology makes the case for comparative work, going even beyond the East Asian region.

²⁵⁾ To cite a personal example, I became aware of this dynamic when a Korean friend's wife gave birth to twins in a hospital, and then sought the advice of a traditional practitioner for her back pain upon returning home.

²⁶⁾ This type of activity would most likely have taken place sometime during the mid to late 1920's. It should not be surprising that Japanese soldiers, who may have had access to *kampo* (Chinese medicine in Japan) at home would seek similar remedies in this new setting.

²⁷⁾ Dr. Byun Kil-Won, interview, 6-16-06, 6-25-06.

²⁸⁾ *Ibid.* Korea is a culture with a long tradition of documents certainly, but personal diaries or similar materials were far less common during Japanese colonialism and the early ROK. Moreover, these sources, when they do exist, remain enormously difficult to access.

role of the practitioner—while relying on official accounts as a guideline.²⁹⁾

Previously, under Chosŏn rule (1392-1910), medical practitioners and related personnel—including here a limited range of educated professionals in fields such as mathematics, art, and astronomy—occupied a secure niche within society, a designation characterized as chungmin (중민), or the intermediate class. Not as exalted as the elite yangban (양반), these individuals nonetheless held a position far more stable than that of the majority, those responsible for furnishing the labor for agricultural production as well as the bulk of tax revenues. Medical practitioners at this time generally served the interests of the yangban, with the court physicians selected from among those few who passed government-sanctioned exams.³⁰⁾ In addition, pharmacists, who produced their own herbal remedies, in tandem with others who sold these products in the market, also held an intermediate status; but again, they were more likely to cater to the needs of the yangban.³¹⁾

The intervention of colonial rule would begin to break down the rigid hierarchy of Chosŏn, introducing a fluidity that would point the way toward a transformation to industrial labor. For the Byun family, too, this represented a radical change in circumstances: whereas Byun Seok-hong, senior member of the family and the patriarch, had worked at the court in Seoul, his decision to relocate in 1902 coincided with Japanese influence, with his family taking up residence at Yangsan. Opening a clinic there, family members would occupy a different social niche, with the majority of their clients now coming from local residents.³²⁾ At Yangsan, moreover, they could grow their own plants, and prepare their own remedies, with relatively minimal interference from Japanese officials. If the family compound and clinic represented a short-term survival strategy, it would raise new questions in the aftermath of the war, when USAMGIK officials needed to generate an accurate count of these practitioners, as well as to determine their role in terms of providing health care.

To consider Byun Sang-hun from the (American) perspective of 1947, he stood as a marker of the past, an anachronism who had somehow survived the colonial period. Lost on U.S. Army officials were the multiple layers embedded within the family’s history: the choice to relocate in 1902 followed key changes to the royal system for educating court physicians, which would have affected the practice of family patriarch, Byun Seok-hong (see Section 1.3).³³⁾ Subsequently, his son, Byun Yeong-mok, and grandson, Byun Sang-hun, assisted with establishing the family clinic and practice at Yangsan, creating a very different mode of existence, catering to local residents. This newer form of practice would lend itself to the creation of a powerful symbol of the rural community with the emergence of an independent South Korea, and Byun Sang-hun would indeed benefit with a corresponding rise in status. For the time being, though, USAMGIK regarded him as but a temporary means to an end, intending to replace this type of practitioner with biomedicine.

“Government of Translators”

²⁹⁾ Official accounts referred to here include Japanese colonial surveys, USAMGIK Bureau of Public Health & Welfare surveys, and estimates provided by associations for practitioners of traditional medicine, with numbers provided by KOMA (Korea Oriental Medicine Association). With these combined resources, it is possible to estimate the number of traditional practitioners. However, the question of patients and their visits to these doctors is another problem, and to date there has been little work on this subject. The December 2006 issue of Korean Journal of Medical History contains a case study of one site during the colonial period.

³⁰⁾ Baker, “Oriental Medicine in Korea.”

³¹⁾ Ibid.

³²⁾ Dr. Byun Kil-Won, Interview, 6-16-06, 6-25-06. While the family does not maintain a log of patients for this period, Byun Sang-hun’s personal prescriptions are kept via his handwritten annotations to his personal library of medical texts.

³³⁾ The end of the royal examination system, along with the training of local physicians in biomedicine, signaled the marginalization of traditional practice within the Korean court. Baker, p. 152. According to the Byun family, Byun Seok-hong was specifically asked by King Kojong to serve the residents of central Korea.

In contrast to neighboring Japan, where the SCAP Occupation (1945-1952) and its accompanying goal of “democratization” represented a major postwar priority, the occupation of Korea was poorly organized and, indeed, something of an afterthought. With a lack of Korean language expertise, USAMGIK had little choice but to function as a “government of translators,” relying on local assistance where possible. Along with the cooperation of locals, the presence of returning missionary families provided a considerable boost in terms of their accumulated knowledge of the peninsula and its practices. Horace H. Underwood was joined at the Education Bureau by his son, Horace G. Underwood, who assumed a position at the newly formed national university, Seoul National University, beginning in the summer of 1946.³⁴⁾ For the Underwoods and like-minded families who had lived in Korea since the late nineteenth century—many departing only with the intervention of war in 1941—medical missionary work formed the core of the American project, both in terms of encouraging doctors to visit Korea for Christian mission work, and more importantly, in terms of establishing new institutions designed to train Korean physicians.³⁵⁾

Two of the institutions designed specifically for this purpose, Yonhi College and Severance Union Hospital, with the former linked directly to the leadership of the founding Underwood family, would produce a significant number of Korean graduates, representing one of the few available sources of higher education during the colonial period.³⁶⁾ The return of missionary figures, while they constituted only a small portion of USAMGIK personnel, represented the resumption of their project, the continuation of education and medical work.³⁷⁾ Moreover, the placement of the two Underwood men in prominent positions at the Education Bureau meant that they were capable of exerting a powerful influence. While the Bureau did not mobilize the rubric “democratization” explicitly, the policy of re-opening schools, mandating enrollment through at least junior high, and subsequently high

school, was clearly designed to promote ease of access. Likewise, the decision to reconfigure a range of facilities to form a national university—while regarded as a controversial decision in the summer of 1946 and well beyond—carried with it a similar set of motives.³⁸⁾

The tension between local practice and Western biomedicine typically centered on critical issues of treatment and intervention, requiring local practitioners to continue adapting their practices to reflect the emergence of these new challenges. The USAMGIK emphasis on disease prevention, along with the opening of new hospital facilities, was one strongly influenced by the expertise of returning missionary personnel who had already spent significant time in country (see Section 1.7). In turn, the reaction of traditional doctors to their American counterparts was likewise one shaped by their prior experience, particularly the encounter with the public health system of the Japanese colonial government. It should not be surprising that traditional

³⁴⁾ Korea in War, Revolution and Peace: the Recollections of Horace G. Underwood. Edited and Annotated by Michael J. Devine. Seoul: Yonsei University Press, 2001. Underwood’s title at SNU was *kyomuch’o’chang* / 교무처장, which translates as Director of Academic Affairs. In his memoir, Underwood describes the position as analogous to that of a university registrar. Also, see interview with Horace G. Underwood, 1-10-03, 1-13-03, and 2-13-03.

³⁵⁾ Donald Clark, Living Dangerously in Korea: the Western Experience, 1900-1950. Norwalk, CT: Eastbridge, 2003. See also Elizabeth Underwood, Challenged Identities: North American Missionaries in Korea, 1884-1934, Seoul, Royal Asiatic Society, 2003; Kim Chong Bum, Christianity in Colonial Korea: the Culture and Politics of Proselytization, Ph. D dissertation, Harvard University, 2004.

³⁶⁾ Moon Man-Young (문만용) and Kim Young-Sik (김영식), Hankuk Kūndae Kwahak Hyōngsōngkwachōng Charyo (한국 근대과학 형성과정 자료) Documentary History of the Development of Modern Science in Korea, Seoul: Seoul National University Press, 2004. See also Geun Bae-Kim, The Growth of Scientific-Technological Manpower during the Japanese Colonial Period, Ph.D. Thesis, Seoul National University, 1996. (Korean); Dr. Kim’s thesis is also available in an updated version published in 2005.

³⁷⁾ Clark, Living Dangerously in Korea. Clark asserts that USAMGIK tried to put this population to use, despite its small size.

³⁸⁾ Underwood, Korea in War, Revolution and Peace.

physicians might hope to avoid calling attention to themselves as a group, even as they continued to serve the needs of the local population.

Still, their presence in terms of sheer numbers was greater than that of Western-trained physicians as of 1947, a development which could not escape the notice of USAMGIK (see ahead to Section 1.6 for numbers and explanation of categories). For Chunbuk alone, there were 74 Western-trained physicians and 48 “limited area” physicians, with these 122 individuals responsible for the care of a population numbering roughly 1,100,000. At the same time, there were also 30 traditional practitioners, with 113 “limited area” practitioners to assist, meaning that this second group slightly exceeded their Western-trained peers in numbers. In terms of practice, USAMGIK officials—especially the Bureau of Public Health and Welfare under the direction of Dr. William R. Willard (see Section 1.6)—recognized that accommodations would have to be made. This group of physicians not only possessed a greater knowledge of the local population, but they also were free of the stigma associated with public health, a legacy of Japanese colonial rule.

In the next four sections—encompassing Sections 1.3 to 1.6—we will trace the story of TKM’s transformation from a set of elite practices deriving primarily from Chinese sources to a marginal form of practice experiencing pressure from Japanese proponents of Western biomedicine. While traditional practice was never actually eliminated in colonial Korea, its professional status was greatly reduced, even as it remained of great interest to Japanese academics during the 1930’s as part of the mobilization for war. In the last of these four sections, 1.6, we will witness the incorporation of TKM as part of USAMGIK’s scheme for public health, a recognition of the lack of trained physicians, particularly in rural areas. Ultimately, TKM would take two related forms by the early 1950’s, a heroic form, embodied in figures such as Byun Sang-hun; and a newly revised form, represented by the emergence of new university training programs starting

in the aftermath of the Korean War.

