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COSMOPOLITAN MEDICINE NATIONALIZED:
THE MAKING OF JAPANESE STATE-EMPIRE AND OVERSEAS PHYSICIANS
IN A GLOBAL WORLD

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Abstract

My dissertation, “Cosmopolitan Medicine Nationalized: the Making of Japanese State-Empire and Overseas Physicians in a Global World,” examines the movement of Japanese physicians across Asia and the globe in the late nineteenth and first half of the twentieth centuries. By showing how doctors migrated to enhance their opportunities for career success, this study investigates the historical emergence of a cosmopolitan medical profession in Japan, its colonies, and other countries. At the same time, the globalization of the medical profession imposed a perplexing challenge to the sovereignty of modern states and empires, because licensing power and border control came to be regarded as essential components of modern state sovereignty in the early twentieth century. As self-proclaimed modern states, both Japan and the countries receiving Japanese physicians sought to impose more stringent regulations on foreign-trained doctors. I argue that this endeavor not only furthered the state’s control over both the medical profession and immigration, but also built an institutional infrastructure allowing for the evaluation of foreign diplomas and licenses. This eventually paved the way for the worldwide migration of medical workers from the second half of the twentieth century onward. Accordingly, this research elucidates a three-fold history: a national history of Japan’s modern state formation, an East Asian history of the Empire of Japan as a space of social mobility, and a world history of the development of physicians becoming state-sanctioned and yet internationally mobile professionals.

My dissertation is organized chronologically and thematically in four parts. The first chapter investigates the evaluation of foreign-trained doctors in Meiji Japan and the countries receiving Japanese physicians, since it posed a problem for the local authorities and licensing system, as it was hard to determine whether a foreign certificate was real and the equivalent of

their own. The second chapter explores how Korea and China, countries without any regulation of medical qualification, became lands of opportunity for Japanese practitioners who struggled within the increasingly competitive medical market at the turn of the twentieth century. Chapter three discusses how overseas Japanese physicians' qualifications and capabilities were called into question when the rise of Japan as an imperial power caused great alarm to the receiving countries. The last chapter illustrates the gaps between the medical certification system in Japan and the sub-systems in Japan's colonies. It also elucidates how the institutional discrepancies enabled colonial Taiwanese physicians to improve their inferior civic status and maximize chances for career advancement by moving to the empire's other territories.

I consider this research as not only a national history of Japan's legitimation and demarcation of its state and empire but also an international history of the genesis of medicine as an internationally mobile profession.

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Introduction

In the late nineteenth and the first half of the twentieth centuries, thousands of Japanese doctors moved abroad for purposes of education, employment, and livelihood. The existence of the doctors is a well-known fact, and our knowledge mostly comes from the experiences of several eminent physicians who studied and/or practiced medicine in other countries: Nagayo Sensai, Gotō Shinpei, Mori Rintarō (aka Mori Ōgai), Noguchi Hideyo, Kitasato Shibasaburō, to name just a few. The doctors' overseas experiences are often regarded as an influential element that shaped their later stellar achievements in many spheres of modern Japan. Except for the individual experiences of the famous doctors, surprisingly very little research has been carried out on the migration of physicians.[1] Who were the migrant doctors? Why did they move? Where did they go? What problems did they encounter and produce, and how did they cope?

This project addresses all the questions mentioned above, and accordingly, offers a social history of the emigration of Japanese doctors. The ultimate objective of this study, however, is to use medical migration as a lens to explore the construction of modern Japanese state and empire. How did Japan set and protect its national boundaries at a time when the world was getting smaller and people were more mobile than ever before?

Medical Migration and Japan's Modern State Building

The international movement of physicians is a modern phenomenon in Japanese history.