0.0 From Chinese Sources to Korean “Tradition” : the Origins of TKM (late 14th –late 19th century)

The origins of TKM date not to the colonial intervention per se, but to a series of developments taking place in the late nineteenth-century, when Korea experienced contact with several Western nations, along with internal political turmoil. As part of the effort to promote reforms, the Great Han Empire (1897-1910), as the nation was then known, adopted its own licensing system for traditional practitioners.³⁹⁾ In part this measure was designed to regulate the increasing number of practitioners, which included not only the category of doctors, but also pharmacists and drug-sellers as well. The measure no doubt represented something of a necessary compromise, as Japanese influence was already on the rise, with the Western missionary presence also playing a prominent role.⁴⁰⁾ From an institutional standpoint, the gesture was extremely significant as well, as it would represent an interruption of a system which had prevailed during much of the late Chosŏn period, supplying the court with its trained medical personnel. This is the world in which Byun Sang-Hun’s grandfather, Byun Seok-Hong, was educated prior to serving as a court physician.⁴¹⁾

Prior to the late 19th century, Choson had long relied on a system of institutions designed to provide medical care to the court, as well as to prevent the spread of disease in the capital. Chief among these institutions were the Cheonuigam (Directorate of Medicine), Naeuiwon (Royal Clinic), and Hyeminso (Capital Medical Clinic).⁴²⁾ Of these three, the first two bodies provided

³⁹⁾ Baker, “Oriental Medicine in Korea,” p. 148. See also Shin Dong-Won, “The License System for Korean Herbal Practitioners in 1900,” in Current Perspectives in the History of Science in East Asia, Yung Sik-Kim and Francesca Bray (eds.), Seoul: Seoul National University Press, 1999, pp. 478-483

⁴⁰⁾ Shin, p. 481.

⁴¹⁾ In addition to Byun family sources, I am currently trying to search through the online *Sillok* to build a wider context for the activity of court physicians.

for the immediate medical needs of the royal family, as well as top officials and their family members. The Hyeminso, in turn, functioned as a form of quarantine within the capital city, offering food, clothing, and shelter to those suffering from illness, thereby decreasing the potential for the spread of disease. Hwarinseo (Suburban Medical Clinics) were established outside the gates of the capital as well, with these clinics similar to the Hyeminso in serving as a form of quarantine. However, medical treatment here was provided free of cost, in contrast to the city; and both Buddhist monks and shaman healers were assigned to work at these facilities to broaden their possible appeal to the local population.⁴³⁾

The monitoring of the population in the form of quarantine fits the portrayal of Choson society as highly stratified, with the most important element here resting on the restriction of the movements of those who were ill. Along similar lines, regional medical centers were also created to anticipate the outbreak of epidemics, with a secondary function being the collection of local plants and materia medica.⁴⁴⁾ Typically these centers would be staffed by a handful of trained personnel, with a Confucian scholar overseeing the activities of a small group of physicians and medical technicians. This arrangement indicates the emphasis still placed on classical learning, and as Don Baker wryly observes, meant that “Confucian scholars with more expertise in Chinese poetry and ancient Chinese history” frequently dominated the ranks of government medical agencies.⁴⁵⁾ Outside the court, moreover, the regulation of medical knowledge was minimal, and practitioners serving the population at large were not subject to the system of exams administered to select court physicians and medical officials.

These specialist exams, which were comparable to the civil service exams required to become a Choson official, resulted in the concentration of medical practice in the hands of a relatively small number of families.⁴⁶⁾ Though there was no legal requirement as such, the preference for hereditary ties reinforced the tendency

toward the formation of a tightly-knit in-group. Moreover, the exam system managed to keep the numbers to a bare minimum, with only 166 examinations held between 1498 and 1894.⁴⁷⁾ On these occasions, an estimated 1,500 candidate successfully handled the medical civil service exam, meaning that the average exam period saw only about nine individuals achieve a passing score.⁴⁸⁾ Of those who subsequently went on to serve the royal family in a medical capacity, more than half came from a small group of families situated near Seoul, again suggesting that the scope of official medical practice was extremely restricted, while the general population came to rely on alternative forms of practice, including Buddhist healers and shamans.

This two-tiered system of practice, with an elite medical corps basing its practice largely on a careful selection of Chinese texts, prevailed for nearly four centuries.⁴⁹⁾ The use of Chinese sources required

42) Baker, “Oriental Medicine in Korea.” pp. 139-140.

43) Ibid.

44) Ibid.

45) Ibid.

46) Ibid.

47) The June 1999 issue of *Dongbak Hakchi* is devoted almost exclusively to the topic of Korean traditional medicine, focusing in particular on the Chosŏn period.

48) Jin Kim, *Chosŏn Sidae ūigwan seonbal*, “Selection of Medical Officials during the Chosŏn Dynasty,” *Dongbak Hakchi* 104 (June 1999): 1-93. This is an exhaustive account of the exams, those who passed, and their family backgrounds. The two articles following Kim’s, Yi Kyu-Keun’s “Medical Institutes and Official Doctors in Chosŏn Dynasty,” pp. 95-162; and Kim Yang-Soo’s “The Actual Condition of Official Doctors and their Advancement to Local Mandarins in Chosŏn Dynasty (1392-1910),” pp. 163-248, both provide a detailed context for the role of court physicians, particularly in terms of documenting the limited numbers of successful exam takers. As Byun family history attests, elite families with members who could pass the exams have tended to retain their status in an independent ROK, albeit in a transformed role.

49) Baker passes over this issue fairly quickly, citing the Han, Sui, and Tang dynasties as “primary sources of [Koryŏ] medical concepts and practices.” (137). To begin to trace the numerous sources underlying what would become Korean tradition, see Kim Dujong, *Hankuk ūihaksa*

adaptation to local circumstances, and the codification of a (Korean) canon began in earnest in the 15th century with the circulation of numerous anthologies. Of these, probably the most famous was the Hyangyak jipseongbang (Great Collection of Native Korean Prescriptions), a pharmaceutical guidebook completed in 1433, encompassing eighty-five volumes in its entirety.⁵⁰⁾ Assembled nearly two centuries later, Heo Jun's Dongui Bogam (A Treasury of Eastern Medicine), a compilation appearing in 1613 under government authorization, represented a further refinement of these sources, and was much easier to distribute due to its relatively compact size. Dongui Bogam would not only become the most influential text of its time, but also continues to influence Korean medical practice today.

Appearing in the midst of a chaotic time after nearly two centuries of stability (1392-late 16th century), Dongui Bogam followed the Japanese invasions of the Korean peninsula in the 1590's, and preceded subsequent Manchu incursions in 1627 and 1636.⁵¹⁾ Although this work, like previous compilations, was intended primarily for the use of physicians, it would have a greater impact in terms of its popularization of medical prescriptions. Portions of the text were published in the form of small pamphlets, which could circulate easily among a population eager for access to medical information. Other authors would continue this trend, and the next two centuries witnessed the publication of information previously available only to a few, a development associated with more frequent outbreak of epidemics on the peninsula, especially smallpox and measles.⁵²⁾ In practical terms, groups of families also began to form pharmaceutical cooperatives, planting and cultivating plants to ensure that a supply of medicine would be available in times of crisis.

The two centuries preceding (17th-18th) the arrival of foreign intervention—here meaning both Westerners and Japanese—witnessed the ongoing indigenization of Chinese textual sources; and more importantly for our story here, an increasingly complex system for the production and distribution of medicines.

Pharmaceutical markets, where prescriptions could be purchased, probably appeared sometime in the 17th century, with the pharmacist's shop following in the 18th century, as private individuals began to consult those skilled in the knowledge of medicine.⁵³⁾ Government regulation of the new professionals continued to be minimal, but the presence of outsiders would introduce change in the 19th century. The end of the Chosŏn exam system in 1894, along with the first attempt to regulate medical practice at the popular level, represented a development which came only after both Western and Japanese advocates of biomedicine had made their presence felt. Regardless of the underlying agenda, the call to modernization was a strong one, one to which the Korean government needed to respond.

In particular, this first effort at establishing a licensing system sought to differentiate among four groups or classes of professional, the first being the official doctors attached to the court, an extremely elite group which we have already discussed.⁵⁴⁾ The second, Confucian doctors, were those possessing knowledge of medical practice, but who opted not to exercise these skills in a public forum. Private doctors, in contrast, marketed themselves to potential clients, catering to the needs of individual patients. Along with this third group, members of the fourth, drug-sellers, also catered to a customer base, supplying the materials used for prescriptions. These last two groups constituted the greatest number of practitioners in late Chosŏn, and tended to have the strongest presence outside the cities, practicing in the countryside.⁵⁵⁾ Whether motivated by

(A History of Medicine in Korea), Seoul: Tamgudang, 1981; and "Middle Eastern and Western Influence on the Development of Korean Medicine," *Korea Journal* 2 (12): 5-7, 1962.

⁵⁰⁾ Baker, "Oriental Medicine in Korea," p. 142.

⁵¹⁾ Ibid., p. 143.

⁵²⁾ Ibid.

⁵³⁾ Ibid., pp. 146-147.

⁵⁴⁾ Shin, p. 480.

⁵⁵⁾ Ibid., p. 481.

concern over unregulated practice or as a conservative gesture to limit the number of doctors, the government's effort to license practitioners anticipated similar strategies undertaken by the Japanese colonial government only two decades later (see Section 1.4).

At the same time, the use of Chinese medical practice within a Korean setting would become identified as uniquely Korean by the mid-19th century, especially as it came under pressure from external forces. If the licensing system represented an effort to limit, it was equally an effort to preserve, to capture an elusive form of practice that was in danger of disappearing. If the Byun family underwent a decrease in status, it would be a temporary one, as their practice would re-emerge in the aftermath of the Korean War, this time reinvented as a powerful symbol of South Korean nationalism. Even as their practice was clearly a hybrid of Chinese, Korean, and Western biomedical techniques, this combination would hold great appeal to clients in a nation seeking legitimacy for its own institutions.

Moreover, in the late 19th century, Choson Korea had to respond to the presence of Western missionaries along with the sharp increase in Japanese influence. The scholarship in recent years has attempted to complicate this relationship—offering a more nuanced portrayal of the interaction between missionaries and their Korean counterparts—and there can be little doubt that the court perceived biomedicine as a means to maintain its power.⁵⁶⁾ The first effort to establish a system of licenses was therefore not so much a punitive measure as an attempt at consolidation, defining the categories of local practitioners according to a scheme borrowed largely from the outside. Along these lines, Yeo In-Seok has argued recently that biomedicine and TKM managed to co-exist through much of the period, with the two sets of practice each regarded as capable of making a distinct contribution.⁵⁷⁾ This spirit of accommodation would end, however, with the imposition of a new licensing scheme early in the following century.

0.0 New Challenges to *Hanŭihak* (한의학) under Colonial Rule (1885-1919)

Ŭisaeng (의생) and Licensing Requirements (1913-1914)⁵⁸⁾

Prior to the advent of formal colonialism, the Japanese presence had been gradually increasing via a series of incremental steps, first with the treaty of Kangwha-do (1876), followed by military victories over regional rivals China (1894-1895) and Russia (1905). With this power came the corresponding ability to dictate Korea's domestic and international affairs, and in particular, the creation of a formal licensing system for traditional practitioners was first announced in late 1913.⁵⁹⁾ Before this, individuals seeking to learn these practices would typically serve alongside a physician for a length of time, usually several years, serving an apprenticeship in the process of acquiring their training.⁶⁰⁾ The new system could not put an immediate end

⁵⁶⁾ At the same time, court physicians were retained in an official capacity through the late 19th century, as Baker points out, meaning that the transition was not an abrupt one.

⁵⁷⁾ Yeo In-sok, *Hanmal ilchaesiki sŏnkyoŭisadŭlŭi Chont'ongŭihak Insikkŏ Yŏngu* (선교의사들의 전통의학 인식거울연구) (The Gaze of the Others: How the Western medical missionaries viewed the traditional Korean medicine) *Korean Journal Medical History* June 2006, pp. 1-21.

⁵⁸⁾ Shin, p. 483. As Shin points out, the drive for licensing began first under the Great Han government as part of an effort to differentiate among several different categories of practitioner. Shin's SNU dissertation (1996) covers the transitional period in healthcare from 1876-1910. See *Hankuk kŭndae Bokŏn ūryosa* (한국근대보건의료사) Seoul: Hanul Academy, 1997 for the full published version.

⁵⁹⁾ Yeo In-sok, *Chosŏn Kaehang ihu Hanŭi ūi tongt'ae* (Herbal Doctors after 1876: The Transformation of Traditional Medicine in a Challenging Period), *Dongbang Hakchi*, June 1999, pp. 291-322.

⁶⁰⁾ This is a speculative point, as most published descriptions cover the earlier period in which students would have been preparing to take the state-administered exams. It fits, however, with the general description of Byun Sang-hun's education.

to this style of training; but it did begin the process of accounting for the number of such practitioners, a strategy preceding that of USAMGIK by more than three decades. Moreover, the time and effort required to acquire a license raised the stakes for entry into the profession, resulting in a decline in the number of practitioners over the long term.

Taking effect as of January 1914, this effort at licensing or *uisongkyuch'ik* (의생규칙) was a comprehensive effort to establish a system of rules for all types of medical personnel, encompassing medical doctors and dentists, along with traditional practitioners.⁶¹⁾ An earlier set of regulations had been established at the end of the nineteenth century (1894), but had not offered such restrictive terms, particularly as there not yet many doctors trained in the style of Western medicine. In contrast, the new set of rules required that traditional practitioners be at least 20 years of age, and more importantly, be able to document at least two years of prior activity in order to qualify for a license / *uisaengmyanho* (의새면허).⁶²⁾ This last measure probably had the greatest effect in terms of discouraging potential applicants, as it required a culture with little emphasis on written documentation to undergo a new process of accounting. Still, more than 5,000 individuals chose to register following the implementation of this measure, petitioning to be among those accorded the new status.⁶³⁾

The reasons underlying this enthusiastic response were no doubt complex, and to some extent, it is possible to regard the new requirements as less stringent than they may at first have appeared. Under these terms, a wide range of related practitioners—including those who merely sold herbal remedies, as well as those who practiced privately without a formal period of study—could be deemed eligible for a license if they could document a two year period of activity.⁶⁴⁾ In addition, the initial procedure called for the granting of hereditary licenses, allowing these individuals to continue their practice, even as this art was expected to wither away. This convention applied only to those

who registered in the first year, however, and subsequent applicants would need to re-apply every five years for a renewal. In this respect, the change in rules brought unexpected results in the short term, as the number of doctors granted licenses greatly exceeded the expectations of the colonial regime.

Although the campaign to exert control over the domain of traditional practitioners ultimately resulted in a reduction in the number of such individuals over the next two decades, it also elicited a response in the formation of professional societies and organizations. Founding one such group in 1915, traditional doctors sought to achieve recognition by bonding together, creating a set of standards and practices to define their common interests.⁶⁵⁾ This particular society sought to organize on a nationwide scale, but soon encountered conflicts with competing interests emerging along regional lines.⁶⁶⁾ Moreover, the colonial regime was at its most stringent during the first decade (1910-1919) of rule, with little emphasis on the needs of the local community, a situation that would subsequently change in the aftermath of the March 1st movement of 1919. This movement, with its call for independence beginning in Seoul, soon resulted in nationwide demonstrations, with Japan suppressing the demonstrators and subsequently enacting numerous changes in colonial policy (1919-1931). A young man at the time, Byun Sang-hun was busy assisting his grandfather and father at the family clinic, and received the bulk of his training during these years in the form of hands-on observation, while his two seniors treated patients.

Byun Sang-Hun's Training (1912-1926)

If it remains difficult to document Byun Sang-hun's education in its entirety, it was clearly a hybrid

⁶¹⁾Yeo, 1999, p. 307.

⁶²⁾Ibid.

⁶³⁾Ibid.

⁶⁴⁾Ibid.

⁶⁵⁾Ibid.

⁶⁶⁾Ibid.

form of training, deriving from three distinct sources: the family legacy, with his grandfather's prior role as a court physician; his formal education at a Japanese school; and the revised "Korean" training he received in the art of TKM.⁶⁷⁾ While he received the benefit of his grandfather's experience in the reading of Chinese sources, the responsibilities of running the family clinic simply did not allow sufficient time to replicate the education of his grandfather's youth. Instead, he served an apprenticeship, providing the bulk of the labor at the clinic, while observing in his spare time. In the evenings, he would receive private instruction in the reading of selected Chinese (and Korean texts), a labor which was difficult, no doubt, after having worked all day. As his father also had not been able to complete his preparation for the civil service exams, it is likely that the family had learned how to adapt this form of training to the clinic setting.⁶⁸⁾

As the Byun family has retained its library of medical texts, we can re-imagine the broad features of this period of training. Byun Sang-hun was responsible for learning numerous tasks and functions simultaneously, beginning his training in 1912 at the age of ten.⁶⁹⁾ Along with daily reading from core texts such as DongEui Bogam, the sixteenth century compilation (1598) considered the formative text of hanuihak (한의학), he began to learn about the composition and preparation of herbal remedies. Through a combination of daily reading and observation, he also learned about the proper placement of ch'im (침, or needles) associated with the practices of acupuncture and moxibustion, although it is likely that he would not have performed these procedures on his own until reaching his late teens.⁷⁰⁾ For the first several years, his major responsibility was to continue with his reading at night, while observing during the day, taking in as much as possible. Again, his major function was to supply the labor needs of the clinic, freeing up his two seniors for the task of patient care and treatment.

In terms of daily routine, Byun Sang-hun typically began early in the morning with a series of household

chores, first by assisting with the preparation of herbal treatments—tending the garden, gathering the plant specimens necessary to provide ingredients, grinding the appropriate amounts—in order to understand their composition. As his two seniors would have handled the interactions with patients, he had few opportunities for hands-on work, but he still needed to watch carefully to prepare for his future. The site for the family clinic, the village of Yangsan, consisted of a family compound and nearby, separate buildings for seeing patients; and while there was a distinction between these two categories, patients could reside on-site during treatment, frequently sharing their meals with members of the family. This was not a hospital site comparable to a Western facility of the same time, so much as a focal point for local village life.

Again, it is worth noting that this setting was itself a recent innovation, as average Koreans would not have had access to this style of medical care previously. For much of the Chosŏn period, access to traditional care meant a visit to either a Buddhist priest or a shaman, although purchase of locally-prepared remedies was also possible by about the 18th century. The Byun family clinic therefore represented a collapse of categorical distinctions, bringing together medical diagnosis, treatment, and the production of pharmaceuticals at a single site. This is precisely the overlap of interests which both the Korean court and the Japanese colonial government hoped to prevent through their efforts at

⁶⁷⁾According to his *iryŏksŏ*, Byun Sang-hun attended a (Japanese) normal school until the age of 19, graduating in 1921. Byun Family Papers

⁶⁸⁾His father, Byun Yeong-mok, was the first member ineligible to take the state exams—which had been cancelled—so it is fair to assume that the family had already begun the process of accommodating to a program of self-study.

⁶⁹⁾Byun Kil-won, interview, 6-16-06, 6-25-06.

⁷⁰⁾Of course, the materials of which the needles were composed, as well as the method of placement, would have been influenced by the interaction with biomedicine. Acupuncture and moxibustion were highly mediated practices, not a "pure" transmission from the past.

regulation. At the same time, Byun’s resistance to Japanese regulatory efforts would later take on nationalist overtones, transforming the hybrid practice of his family into a symbol of indigenous virtue to be preserved.

In the course of completing his apprenticeship, Byun came of age at an unusual time, as the Japanese colonial government held a contradictory set of attitudes toward the practice of traditional medicine. For much of this first decade (1910-1919), Korean medicine was recognized as roughly equivalent to *kampō*, the (Japanese) term for the practice of traditional Chinese medicine through the Meiji period. At least officially, *kampo* being replaced by the adoption of Western medicine in Japan; and medical personnel viewed their mission in the colony in modernizing terms, or such was the rhetoric of justification. At the same time, traditional practitioners in the countryside were generally left alone—with the exception of the need to register as a bureaucratic formality—and it is likely that training continued under these adverse conditions. In light of these circumstances, the apocryphal stories concerning visits from Japanese soldiers to the clinic now take on added significance. Japanese military personnel, familiar with *kampo* at home, felt comfortable availing themselves of an analogous set of practices in the colonial setting, even if it ran contrary to the rhetoric of their mission.

The Byun family library still contains many editions of texts reprinted during this period—especially Byun Sang-hun’s personal copy of *DongEui Bogam* (동의보감), or *Thesaurus of Eastern Medicine*—thereby maintaining a certain degree of continuity with previous practice. The family version of this text contains numerous handwritten emendations, although the majority of these marginalia probably were composed much later, dating to the late 1970’s, near the end of Mr. Byun’s life (1902-1989). Still, the compiled notes comprise a personal commentary on the herbal treatments contained therein, reflecting his adaptations to a particular prescription or recommended form of treatment.⁷¹⁾ As we can date the

beginning of Byun’s personal period of study from family accounts, he first began reading this text, along with others in the family’s possession, sometime around 1912, and continued to train intensely through the 1920’s. The premature death of his father at an early age in 1923, at 45 years old, along with the death of his grandfather three years later in 1926, left him to assume his role as head of the household.⁷²⁾ From this point, responsibility for the clinic would be his primary task, and if he continued to study, it would be in the course of following his chosen profession.

1.5 *Hanŭihak* (한의학) and its Relationship to Imperial Medicine (1926-1945)

When administering to members of the local community, Byun Sang-hun did not present a problem to Japanese authorities, as he had registered his presence—doing so for the first time in 1938—and was willing to do so again if called upon.⁷³⁾ The contested space during much of the colonial period centered not on TKM; but instead, the promotion of new models of biomedicine, as well as the terms under which it would be taught and authorized. As this was a debate conducted largely in terms of a new vocabulary, traditional medicine was beginning to change its lexicon, borrowing many of the terms of competing forms of medicine.⁷⁴⁾ Some scholars have even characterized this

⁷¹⁾These transcribed notes indicate that the medical tradition was viewed as a process in transition, rather than a static set of practices. ROK practitioners of TKM frequently attempt to claim the opposite, and North Korean practitioners generally make this claim even more emphatically.