[1] The research of Hoi-eun Kim on Japanese medical students in Germany and German physicians in Meiji Japan is an exception. Hoi-eun Kim, *Doctors of Empire: Medical and Cultural Encounters between Imperial Germany and Meiji Japan* (Toronto: University of Toronto Press, 2014). Also see, Pierre-Yves Donzé, "Studies Abroad by Japanese Doctors: A Prosopographic Analysis of the Nameless Practitioners, 1862-1912," *Social History of Medicine* 23: 2 (2010):244-260.

From the 1630s to the 1860s Japan was under national isolation. To restrict the interaction of people in Japan with those outside, the Tokugawa shogunate banned foreign travel to Japan and prohibited Japanese from leaving the country. Emigration was a capital crime. This is not to say, however, that there were no medical exchanges between Japan and the outside world. Japan kept its relationship with Asian countries, and trade with the Dutch was permitted, although only at the port of Nagasaki. Although the Dutch had only limited contract with the native people, some Japanese were able to study medicine from resident doctors at the Dutch factory in Nagasaki by learning from imported medical books. One doctor who helped teach medicine to the Japanese was Philipp Franz von Siebold. After the "opening" of Japan by the United States in the 1850s, a small number of Western physicians came to practice in the treaty ports of Japan. Some of them, like William Willis, also taught medicine to the Japanese. The establishment of a new modern regime after the Meiji Restoration in 1868 furthered the international exchange of medical personnel. More than one thousand Japanese were sent abroad by the Meiji government to receive the most authentic and cutting-edge medical training. At the same time, a handful of Western physicians, mostly German, were invited to Japan to assist the government's modernization reforms.

Despite their small in number, the migrant doctors played an important role in writing about the history of Western medicine in Japan. In addition to the contributions of individual physicians, their presence as a whole unit offers a mega-narrative on the medical opening of Japan to the world: from the restricted small-scale private encounters among interested people in the pre-modern (or early-modern) period to the grand medical modernization projects initiated

and implemented by the modern state.[2] In this narrative, the increasing international movement of doctors was part and parcel of the global diffusion of Western medicine as a cosmopolitan science. Doctors trained in Western medicine were able and encouraged to study and/or work abroad, because their expertise was believed to have a universal value. This understanding was clearly revealed in a guidebook written for Meiji Japanese students, in which readers were encouraged to study medicine abroad. Since "the anatomy of Americans, Japanese and Indians are all the same," the author stated, the knowledge and technologies learned in American medical schools could surely be used in the States, Japan, and indeed, any place in the world.[3]

The active international movement of medical personnel has led to the neglect of an equally important development. As a matter of fact, physician mobility was becoming more, not less, stifled in the late nineteenth and the first half of the twentieth centuries. More or less simultaneously, many countries started to institute more rigid restrictions on the immigration of medical doctors, mainly through the design of the licensing system. Many common contemporary legal requirements for overseas-trained medical professionals were established at this time, including the evaluation of foreign credentials, the possession of local medical licenses, and fluency in the national language of the receiving country. Today, these requirements might be viewed as natural and are taken for granted, but they caused great debate and dispute when first introduced. Moreover, the requirements enacted by law were not merely to assure the quality of medical practitioners and practice, but very often were instituted to protect the nation and state of the receiving country.

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[2] For two examples of the narrative, see Ann Jannetta, *The Vaccinators: Smallpox, Medical Knowledge, and the "Opening" of Japan* (Stanford, California: Stanford University Press, 2007) and Hoi-eun Kim, *Doctors of Empire: Medical and Cultural Encounters between Imperial Germany and Meiji Japan* (Toronto: University of Toronto Press, 2014).

[3] Katayama Sen, *Gakusei Tobei Annai* (Tokyo: Rōdō Shinbunsha, 1902), 47–48.