⁷²⁾He also became a father in 1925, adding to his responsibilities.

⁷³⁾Byun’s personal papers indicate that he registered three times under Japanese rule (1938, 1941, 1944) prior to his encounter with USAMGIK. Byun Family Papers.

⁷⁴⁾Particularly in the 1930’s, the *T’ongsŏ nonjaeng* (통서 논쟁), or East-West medical controversy, was the subject of numerous editorials and opinion pieces. This is currently the subject of an ongoing research project conducted by Yeo In-Sok of Yonsei university and scholars from Aoyama University in Japan. Although the colonial government was officially devoted to biomedicine, it expressed a surprising amount of interest in *hanŭihak*.

period—beginning in the late nineteenth century, and continuing through the late 1920's—as one marked by the professionalization of traditional medicine, with doctors first beginning to publish their own newsletters at regular intervals.⁷⁵⁾

The period following the independence demonstrations of March 1919 is generally considered the point at which the style of government in the colony witnessed the greatest change (1919-1931), adopting an approach geared to *bunka seiji*, a term usually translated as “cultural rule.” Many Korean civic institutions date to this period, including major newspapers, public facilities, and academic disciplines. It is precisely the link to the colonizer that introduces an element of unease into the discussion even today when scholars examine the origins of these institutions.⁷⁶⁾ In terms of traditional medicine, it is helpful to recall that the typical strategy was not one of outright suppression, but rather, of replacement. With new medical facilities under construction, traditional practitioners needed to demonstrate the viability of their practice, which would otherwise lose its hold or appeal. New associations of practitioners were formed in an effort to achieve solidarity, and the topic of traditional medicine gained increasing visibility through newspaper articles and editorials.

This activity was undoubtedly influenced by the corresponding visibility of biomedicine, both in its institutional form and as a set of practices. Sponsored both by the Governor-General and by a variety of different missionary groups, new hospitals were beginning to appear, bringing with them the opportunity to train a new brand of practitioner.⁷⁷⁾ At the same time, it was not clear whether these facilities, particularly those sponsored by the state, were actually intended to serve the local community, a set of circumstances which may have unintentionally strengthened the claims of traditional healers. Regardless of whether they were educated at missionary colleges, or at nearby Keijo Imperial University (1926-1945), the small group of Korean doctors constituted

one of the major paradoxes of colonial modernity, representing a regime which mobilized the benefits of new practices to present its message, while clearly restricting access to these practices to an elite group.

Keijo Imperial University (1926-1945) and Its Peer Institutions

Located in Yongon-dong, a northern district of Seoul, the facilities that would later make up the Medical Campus of Seoul National University (August 1946) had a lengthy history dating back to the late nineteenth century. With the foundation of the original facility, the Daehan Hospital in 1899, the reforms sponsored by the Korean government appeared to be yielding results.⁷⁸⁾ The hospital site was subsequently reorganized under Japanese rule, first in 1916 as a part of a technical school; and then in 1926, it was formally incorporated as the medical campus at Keijo Imperial University. As the sole university recognized in the colony, Keijo held a high degree of prestige, and its graduates received access to the best opportunities and positions. Moreover, from its inception, the university was perceived as a site intended primarily to educate the offspring of elite Japanese officials and businessmen residing in Seoul, rather than an institution providing education to the local population.

The competing hospitals and educational institutions established by missionary groups had to work within the boundaries set by the colonial government, which served both as their competitor and as a means of oversight. Aware of these constraints, the faculty at nearby Severance Union Medical College chose to define their mission in opposition to their colleagues at Keijo,

⁷⁵⁾There are published anthologies of these editorials, and again, see the current joint project headed by Yeo In-Sok of Severance Hospital at Yonsei University.

⁷⁶⁾C. Sawada, *Cultural Politics in Imperial Japan and Colonial Korea: Reinventing Assimilation and Education Policy, 1919-1922*, Ph. D. dissertation, Harvard University, 2004.

⁷⁷⁾Ibid.

⁷⁸⁾*Seoul Taehakkyo Charyo Chip I.* covers the transition from government hospital to a Japanese-run facility. See especially pp. 1-40, for the photographic record.

attempting to provide the local community with Korean physicians, an aim explicitly set forth in the college catalog. Medical education would encompass both the clinical and research traditions, training students "practically and scientifically, so that they may be able to meet the problems of life and disease in Korea."⁷⁹ In the interests of conserving its resources, however, the College was forced to limit enrollment to about twenty new students each year. Upon graduation, although these students had taken many of their classes in Japanese, and were trained specifically to work in the colony, a significant number of them took positions elsewhere, including neighboring China and Japan, and occasionally, the United States.

By the late 1920's, administrators at nearby Chosun Christian College were also contemplating a series of curriculum changes designed to respond to the challenge created by the presence of Keijo. A faculty committee convened to consider revisions to the curriculum wrote that "as a special school (*chunmun hakkyo*), the fullest attainment of our aims can scarcely be arrived at," given the heavy restrictions imposed.⁸⁰ Like other mission schools at this time, the college could not attain full university status, and was forced to operate as the equivalent of a two-year college. In the short-term, therefore, the committee recommended the creation of two new programs in electrical and chemical engineering, thereby meeting a need for technically trained specialists. A commercial course was another option considered, as it would provide practical training within a relatively short period of time. With these programs, many of the college's graduates would later be among the first Koreans to receive graduate degrees in the natural and physical sciences, although they had to travel abroad to do so.⁸¹

The cautious attitude adopted toward Keijo by these neighboring institutions was not simply due to its prestige, but more importantly, to its sanction from the colonial government, which permitted the new institution a relatively free hand in pursuing new lines of inquiry, while providing superior funding and resources. In the

early 1920's, there had been a local movement headed by Yi Sang-jae, a former Choson official, to create a national university.⁸² The group collected donations from across the nation, hoping to generate funding sufficient to undertake construction of a university campus on an independent basis, thereby bypassing the need to appeal for government support. The announcement of the plans for Keijo, however, undercut any momentum that had been generated, leaving the group in disarray. Whether the university's founding was truly intended to accomplish this end remains a subject of debate; but regardless, the effect on a nationalist drive for higher education was palpable. Moreover, as the sole university prior to 1945, Keijo would play a formative role in shaping the nascent Korean academy, particularly in its choices of subject areas to pursue.

As a Japanese imperial university, Keijo took a role similar to the one played by its seven sister institutions in the home islands—Tokyo, Kyoto, Tohoku, Kyushu, Hokkaido, Osaka, and Nagoya—doing its part to integrate the colony into the aims and practices of the nation. Although the number of graduates would be comparatively small—with the corresponding number of Korean or Chosŏnin (조선인) graduates even smaller—their influence would be significant in terms of social impact. The figures for the entering medical class in 1926 support this impression of a university designed primarily with a Japanese population in mind, as there were 52 entering Japanese students, along with 14 Koreans.⁸³ For the period 1926-1938 cumulatively, the

⁷⁹*Severance Union Medical College Catalog, 1925-1926*, 378.51 Se 83, p. 20. Rare Books and Special Collections, Yonsei University.

⁸⁰"Report of the Special Committee of the Faculty of Chosen Christian College," 378.51 C45e, Yonsei University, Rare Books and Special Collections.

⁸¹Moon Man-Young and Kim Young-Sik, 2004.

⁸²Ken Wells, "The Rationale of Korean Economic Nationalism under Japanese Colonial Rule, 1922-1932: the Case of Cho Man-sik's Products Promotion Society," *Modern Asian Studies* 19, 4, (1985), pp. 822-859.

⁸³*Seoul Taehakkyo Ŭikwahaksa Charyo Chip I*, p. 89.

aggregate numbers would depart only slightly from this ratio of 3 to 1, with 2413 Japanese (74%) and 868 Koreans (26%) enrolling. Comparable figures at the law school and dental schools were slightly better, with entering Korean students reaching as high as 40% in some years.⁸⁴⁾ If these numbers are valuable in highlighting the skewed character of colonial education, they also emphasize the potential results to which this type of education might lead.

From the standpoint of its curriculum as well, the Medical School at Keijo reflected a high degree of continuity with its peer institutions in Japan, following a program similar to that adopted during the Meiji period. A four year program, the medical course was based heavily on attendance at lectures, with anatomy representing its core.⁸⁵⁾ Lengthy periods of observation in the anatomy hall did not, however, provide for a great deal of hands-on experience, and the practice of dissection was probably not as common as in comparable American or Western European medical schools. In this sense, Keijo graduates tended to be well-trained in the elements of the research tradition, but often did not acquire their clinical experience until after graduation, when engaged in their own practice.⁸⁶⁾ In terms of their social status, Keijo graduates—regardless of whether Japanese or Korean—were trained to function as elites, and were more likely to take positions treating Japanese residents of the colony in an urban setting; this clustering of doctors in the cities created a problem which persists to this day.

Finally, the medical facilities at Keijo would play a critical role in the creation of social policy regarding research into the production of new pharmaceuticals.⁸⁷⁾ Although this particular story begins somewhat later in the 1930's, it would have an impact on the conduct of the war, as well as on subsequent USAMGIK policy regarding medical supplies. Specifically, war with China in the 1930's brought difficult circumstances, with medical personnel and resources in particularly high demand. While traditional physicians would remain marginal as individuals, their practice became of interest

to Japanese military authorities in terms of providing new applications. War with China had already created shortages, and the military was seeking any alternative drugs and therapies that might be used in the field. Beginning in 1938, a research institute was established at Keijo devoted to the study of traditional pharmacopoeia. Researchers at the institute looked specifically to the cultivation of plants and the preparation of prescriptions, recognizing that alternative therapies might yield results. In this sense, traditional medicine again filled a gap where practitioners of Western medicine had not yet ventured.

Byun Sang-hun and the Colonial Experience (1926-1945)

For Byun Sang-hun and others like him, the latter part of the 1920's and the early 1930's were a surprisingly busy time, one marked by more frequent contact with officials from the police bureau.⁸⁸⁾ Despite the marginal role attributed to traditional practitioners, they often assumed the burden of providing basic health care to the population, particularly in rural areas. The apocryphal stories cited previously concerning visits from Japanese soldiers take on significance in this context, as there were certainly not enough physicians in the colony to treat Japanese residents satisfactorily, let alone the much larger population of Korean residents. If having to document his practice on several different occasions forced Mr. Byeon to adopt an attitude of discretion, it also underscores a growing interest on the part of the Japanese. Rather than simply eliminate this

⁸⁴⁾Ibid.

⁸⁵⁾Ibid.