By discussing the migrant doctors within Japan and the foreign countries receiving Japanese doctors, this research aims to contextualize the building of the modern Japanese state and empire in a global wave of medical regulation. In doing so, it seeks to participate in the burgeoning scholarship on the central involvement of medicine in Japan's modern state building and colonial expansion. Focusing on public hygiene and epidemic control, current literature has elaborated the dominant role of the state in the adoption of modern medicine as part of the Western formula for wealth and power. With the emergence of a new consciousness that the (individual and collective) health of citizens was a government responsibility, it became a state's right and obligation to intervene in medical affairs.[4] The application of Western medicine in Japan was thus also involved in the establishment of an organizing principal that "focused on public administration and presented a formula through which individuals could be subsumed under, guided by, and dedicated to the nation."[5] This "hygienic modernity," to use the terms of Ruth Rogaski, was not only centrally engaged in the construction of Japan's modern state but was a key strategy in Japan's imperial expansion into Taiwan, Korea, Manchuria and China. As a result, the understanding of Western medicine as a key to create a wealthy and powerful state became a shared conception and experience among East Asian countries.

What remained obscure in current scholarship is the relationship with the world outside East Asia. Although the Western origin of Japanese medical institutes and institutions is frequently mentioned, little academic attention has been paid to this thread thus far. This research contends that the medical regulation in modern Japan was not an isolated phenomenon; rather, it

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[4] William Johnston, *The Modern Epidemic: A History of Tuberculosis in Japan* (Cambridge, Massachusetts: Council on East Asian Studies at Harvard University, 1995); Alexander R. Bay, *Beriberi in Modern Japan: The Making of a National Disease* (Rochester, New York: University of Rochester Press, 2012).

[5] Ruth Rogaski, *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China* (Berkeley and Los Angeles, California: University of California Press, 2004), 161.

took form in an interaction with similar movements that occurred simultaneously in other countries. In this regard, the migration of doctors was an important research subject, because it clearly shows the simultaneity and interaction between the developments in different states: while Japan was imposing closer supervision over foreign doctors, other countries were also trying to place Japanese physicians under stricter surveillance.

Medical Migration and the Japanese Colonial Empire

The approach taken in this project builds on a recent trend that seeks to situate the history of Japan in international and global contexts. Unlike previous literature on Japan's foreign relations, which focuses on diplomacy between countries, newer scholarship aims to "break down the barrier between 'domestic' and 'international' history" and therefore further open the framework of the nation.

A significant result of the transnational turn is the reorientation of modern Japan from a state to an empire. The term "empire," Louise Young observed, has become pervasive if not ubiquitous in the study of Japan's history between 1868 and 1945.[6] Scholars are more aware than ever that Japan in the early twentieth century was not only an island country in the Japanese archipelago but also a massive empire that controlled most of East Asia: Taiwan, Korea, Manchuria, and to lesser extent, China. The formation of modern Japan thus, is in part, a history of Japan's expansion in Asia and, also in part, a story of the incorporation of Asia into Japan. The new imperial "Asia as one" consciousness stimulated scholars to explore the exchange and flow of people, goods, and ideas that helped, or undermined, the formation of the Japanese empire as a

[6] Louise Young, "Introduction: Japan's New International History," *The American Historical Review* 119:4 (2014): 1117-1128.

whole.

By studying the movement of physicians, this project attempts to engage with two burgeoning subfields in the study of Japanese empire: colonial medicine and migration. Over the past three decades or so, much research has been done on the central involvement of medicine in building the Japanese colonial empire.[7] Despite their different research subjects and geographical focuses, the big questions they asked are very similar: How did Japanese colonial government coercively apply its medical regulation and surveillance to the native society in order to protect the health of Japanese colonizers and legitimate the rule of Japan? In this literature, the actors were not medical doctors, but medical institutes (e.g., schools, hospitals, and research organizations) and institutions established by the empire. Consequently, the only medical personnel who appeared in the narrative were medical officials and several scientists who worked for the empire, while ordinary physicians basically got lost in the picture. In short, in this literature, colonial medicine is largely conceived as state medicine and state hygiene in the colonies.[8]