⁸⁶⁾Choo Kun Won (주근원) Interview, October 20, 2005, SNU Hospital, Alumni Building. Dr. Choo is a 1943 graduate from KIU (Keijo Imperial University), and also holds two degrees from SNU (M.S. 1950, Ph. D., 1960). The videotape for this interview is available through Dr. Kim Ock-Joo of SNU Hospital, Office of Medical History.

⁸⁷⁾ Shin Dong-won, *Chosŏn ch'ongdokbuŭi Hanŭihak chŏngchaek: 1930 nyŏndae ihŭi byŏnwha lŭl chungsimŭlo* (조선총독부의 한의학 정책: 1930년대 이후의 변화를 중심으로), *Korean Journal History of Medicine*, December 2003 (2), pp. 100-128.

⁸⁸⁾Interview, Byun Kil-won, 6-16-06, 6-25-06.

category of practice, colonial officials chose to study and evaluate it exhaustively, looking for elements worth developing.⁸⁹⁾

In a 1947 letter submitted to his local government, Byun would furnish a detailed resumé or *iryöksö* (이력서) for this period, accounting for his activities to date (1902-1947).⁹⁰⁾ This document indicates that, perhaps contrary to expectations, Byun’s involvement in local affairs actually called for a good deal of contact with local officials beginning in the 1930’s, although his motives—whether driven by a desire to participate actively or simply out of instinct for survival—remain a subject for speculation. In either case, Byun renewed his license to practice on several different occasions—following his 1938 registration, again in 1941 and 1944—as the colonial policy of documenting traditional medicine now granted these privileges for only short intervals.⁹¹⁾ The last of these occasions was in August 1944, indicating that the bureaucratic apparatus remained functioning throughout the war. Moreover, Japan had begun to shift portions of its industrial production to Korea as American bombers reached the home islands, and it is possible that this activity had effects in the countryside as well.⁹²⁾

Also of great interest is a reference to a meeting of traditional practitioners held in late July 1943, a gathering which lasted six days.⁹³⁾ The meeting appears to have been organized with the cooperation of local government officials, suggesting that its purpose was not simply the sharing of knowledge among local practitioners, but perhaps a pedagogical intent. An undated reference to a subsequent workshop also appears on the same document, an event which probably took place sometime in 1944.⁹⁴⁾ Together these activities suggest that the participation of local *üsaeng* (의생) needs to be re-examined, certainly in terms of the extent to which they were enrolled in the affairs of the colonial authorities. For now, the most likely interpretation remains one with motives comparable to the institute for pharmaceuticals at Keijo organized in

1938. That is, as traditional doctors held the trust of the population, it is quite feasible that the government hoped to learn from them, and perhaps mobilize their consent under the circumstances of wartime.

Certainly the shortage of trained medical doctors represented an obvious target for change, and one of the major steps in the direction of a new policy involved the implementation of public health measures, with sanitation and water carefully monitored.⁹⁵⁾ From the standpoint of the colonial bureaucracy, however, the responsibility for carrying out specific measures of public health enforcement typically fell under the jurisdiction of the police, with doctors directly reporting any outbreak of disease. Under these circumstances, the police would come to establish conditions for a quarantine if necessary, taking with them those patients requiring further treatment. Similarly, when preventive measures such as inoculation were offered, a temporary clinic would be set up, appealing to the local population to receive the inoculation. These measures, framed within a public health regime, would translate into anxiety for Korean villagers, who resented the intrusion into their daily lives. If inoculation carried with it a negative connotation, moreover, this negative association

⁸⁹⁾This point remains speculative, but the numerous meetings held during the war years indicate that the local government was interested in using traditional doctors in some fashion.

⁹⁰⁾*Iryöksö*, Byun Family Papers.

⁹¹⁾*Ibid.*

⁹²⁾The U.S. Strategic Bombing Survey took numerous aerial photographs of Korean industrial sites, primarily in the North, in late 1944 before deciding not to pursue the option of bombing the peninsula. These images would be put to use, however, in September 1950, during the Korean War.

⁹³⁾*Iryöksö*, Byun Family Papers.

⁹⁴⁾*Ibid.* Byun did not specify the content of this meeting, but it would not be surprising if Japanese authorities sought to utilize the knowledge of local practitioners.

⁹⁵⁾Barabra J. Brooks, a historian of modern Japan at City University of New York, has presented on the Japanese public health regime at AAS in recent years, although no publications have appeared to date.

probably only increased as time went on. This style of practice also brought local practitioners into more frequent contact with local officials.

The activity of traditional physicians from the mid-1920's through the 1940's remains one of many stories of colonial Korea yet to be documented, particularly as the majority of existing accounts draw almost exclusively from primary materials such as Japanese colonial documents. The ambivalence of the colonial government in marginalizing these practitioners, while simultaneously exhibiting great interest in their contribution to new medicines, only highlights the contradictions inherent to the colonial project. For their part, these practitioners could no longer make claims to the "purity" of their practice by the 1930's—if indeed they ever could—which was increasingly an eclectic blend of late Chosŏn practice married to the rhetoric and vocabulary of biomedicine. In the period after 1945, TKM would successfully make its return, taking two distinct forms: it would become part of the new university curriculum, accepted as both an alternative and a complement to biomedicine; while those who, like Byun Sang-hun, stood outside this new university tradition would benefit from nationalist motives attributed to their work.

0.0 Introducing American Public Health to Korea (1945-1948)

To review the narrative to this point, Byun Sang-hun emerged from the war with his clinic and practice intact. Indeed, his personal and family documents suggest that the activity of TKM practitioners in the Korean countryside was probably more extensive than Japanese public health records might indicate.⁹⁶⁾ Individuals like Byun not only provided health care to members of the local community, but also held meetings and conducted their affairs on a regular basis precisely at a time when many scholars have argued that traditional medicine was at its weakest as a form of practice.⁹⁷⁾ With the arrival of American forces in 1945, Byun encountered yet another public health regime and licensing procedure, and he would find

himself enrolled in USAMGIK's program of encouraging local physicians to continue their practice as "limited area" physicians, as the visiting Americans discovered a shortage of Western-trained personnel in the course of conducting their survey.

Epidemiology and Vital Statistics (September 1945-May 1946)

If a lack of time had resulted in poor planning for USAMGIK, the improvised government nonetheless succeeded in attracting a number of personnel whose prior work was highly relevant to the Korean context. Appointed to serve as the head of the Public Health & Welfare Bureau, Dr. William R. Willard, previously with USPHS, had completed his doctoral work at Yale in the late 1930's, researching the contingency of an outbreak of tuberculosis in the surrounding community of New Haven.⁹⁸⁾ With this background, it is perhaps not surprising that Willard tended to view his new posting in terms of similar concerns, focusing on disease control and the administrative work necessary to establish an appropriate level of quarantine. What caught him by surprise in Korea was that his job actually had far less to do with medicine than administration. Indeed, he would lament the lack of preparation, observing that,

A medical officer with no previous experience in Military Government cannot visualize clearly the problems in the early stages of an occupation. Those who had theoretical training in Military Government Schools acquired some familiarity with the nature of the

⁹⁶⁾*Iryōksō*, Byun Family Papers.

⁹⁷⁾In most accounts, there is a "rise" in Korean traditional medicine associated with the 1960's and economic development, thereby implying a "fall" which had occurred previously.

⁹⁸⁾Willard would resume work with the Department of Public Health at Yale University upon returning from Korea. For Willard's biography, see *Journal of Medical Education*, December 1972, pp. 851-852, and for a longer account, see Patricia J. West, with Wilmer J. Coggins, *A Special Kind of Doctor: a History of the College of Community Health Sciences*, CCHS: Tuscaloosa, Alabama, 2004, pp. 30-32. Willard would later help build public and community health programs at the University of Kentucky and the University of Alabama.

problems, although theory and practice differed widely. The time required for administrative work far overshadowed that devoted to medical work.⁹⁹⁾

Specifically, Willard's observations here were directed not at the problem of controlling for disease on the Korean peninsula, but instead, the difficulties involved in decoupling the work of Public Health from that of the police bureau, as had been the standard practice under Japanese rule.¹⁰⁰⁾ Despite calling for an independent Bureau of Public Health in the Fall of 1945, Willard recognized that he did not have the personnel—either on the American or the Korean side—to implement the measures for enforcement. While there had been some provision for Public Health education at the CATS training sites from 1943 on, only a limited number of these individuals were assigned to USAMGIK.¹⁰¹⁾ In perhaps a testament to the penetration of the police within Korean society, Willard came to realize that the diverse functions required—observing movements at entry points and ports, enforcing sanitation at restaurants, policing prostitution—cut a wide swathe across the bureaucracy of USAMGIK, threatening to engulf the limited number of personnel available.

Upon establishing its presence in the fall of 1945, USAMGIK was primarily concerned with establishing order and taking stock of the current situation. With respect to Public Health, these concerns were framed directly in terms of the approach of winter, and with the arrival of colder weather, the likelihood of the outbreak of disease. In particular, Willard would later observe, typhus represented the major cause for concern; but smallpox, though perceived as a danger, was believed to have been held in check by a regimen of vaccination enforced in previous years.¹⁰²⁾ As a precaution, the first major step taken in the direction of a health policy was the enforcement of controls in the four major port cities—Inchon, Pusan, Mokpo, and Kunsan—that would see the greatest amount of activity.¹⁰³⁾ These cities represented key points of entry for Korean nationals returning from Manchuria and Japan;

and they also would serve as the mechanism for the repatriation of Japanese military and affiliated personnel, a process that would continue well into 1946.¹⁰⁴⁾

Despite these efforts at control, epidemics did occur, albeit on a small scale, causing consternation to Willard and those under his command. In acknowledging the difficulties associated with the situation—a lack of trained personnel, lax inspection standards at port sites, failure to vaccinate regularly under the colonial government—Willard placed the blame for the problem on an unexpected source, the lack of a reliable statistical base. Prior to 1945, the koseki (family register), which had been the primary means of data collection under the Japanese, requiring that families report the major events in their lives—birth, marriage, death—to the police so that this information could be updated and compiled for legal purposes. There was typically a delay of several years before the publication of the data, however, and it was not compiled with the needs of public health in mind. In Willard's estimation, the results of such a system tended to underreport the incidence of disease, making his job all that more difficult. Along with a reliable source of medical supplies then, Willard urged the introduction of a "modern vital statistics program."¹⁰⁵⁾

⁹⁹⁾William R. Willard, "Some Problems in Public Health Administration in the U.S. Army Military Government in Korea," *Yale Journal of Biology and Medicine*, March 1947, p. 666.

¹⁰⁰⁾*Ibid.*, p. 663.