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[7] For the relationship between medicine and Japanese colonization in Taiwan, see Michael Shiyung Liu, *Prescribing Colonialization: The Role of Medical Practices and Policies in Japan-Ruled Taiwan, 1895-1945* (Ann Arbor: the Association for Asian Studies, 2009); and Fan Yanqiu, *Yibing, Yixue yu zhimin xiandaixing: rishi Taiwan yixueshi* (Taipei: Daoxing chubanshe, 2005). For Japanese colonial medicine in Korea, see Todd A. Henry, "Sanitizing Empire: Japanese Articulations of Korean Otherness and the Construction of Early Colonial Seoul, 1905-19," *Journal of Asian Studies 64: 3*(2005): 639-75; For the Manchurian cases, see Robert John Perrins, "Doctors, Disease, and Development: Engineering Colonial Public Health in Southern Manchuria," in *Building a Modern Nation: Science, Technology, and Medicine in the Meiji Era and Beyound*, ed. Morris Low (New York: Palgrave Macmillan, 2005), 103-132; Mariam Kingsberg, "Legitimating Empire, Legitimating Nation: The Scientific Study of Opium Addiction in Japanese Manchuria," *Journal of Japanese Studies* 38:2 (2012): 325-351. For Japanese colonial medicine in China, see Ruth Rogaski, *Hygienic Modernity*, 165-192.

[8] Alexander Bay has described the adoption of Western medicine in Japan as a process of "internal colonization." In using this term he meant the nationalization of medicine and the regulation of citizens' bodies through legislation. Although his research does not deal with "real" Japanese colonial medicine, his rhetoric suggests there were indeed some similarities between Japan's medical enterprises in the home islands and in the colonies. Alexander R. Bay, "Beriberi, Military Medicine, and Medical Authority in Prewar Japan," *Japan Review* 20 (2008): 113.

Recently, some Japanese medical historians started to challenge the presumed image of a powerful and aggressive state. Suzuki Akihito and Susan Burns, for example, argued that although the Meiji government's medical reforms made Western medicine the only orthodoxy recognized by the state, other therapeutic choices such as patent drugs, acupuncture, and traditional herb medicine were still quite popular in the society, and the state showed little interest in intervening in the medical marketplace.[9] The disciplinary power of the state was not as strong and ubiquitous as is often imaged.

This leads to an essential question of modern Japanese history: to what extent was the construction of the modern Japanese state and empire directed and designed by the state? Has the agency of ordinary people in the making of modern Japan been underestimated? By discussing the movement of Japanese private practitioners from the main islands to overseas territories, this research aims to counter-balance the predominant state-center narrative of Japanese colonial medicine. In doing so, this project also seeks to associate colonial medicine with another major issue in the medical history of modern Japan: the increase of doctorless villages. A significant but seldom noticed fact is this: the mass emigration of Japanese doctors occurred at a time when Japan's hinterland was suffering from unequal distribution of medical resources and increasing shortages of medical practitioners. Obviously, for many Japanese physicians, pursuing a career in a presumably backward and hazardous colony was more promising than opening a rural clinic at home. What attracted doctors to go abroad?

Ultimately, this question reveals how the empire was socially understood and experienced

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[9] Akihito Suzuki, "Illness Experience and Therapeutic Choice Evidence from Modern Japan," *Social Science History* 32:4 (2008): 515-534; Susan L. Burns, "Marketing Health and the Modern Body: Patent Medicine Advertisement in Meiji-Taishō Japan," in Hans Thomsen and Jennifer Purtle, eds, *East Asian Visual Culture from the Treaty Ports to World War II (*New York: Paragon Publishers, 2006*), 173-196.*

at this period. This study suggests that, with Japan's territorial expansion in Asia, Japanese doctors had become quite imperially conscious. They were alert to the new opportunities in different territories of the empire and eager to spread their wings abroad. Initially, colonial subjects were institutionally excluded from the migration network because their qualifications were recognized only in the respective colonies. However, many Taiwanese were able to embark on a medical career overseas, especially after the 1920s, and they used this as a method to pursue upward social mobility and improve their inferior civic status at home. What circumstances that gave rise of the emigration of Taiwanese doctors? What impact did their geo-social movement have on the colonial rule and imperial order of Japan? To what extent could colonial subjecthood be improved?