¹⁰¹⁾The advisor to CATS for Public Health training was Dr. C.E.A. Winslow, like Dr. Willard, affiliated with the Yale Department of Public Health. For an introduction to Dr. Winslow's work, see *The Evolution and Significance of the Modern Public Health Campaign*, New Haven: Yale University Press, 1923.

¹⁰²⁾Willard, p. 661. See also Turner, p. 695.

¹⁰³⁾Turner, p. 692.

¹⁰⁴⁾This is the subject of a forthcoming dissertation by Matt Augustine of Columbia University, focusing specifically on the movements of repatriated persons between the occupied areas of Okinawa, Korea and Japan.

¹⁰⁵⁾Willard, p. 669. According to Turner, officers in the field were able to begin gathering numbers, although the figures were highly elastic given the circumstances.

Willard was not alone in noting the deficiencies of the Japanese data collection system, as similar complaints were emerging from the simultaneous occupation of Japan. For one, the koseki, while capturing the notion of a family tree with faithful accuracy, did not allow for the ready compilation of vital statistics. Rather, this was a portrait of the family as a unit, and the state was left with the task of abstracting larger sets of generalizations from the record. This goal was complicated by the system's reliance on the notion of honseki (legal residence), linking the koseki to the traditional family household, where the log would be maintained. When individual members relocated to another residence, or made a temporary stay in another location, the records were unable to accommodate this movement.¹⁰⁶⁾ Moreover, as one writer was to observe in 1946, the degree of unreliability only increased as Japan underwent industrialization, entailing the movement of large populations not only within the country, but also including the forced migration of Korean laborers.¹⁰⁷⁾

Both in Japan and at home, the degree to which Koreans consented to the system varied widely, with compliance generally correlated to those (urban) areas with a greater police presence. Late in the colonial period, the enforcement of the adoption of Japanese names, a practice causing enormous resentment, only strengthened the resolve of those holding out, hoping to remain undocumented for a variety of reasons. As war approached, the government attempted to match newer data with existing records of household residence, but few resources could be devoted to the task of conducting a comprehensive census. With the limitations of the existing data, Willard had little choice but to begin anew, recognizing that the numbers lacked reliability, especially when it came to the purported success of previous vaccination programs. Instead, he opted to start anew, implementing a vital statistics program directed by the Bureau of Public Health and Welfare.

The period which inspired Willard to call for this

step, the nine months marking the arrival of American forces (September 1945-May 1946), saw at least three minor outbreaks of communicable disease, including cholera, smallpox, and typhus.¹⁰⁸⁾ While this pattern had peaked by the late spring of the following year (April-May 1946), the number of reported cases was sufficient to motivate USAMGIK to implement a number of changes. For one, the lack of refrigeration facilities in the first year had caused the spoilage of vaccine left behind by departing Japanese forces.¹⁰⁹⁾ This failure justified the intervention of Public Health personnel, continuing a trend of establishing control over medicinal supplies and their producers, including the import of the majority of pharmaceuticals from external sources.¹¹⁰⁾ It also resulted in the creation of a standard bureaucratic form, available as of May 1946, which was to be used for the purpose of data collection. The gathering of the statistics for the first year generally centered around the Kyonggi region surrounding the capital (Seoul), and Willard was aware that the reliability of information outside this area was suspect.

Moreover, Willard's characterization of the data base as insufficient fit a general perception of deprivation under Japanese colonial rule, strengthening American resolve to provide something better in the future. At the same time, the new system for collecting information also held the potential for creating conflict, although this objection does not appear to have come up. From the spring of 1946, the Bureau of Public Health attempted to carry out its plans not just on the national level, but also to provide for a corresponding bureaucracy at the provincial level, creating a structure that would be handed over

¹⁰⁶⁾ "The Statistical System: Evolution to 1868," in Irene B. Taeuber and Edwin J. Beal, Jr. (Eds.) Population Index (October 1946 Supplement): Guide to the Official Demographic Statistics of Japan, Princeton: NJ, Office of Population Research, 1946, pp. 5-19.

¹⁰⁷⁾ Ibid.

¹⁰⁸⁾ Willard, p. 666.

¹⁰⁹⁾ Ibid., p. 669.

¹¹⁰⁾ Ibid., pp. 668-669.

subsequently to Koreans. Along with data collection, the Bureau assumed responsibility over licensing, and here again, significant change was in the works. No longer would traditional physicians be eligible to receive a license, and the notion of “limited” physicians would be eliminated as a category.¹¹¹⁾ Although this measure was not meant to be punitive; but rather, to upgrade the level of medical education required for such physicians, its effect on local doctors made it extremely unpopular.

In practice, USAMGIK did not hold any particular bias against traditional practitioners, even creating a separate section within the Bureau of Public Health and Welfare to handle the group.¹¹²⁾ From the standpoint of Willard and others at the top, the problem represented a question of statistical accuracy: traditional practitioners historically tended to outnumber Western-trained physicians, and in fact, continued to do so in 1945, although the proportions were by now nearly equal. The need to survey this population reflected a need to understand the geographic distribution of these individuals throughout the southern provinces, as well as their potential base of clients. Actually, this latter category posed a much larger problem, as this was a significant population that remained largely undocumented. The assumptions on which a public health program would be based—including a stable and reliable system of reporting for the incidence of disease, while improving access to vaccination as a preventive measure—could not possibly be established without including these two groups, traditional doctors and their patients. It was with aims such as this in mind that Byun Sang-hun found himself coming into contact with USAMGIK in March 1947.

Four Categories of Physicians (1946-1949)

If the ratio of available physicians to a given population was an issue which greatly concerned USAMGIK, the decision to implement new standards for licensing only complicated the issue. Chung-buk province, where Byun Sang-hun based his clinic, recognized 74 licensed physicians, and an additional 48 limited area physicians, for the period 1946-1949.¹¹³⁾

This latter group comprised physicians who were permitted to practice only within a particular district or region, as their training was regarded as less substantial than that of fully licensed physicians. With limited resources available, these individuals were called upon on a contingency basis, recognizing that the original plan to eliminate such categories was not feasible. As a general rule, the situation tended to be slightly better in the areas immediately surrounding Seoul with its metropolitan resources; and corresponding figures were worse in the rural south-central and southwestern regions.

With the exception of Cheju-do, the island situated off the southern coast, the numbers for Chung-buk were the worst in Korea in this regard, surpassing even the region traditionally known for its rural poverty, the southwestern province of Cholla. The new plan to raise the standards of medical education across the nation, while ambitious, was proving to be quite a different matter in practice. At least officially, the “limited area” physicians, who had gained their training by serving an apprenticeship in lieu of formal medical education, were being phased out, although the figures above indicate that the situation on the ground was somewhat different. This distinction between a fully titled and a “limited” doctor was also enforced with respect to hanŭihak / 한의학, meaning that there were now a total of four different categories recognized. In the case of hanŭihak / 한의학, it is not clear whether the distinction was made on the basis of criteria adopted from the colonial period, or whether an entirely new set of criteria were developed.

For Chung-buk, the number of “herb doctors” slightly exceeded the number of medical doctors, with 30 licensed practitioners, and an additional 113

¹¹¹⁾Turner, p. 694.

¹¹²⁾Ibid.

¹¹³⁾Report on Public Health Problems in South Korea, also known as the “Smith Report,” p. 19. This report, assembled in 1949, is available in numerous places, and the copy cited here is the PHW (Public Health and Welfare) copy available at NARA II.

individuals assigned to the category of limited area.¹¹⁴⁾ The significance of this statistic did not escape the attention of American observers, who acknowledged the longstanding appeal of traditional practice, particularly in outlying areas. Rather than look at the historical circumstances underlying this development, Willard and his colleagues instead worried about the problems the trend might pose for future surveys. In particular, the number of reported deaths and the incidence of disease was probably underreported, as many of these cases never approached the office of a “regular” doctor. At least implicitly, these figures strongly suggested an urban / rural divide: that is, those residing in urban areas continued to have access to a small number of Western-trained physicians, while those residing in the country continued to visit the traditional practitioner almost exclusively.

At this point, we can return to the document with which this chapter opened, the license granted to Byun Sang-hun in March 1947. Given its geographical specificity, the license most likely was identical to those distributed to limited area herbal doctors. Despite his acquisition of a license under colonial rule—an act reaffirmed on several occasions—Byun Sang-hun had been educated through an informal apprenticeship system, and he had learned primarily through his practice, rather than a series of exams and laboratory procedures. The act of granting the license embodied the paradox of the USAMGIK claim to assist the Korean peninsula via improved medical care: at least officially, there was no longer a need for individuals like Byun, as new supplies of vaccine and American doctors were arriving to fill gaps in health care. At the same time, the disparities between Kyonggi and other areas, especially Chungbuk, continued to be a problem. Byun Sang-hun could continue his practice because USAMGIK was willing to acknowledge that its ambitious claims had yet to be fulfilled, requiring contingency measures in the meantime.

In addition, the need to document these practitioners and their activities was a policing measure

bearing similarities to earlier surveys undertaken during the colonial period. In this case, however, the strategy was not one of reducing the number of practitioners by calling their credentials into question, but one of increasing the availability of health care, thereby rendering these practitioners obsolete. In the end, the object of the survey was not so much a group of individuals, as their potential statistical implications. Working from his office in Seoul, Willard wanted to be able to make precise estimates—of the number of patients treated, of instances of illness, and most importantly, of deaths—in the process of implementing a public health regime. He would never be able to document local practitioners completely, but this effort would give him a greater degree of control over the numbers, making him a more effective administrator. In his estimation, Willard had the interests of the community in mind, and he would take these skills and apply them in his subsequent career at the University of Kentucky and the University of Alabama upon his return to the United States. Here he would be known particularly for his work with community health programs, bringing increased access to hospital facilities to local people.¹¹⁵⁾

Willard’s approach was similar to the one taken by Korean administrators who would follow him in that he wanted to document Korean traditional medicine, but did not recommend any significant intervention that would affect their daily practice.¹¹⁶⁾ The approach he urged, in other words, featured a minimum of regulation and administration, without providing much in the form of an accompanying bureaucratic structure. This had the effect of further marginalizing traditional practice to the extent that it left little opportunity for addressing complaints. In the late 1940’s, traditional practice was

¹¹⁴⁾Smith report, p. 21.

¹¹⁵⁾See Coggins, A Special Kind of Doctor: a History of the College of Community Health Sciences.

¹¹⁶⁾By not regulating traditional physicians, Willard allowed them to continue their practice, but provided no mechanism by which they could participate within the framework of a national system.

regarded essentially as a stopgap measure, one that would soon be superseded by biomedicine. The attention devoted to reopening existing health care facilities, while also constructing new ones, represented the dominant approach, and the Korean War would only strengthen the prevailing image of a nation requiring assistance.

1.7 The Dominance of Biomedicine?: Reforms to Medical Care and Education (1946-1948, 1953-)

Reshaping Keijo: Seoul National University (1946- 1948)

Despite its use of a broad statistical survey to count physicians nationwide, USAMGIK was primarily concerned with the reopening of hospitals and universities, with the explicit goal of providing medical training for new personnel as rapidly as possible. And, given the growing urban / rural divide in terms of access to care, many members of the U.S. military believed that progress could be achieved through a strictly material approach, that is, the import of equipment and doctors in large quantities. Toward this end, a debate began concerning the facilities of Keijo imperial university, and this conversation would extend through the summer of 1946.¹¹⁷⁾ Though the university site had already served as a temporary billet for American soldiers during the winter of 1945-1946—an unfortunate decision that would later be exploited for propaganda purposes—the campus buildings held enormous promise as a resource.¹¹⁸⁾ Along with the facilities of a number of chunmun hakkyo in the surrounding area, Keijo was reconfigured as a university approximating the model of an American land grant university, with the various technical schools assuming the role of individual departments.¹¹⁹⁾

The impact of this controversial decision on Korean higher education was almost immediate, and the public outcry began as early as July 1946, well before the “new” university’s planned opening the following month.¹²⁰⁾ With respect to medical education specifically, the medical campus would allow Keijo students to complete their studies, before introducing a new curriculum following their graduation. In addition,

students from the nearby chunmun hakkyo, especially Keijo Medical College, were now eligible to enroll for an elite degree, a possibility which upset their peers.¹²¹⁾ When the university subsequently held its first classes in the fall, the Medical campus was marked by frequent disturbances, and there were reports of groups of students barring others from attending lectures.¹²²⁾ The most likely interpretation of this behavior attributes the activity to a loose collective formed by students of Keijo (Imperial University), who planned to resist the union of their school with a medical school of lesser status.

The perception of a reduction in status was not the only problem with medical education, and the majority of student complaints stemmed from the effects of the newly introduced system on their study plans. Keijo, like other Japanese institutions, offered a four year medical curriculum, meaning that one could specialize immediately from the time of entrance to university. The chunmun hakkyo, likewise, provided a full two years of instruction, but its graduates were trained as medical technicians, rather than as doctors, given the time constraints. Placing these graduates together in the same institution created a new set of problems, particularly in terms of how to place students of comparable ability together in classes designed to accommodate their different needs. While fourth year students who had their education interrupted by the events of 1945 were permitted to graduate, returning students found that they faced a series of diagnostic

¹¹⁷⁾Horace G. Underwood, interview, 1-10-2003, 1-13-2003, 2-13-2003.

¹¹⁸⁾A. Gitovich and B. Bursov, *North of the 38th Parallel*, Shanghai: EPOCH Publishing Co. 1948

¹¹⁹⁾Horace G. Underwood Interview, 1-10-2003, 1-13-2003, 2-13-2003. Also see SCAP,

¹²⁰⁾Monthly Summary of Nonmilitary Activities in Korea and Japan (SCAP: Supreme Command Allied Powers), August 1946, “Seoul National University.”

¹²¹⁾Dr. Choo Kun Won, Interview, October 20, 2005, SNU Hospital, Alumni Building.

¹²²⁾Harry B. Ansted, Jr., November 2002, interview. Also see Personal Papers, Harry B. Ansted.

exams intended to estimate their knowledge base.¹²³⁾ The results of these exams required a delay in graduation for many, with some requiring an additional year, or possibly even two, to meet the newly created standards.

This was not simply a question of establishing a common knowledge base, but rather, one of adjusting the different systems at Keijo and neighboring institutions to an American set of medical models. The university, while offering a four year degree, was preceded by a two year preparatory school, which in effect lengthened the period of study to six years. With the elimination of the preparatory school in 1945, the chunmun hakkyo students were, at least in theory, finally on equal footing with their peers. Based on the results of new exams, classes for the new Medical Program would be formed, and in the case of students who were not admitted to regular status, a small number were permitted to attend lectures as auditors.¹²⁴⁾ Students who had previously enrolled at Keijo now found themselves part of a much larger system, one that did not necessarily accord them special privileges. The awareness that this activity was being directed by outsiders, a claim already put forth in the summer of 1946, became a rallying point for disgruntled students during the fall semester.

If the politics of this situation were enormously complicated—indeed, a broad range of student groups from across the political spectrum held rallies on the SNU campus that first year, shutting down the campus first in December 1946, and again in February 1947—the focus for remedying their discontent was surprisingly simple.¹²⁵⁾ It involved handing over institutional control, whenever possible, to Koreans, which meant a significant turnover in faculty. More importantly, Harry B. Ansted, appointed to head the university as of July 1946, agreed to step down in favor of a replacement, removing one of the symbolic obstacles to Korean control. Ansted, a captain with the U.S. military, had previously served as a Chaplain in the Philippines during World War II, and had also headed a

Methodist-affiliated junior college, Wessington Springs, in South Dakota during his civilian days.¹²⁶⁾ The joint combination of his religious work and educational background made him an appealing candidate for the SNU job, in which he was viewed as a temporary figure during the period of transition.

Maintaining USAMGIK Priorities: Reopening Medical Facilities (1946-)

Writing in August 1947, Horace H. Underwood would single out higher education as the strongest rationale for continuing the American mission, arguing that the facilities which had been handed over represented the “central organ for training of the great majority of the [new] specialists” that Korea would need.¹²⁷⁾ At the same time, he criticized their condition, characterizing the Keijo campus in particular as being “in a deplorable state of repair,” with many classes held in buildings lacking access to “heat, light, water, or gas.”¹²⁸⁾ In the year leading up to these observations, several other medical schools had planned to reopen, but delays in returning personnel and bureaucratic processing held up this activity until sometime in 1947. Reflecting on the problems experienced during the first full year at SNU, Underwood’s remarks emphasized the need for implementing a long-term plan, one calling for regular intervals of education abroad as part of the process. In this case, Underwood was referring not to the current generation of students, but to their professors, the majority of whom were Korean graduates of Japanese universities.

This measure was implemented on a small scale, with a number of health care professionals traveling to the U.S. for six-month study tours during the period immediately preceding the Korean War (1948-1950).¹²⁹⁾

¹²³⁾Harry B. Ansted, Jr., November 2002, interview.

¹²⁴⁾Horace G. Underwood, Interview, 1-10-2003, 1-13-2003, 2-13-2003.

¹²⁵⁾SCAP, March 1947, “Student Unrest,” p. 65.

¹²⁶⁾Harry B. Ansted, Jr., November 2002, interview.

¹²⁷⁾Underwood, “Education in Korea,” p. 4.

¹²⁸⁾Ibid. p. 5.

Although there were a total of six medical schools operating by 1949, four of them were based in Seoul, with the other two located in Taegu and Kwanju.¹³⁰ The student population numbered only about 2,000 across the six institutions, with the majority of these students—slightly less than 1,600, or nearly 80%—male.¹³¹ Given these circumstances, as well as the different backgrounds at the various sites—including distinct categories for private, Korean government-sponsored, and missionary facilities—it was proving difficult to establish a uniform set of standards for medical education and practice. Moreover, SNU was the only site which mandated a two-year period of premedical training prior to entrance, distinguishing itself from its peer institutions. Just as Keijo had uneasy relations with neighboring institutions, SNU, even with its “fresh” start, would soon develop tense relations with many of its peers institutions.

The controversy over securing a national site for higher education transformed the problems at SNU into an ongoing concern, one that was not settled by the student demonstrations of fall 1946, nor by the replacement of Dr. Ansted with a local Korean official. Historian of education Michael Seth has referred to the campus as being in “almost constant turmoil” during the entire three years of the occupation, situating the troubles in the context of debates over the extent to which to introduce new models of practice.¹³² To be fair, the Korean peninsula itself was a hotly contested site in these years prior to the Korean War, making it extremely difficult to separate the debates taking place on campus from the larger political struggles among various factions. Still, those present at the time recall the debate at the Medical Campus as one shaped strongly by class concerns, with a strong division between the remaining students from Keijo and a diverse group of newcomers.¹³³ Political labels such as right and left may have been mapped onto this discussion, but it was at its core a struggle for control over the institution itself.

This activity was significant for our story here, moreover, because the controversy kept the primary focus on the mobilization of biomedicine and the need

for increasing supplies of pharmaceuticals and trained personnel. Just as under Japanese colonialism, a small number of traditional practitioners continued to meet the need for basic healthcare, primarily in the countryside, although these individuals were still regarded as at best a temporary measure. In metropolitan areas, traditional practitioners were beginning to restore their professional ties, with KOMA (Korean Oriental Medical Association) convening as of May 1947.¹³⁴ These individuals would mobilize for recognition, anticipating the formation of the first training programs for physicians at the university level following the Korean War. Still, a practitioner like Byun Sang-hun stood well outside such a scheme, continuing with his practice at his private clinic in Yangsan.

TKM Transformed: Mobilized on Behalf of the Nation (1953-)

Byun’s primary form of authorization—if it can be termed as such—for his practice was his lengthy period of service, both in terms of its duration and in terms of having survived for the entire span of the colonial period. In the years immediately following independence (1948-1950), these twin claims would not earn him any special privileges, as he and other traditional practitioners were still part of the Korean social fabric. The education boom which began with the occupation would continue during these years, with a corresponding push for medical education, almost exclusively in biomedicine. This was the approach that would earn scholarships for medical students and nurses to study abroad, primarily in America.¹³⁵ In the National

¹²⁹) The Smith Report refers to this recommendation, but does not cite any figures as to how many participants were able to travel to the U.S.

¹³⁰)Smith Report, p. 27.

¹³¹)Ibid., p. 31.

¹³²)Michael Seth, *Education Fever: Society, Politics and the Pursuit of Schooling in South Korea*, Honolulu: University of Hawaii Press, 2002. The title of this work is a literal translation of the Korean phrase *kyoyuk yol* (교육열).

¹³³)Dr. Choo Kun Won, Interview, October 20, 2005, SNU Hospital, Alumni Building.

¹³⁴)Son, p. 546.

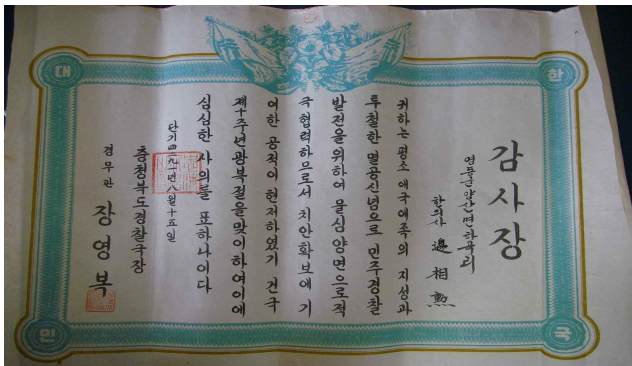


Figure Three: Certificate of Recognition (*kamsachang* / 감사장) awarded to Byun Sang-hun in 1958.