Medical Migration and the History of Globalization

Another objective of this study is to historicize medical migration, a live issue that has attracted the great interest of social scientists for decades. As early as the 1970s, the World Health Organization (WHO) noticed the unprecedented rapid growth of the international movement of physicians and nurses, usually from poorer to richer countries. Although medical professionals were not the only workers on the move, the decision to go abroad was often made easier for them, the WHO stated, because they were trained "up to international standards based on patterns of disease and health care in the affluent societies." Moreover, because of the mutual recognition of medical diplomas and degrees between nations, credentials give doctors and nurses "the assurance of an easy passage to one of the industrialized countries." However, their movement further widened global health inequality between developing and developed

countries.[10]

Unlike social scientists, historians have so far paid little attention to the global migration of healthcare providers. The neglect, Catherine Ceniza Choy observed, reflected the persistent centrality of the framework of the nation in the history of the medical profession, which caused the hitherto trivialization of foreign-trained medical personnel. As a result, the international movement of physicians and nurses is mistakenly conceived to be a late-twentieth-century phenomenon. However, the seemingly recent development has an imperial root in the history of the early twentieth century. The migration trend of Filipino nurses to the United States, for example, is intimately tied to U.S colonialism in the archipelago, which introduced the American medical school education and hospital system to the native women and incidentally prepared them to work abroad.[11]

This research is a response to the call of Choy to foreground the significance of medical migration in history. By studying physicians on the move one century ago, it aims to elucidate the global development of medical doctors as state-sanctioned and yet internationally mobile professionals, a characteristic that continues today. To this point, a study of overseas Japanese doctors is a study of our contemporary globalized world.

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[10] Alfonso Mejia, Helena Pizurki, and Erica Royston, *Physician and Nurse Migration: Analysis and Policy Implications* (Geneva: World Health Organization, 1979).

[11] Catherine Ceniza Choy, "Nurses Across Borders: Foregrounding International Migration in Nursing History," *Nursing History Review* 18 (2010): 12-28. For more detailed discussion about the historical origins of the migration of Filipino nurses to America, see Catherine Ceniza Choy, *Empire of Care: Nursing and Migration in Filipino American History* (Durham: Duke University Press, 2003), 41-58.

Chapter One

Setting the Institutional Ground: The Emergence of Modern Medical Profession and the Evaluation of Foreign Medical Certificates in Meiji Japan

In *A Student's Guide to Studying in the United States* (*gakusei tobei annai*), a bestseller in 1910s Japan, medicine was recommended as the most valuable profession for Japanese youth to study in the United States.

[1] The advantage of medicine over any other disciplines, the author claimed, was the universality of medical training and qualifications that allowed doctors to transcend national boundaries. Since "the anatomy of Americans, Japanese and Indians are all the same," healing skills learned in U.S medical colleges could surely be used in the treatment of Japanese patients. Moreover, because the Japanese government recognized the validity of foreign medical degrees, graduates from American medical schools could apply for government verification of their diplomas and, if approved, automatically obtain license to practice. Hence, in law and in practice, it was not difficult for U.S-trained doctors to work in Japan. In contrast, foreign diplomas in other disciplines were not as useful. An American law degree holder, for example, had to take national qualifying exams to become a lawyer or a judge in Japan.

This chapter examines the "border-crossing" of medical certificates in Meiji Japan: how foreign medical certificates were evaluated and verified in Japan and vice versa. Accordingly, it seeks to explore the encounter between two essential but countervailing developments in modern medicine. The first development is the centrifugal spread of Western medicine as universal knowledge and practice and the consequent transnational migration of medical practitioners. The

[1] Sen Katayama, Gakusei Tobei Annai (Tokyo: Rōdō Shinbunsha, 1902), 47–48.

second development is the centripetal formation of a state-sanctioned medical profession and a state-monopolized system for granting medical diplomas and certificates with an exclusive character among nation-states. While the first trend suggests a "border-opening" or "border-crossing" nature of modern medicine, the second development indicates a counter effort by the nation-state to erect a national boundary around the practice of medicine.