Assembly as well, it was biomedicine that would receive favorable treatment as the new government began to consider how to regulate its affairs. It is perhaps surprising to note that in subsequent years the situation would change, and Byun Sang-hun would become a significant figure for many of the very qualities which had previously earned him criticism.

In fact, his legacy would earn him, and a select few like him, a good deal of acclaim, even as new university-authorized programs in traditional medicine began to open in the late 1950' s and early 1960' s. Rather than being marginalized by this renewed drive for professionalization, Byun Sang-hun would become a celebrated figure, even a minor celebrity. By the early 1960' s, he began to receive letters from newly organized societies of traditional doctors, inquiring as to his whereabouts.¹³⁶⁾ In 1958, moreover, he was recognized at the national level, and would receive a certificate of thanks attesting to his career as a traditional practitioner.¹³⁷⁾ His herbal preparations and remedies would even be solicited by famous politicians, and while it is difficult to document this activity, it would be fair to characterize it as bearing the imprint of nationalism.¹³⁸⁾

What was different in 1958, as opposed to slightly more than a decade earlier (1947), when Byun Sang-hun had first encountered the public health system of USAMGIK? The intervening period, marked by the Korean War (1950-1953), had intensified nationalist zeal on the part of South Koreans, and President Rhee became known for his frequent proclamations about

marching north. In the aftermath of the war, the receipt of aid from a wide range of international sources began to effect rapid change—typically in the form of construction projects and health care—even as the economy remained stagnant. There was a need, therefore, to complement the project of reconstruction not only with material change, but also the work of symbolic reclamation. In this sense, figures like Byun represented a safe and reassuring gesture on the part of the government, an embrace of the past, while looking forward to a modern—although what form this would take was still uncertain—future.

More specifically, the certificate awarded to Byun by the government recognized his perseverance and longevity, having maintained the family practice during a difficult time. The language of the document went so far as to characterize his service as a traditional physician with anticommunist rhetoric—the term *myōlkong* / 멸공 appears in the fifth line, with the document reading from right to left—reflecting the unique circumstances of the late 1950' s. The polarized climate of the time, with Rhee Syngman representing the far right in the South, permitted the characterization of Byun' s legacy in anticommunist terms. In effect, Byun' s length of service as a TKM practitioner now represented a form of service that could be appropriated to serve political ends. What was important was not historical specificity, but a comforting association with the Korean past, and more significantly, a past invoked on the 10th anniversary of nationhood, August 15, 1958. Subsequent efforts by ROK politicians to solicit herbal treatments from Byun should be read in a similar fashion, motivated by an effort to evoke these traditional associations, rather than out of concern for health.

¹³⁵⁾The numbers were likely very low prior to the war, as it was difficult to find sponsors.

¹³⁶⁾The Byun Family papers contain several letters to this effect.

¹³⁷⁾*Kamsachang* (Certificate of Thanks), August 15, 1958, Byun Family Papers.

¹³⁸⁾Interview, Dr. Byun Kil-Won, 6-16-06, 6-25-06.

While the herbal remedies Byun Sang-Hun allegedly prepared for at least two ROK presidents remain difficult to document, his place within the national order was now secure. With the receipt of the *kamsachang* / 감사장 (certificate of thanks) in 1958, he had been officially recognized; with the government of Rhee Syngman characterizing his contribution specifically in anticommunist terms.¹³⁹⁾ In effect, his practice constituted a form of service on behalf of the nation, and also it represented a way of life that the nation hoped to appropriate for its own ends. More importantly, any questions that might emerge about his prior activities were no longer relevant, as the critical issue lay in his enduring practice, one that had survived the colonial period. For Byun, life was now somewhat different, as he had perhaps unwittingly assumed the role of a minor celebrity.

In becoming a symbol of national pride, Byun Sang-hun and other senior practitioners took on this new meaning even as the very nature of their profession was changing around them. By the late 1950's, the first university-sponsored programs, such as the one at Kyunghee University, were taking shape, beginning to produce the first graduates by the early 1960's.¹⁴⁰⁾ The cost of earning greater professional status, and eventually recognition parallel to that with Western biomedicine, would be a lengthy period of professionalization lasting several decades.¹⁴¹⁾ At the same time, senior figures, who had appeared prior to this process, gained added respect, as they had practiced under much more difficult circumstances. Their art would assume a variety of new commercial forms, and the transition from the figure of Byun Sang-hun to the Byun family's current online food service in the twenty-first century is not as radical as it might seem. Even in the early 1950's, some of the first products to be mass-marketed were traditional medicines and remedies, packaged for wholesale distribution.¹⁴²⁾

8.9 Concluding Remarks: the ROK and Establishing Public Health Policy (1948-1950)

The historiography concerning the transformation of TKM from its Chinese origins to its current university-based form in the decades following the Korean War—emphasizing the late 1970's and early 1980's in particular, a revival associated with renewed economic growth—has often been characterized in terms of a resurgence, a return to prominence.¹⁴³⁾ While this characterization may be accurate in terms of numbers and public visibility, such an approach attributes to traditional practitioners the role of a victim within the South Korean national story. This view overlooks the consistent presence of these practitioners during long periods when their activities went largely unnoticed in Seoul. At the same time, it attributes a constraining role to outsiders exclusively, first the Japanese (Sections 1.4, 1.5), and then the American USAMGIK (Section 1.6), with both parties attempting to restrict the scope of this activity. In fact, it was frequently other groups of Korean who participated in this activity, especially those possessing Western medical training. If this was true for the colonial period, it was also true for the early years of the ROK, when the National Assembly included several members who had been trained as doctors.¹⁴⁴⁾ These members were visible markers of modernity, while their counterparts, traditional practitioners, represented Korea's past, and lacked comparable representation.

¹³⁹⁾*Kamsachang*, Byun Family Papers.

¹⁴⁰⁾Baker, “Oriental Medicine in Korea,” pp. 150-151.

¹⁴¹⁾ While there are many accounts of Korean traditional medicine, there is no recent account from the standpoint of professionalization, especially as **TKM** became a hybrid form of practice taught at University sites.

¹⁴²⁾ Korean museums generally do not preserve such items from material culture, but individual collectors of popular culture have preserved some of these products.

¹⁴³⁾Gil Soo Han's (1997) account is representative here.

¹⁴⁴⁾Son, p. 546.



Figure Four: Portrait of Byun Sang-Hun, Byun Family Museum (Yangsan)

Moreover, it should not be surprising that this attention devoted to traditional practice took place at a time of national division, when it was critical to distinguish nascent South Korean institutions from those of its neighbor to the North. Indeed, North Korean physicians would subsequently offer their own claims regarding the purity of tradition, characterizing their own practice as superior, especially as it contained fewer elements borrowed from abroad. North Koreans would also devise their own variation of a “scientific” form of traditional practice, a new theory referred to as *Kyungrak*, announced to the world in 1963.¹⁴⁵⁾ In making their own choice to adopt a “progressive” stance, South Korean TKM practitioners embraced the techniques provided by modern biomedicine, incorporating both strands of practice within new university training programs that have continued to grow to the present. More importantly, the rubric of tradition allowed this new form of practice to remain identified with the past, even as it was clearly something of recent construction. The question lingered, however, whether this practice could be successfully integrated into a national system of healthcare.

The issue would be decided after the transition to independence, with a lengthy campaign regarding which system to recognize as a core part of national health

care.¹⁴⁶⁾ Occupying much of the period 1949-1950, the National Assembly considered two bills, both of which outlined plans for restricting the authority of traditional practitioners. The first would have prevented this form of practice from gaining recognition altogether, while the alternative would have granted recognition, placing these doctors under the rule of their counterparts, Western-trained physicians. Only a vigorous lobbying campaign prevented the passage of the two bills, and in a resolution which satisfied very few, the matter was left unsettled with the intervention of the Korean War. In comparison to USAMGIK personnel, Korean doctors of the late 1940’s and early 1950’s were probably more vigorous in pursuit of their interests against perceived rivals, especially in terms of creating and defining a professional space within the newly formed government.

Indeed, the period marking the transition to an independent Korean government witnessed an increase in terms of investment in biomedicine. With the formation of the ROK in August 1948, the Bureau of Health took formally took charge of bureaucratic oversight, although it continued to receive technical assistance from outside bodies. Two programs in particular deserve mention here, the first involving the transfer of funds from the CMB (China Medical Board), sponsored by the Rockefeller Foundation, which began to divert its resources to South Korea following the transition in government in China.¹⁴⁷⁾ The second, the ECA (Economic Cooperation Administration), a small-scale

¹⁴⁵⁾ Kim Bong Han, “On the Kyungrak System,” *Journal of the Academy of Medical Sciences, DRPK*, 1963, #5, (November 10, 1963), pp. 3-41.. See also the development of this model as a separate text: Kim Bong Han, *On the Kyungrak System*, Pyongyang: Foreign Languages Publishing House, 1964.

¹⁴⁶⁾Son, p. 546.

¹⁴⁷⁾Laurie Norris, *The China Medical Board: 50 years of Programs, Partnerships, and Progress, 1950-2000*. New York, China Medical Board of New York, 2003. Also see Mary E. Ferguson, *China Medical Board and Peking Union Medical College: a Chronicle of Fruitful Collaboration, 1914-1951*. New York: China Medical Board of New York, 1970.

plan (1948-1951) authorized under the same set of conditions as the Marshall Plan, was designed to promote economic recovery, but had to radically alter its plans with the outbreak of the Korean War. While ECA offered little in the way of direct medical assistance, it promoted economic welfare, and created a context in which much larger sources of funding would become available with the start of the war.

Prior to the Korean War then, the situation with respect to health care remained similar in surface appearance to what had existed at the end of colonialism, with a dual system in which access to Western medical care tended to favor those residing in cities. However, the content of medical practice had changed significantly, and was increasingly geared toward the adoption of Western models. Six medical schools, four of them in Seoul, produced an increasing number of graduates, although these new doctors were still outnumbered by traditional practitioners, who continued to handle a large share of the responsibility for meeting basic needs. Viewed in strictly legal terms, the traditional practitioners were now in a state of limbo, as the government favored Western-trained doctors in terms of providing for health care. Following the war, the institution of national health care would for a long time provide coverage only for the latter, in fact, a sore point with traditional doctors, who continued to lobby for their interests. This stage for this debate was restricted to South Korea, however, and in the eyes of its partner nations, the ROK needed, above all else, doctors and nurses to begin the process of recovery. Indeed, the interactive dialogue between traditional practice and Western biomedicine tends to be omitted from many accounts, with the latter regarded as having successfully replaced the former. As we have seen in this chapter, though, TKM—borrowing from a variety of different sources—continues to form an essential part of the South Korean story.