In the field of Japanese studies, the adoption of Western medicine and the establishment of medical licensure have long been popular topics. Several studies have been conducted on various aspects of the great impact of Western medicine in Meiji Japan, such as the introduction of the idea of hygiene,[2] the rise of laboratory medicine,[3] the appearance of hospitals,[4] and the emergence of new concepts in the study of diseases and disease control,[5] to name just a few. There is also a body of literature, albeit much smaller, on the Japanese licensing system for practitioners and the subsequent emergence of a new medical profession.[6] Generally speaking, these works consider medicine as an integral part of Meiji Japan's modern state building, depicting how medicine was shaped or served the state's pursuit of wealth, power, or modernization. Although the modernization of medicine was a process that involved multidirectional and transnational flows of knowledge and people, because of this nationalistic

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[2] Ruth Rogaski, Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China (Berkeley: University of California Press, 2004), 136–164.

[3] Christian Oberländer, "The Rise of Western "Scientific Medicine" in Japan: Bacteriology and Beriberi," in Morris Low ed., Building a Modern Japan: Science. Technology, and Medicine in the Meiji Era and Beyond (New York: Palgrave Macmillan, 2005), 13-36.

[4] Susan L. Burns, "Contemplating Places: the Hospital as Modern Experience in Meiji Japan," in Helen Hardacre and Adam L. Kern ed., New Directions in the Study of Meiji Japan (Leiden; New York; Kőln: Brill, 1997), 702-718.

[5] William Johnston, The Modern Epidemic: A History of Tuberculosis in Japan (Cambridge, Mass.: Harvard University Asia Center, 1995).

[6] For example, see Hashimoto Koichi, "Kindai nihon ni okeru senmonshoku to shikaku shiken seido: ijyutsu kaigyō shaken wo chūshin toshite (Professions and Licensing Examination Systems in Modern Japan: Focusing on Medical Licensing Examination)" Kyōiku shakaigaku kenkyū 51(1992): 136-153. Taguchi Hiroaki, Byōki to iryō no shakaigaku (Kyoto: Sekai Shisosha, 2001), 192-227.

orientation only Japan's side of the story (i.e., what happened within its own national boundaries) has been narrated. Consequently, the transnational aspect of the story has seldom been emphasized in the relevant scholarship.

The Meiji government's reform of medicine was however not an isolated phenomenon. Similar efforts occurred simultaneously in other places in the world during the end of the nineteenth and the beginning of twentieth century. Like Japan, many countries in Asia and Latin America were seeking to transplant Western medical knowledge and institutions within their own borders, even as the modernization of medicine was still on-going process in both Europe and the United States. Though Japan may have been a late-comer in the Western-centered modern medical world, it did not lag behind in all the major developments in modern medical science and the medical profession. For example, Japan launched one of the earliest and strictest professional monopolies in medicine. The Japanese state's relationship with, and control over, the medical profession was stronger than in many other more "advanced" countries at the time.

Focusing on the evaluation and verification of foreign medical certificates, this study attempts to examine the establishment of the modern Japanese medical licensing system within the broader context of a global wave of medical legislation. Greater emphasis on the transnational aspect of this subject leads to the opening up of the frame of modern Japanese medical history that has so far been focused solely on the state while ignoring the interactions at the international level. Furthermore, because the evaluation and verification of foreign medical certificates went both ways—while the Japanese government insisted on the verification of the authenticity of medical diplomas, licenses, or other papers of qualification issued outside the country, other countries too on their part evaluated similar documents issued by the Japanese government, medical schools or other authorities. This reveals not only the Japanese

government's attitude towards foreign (trained) doctors but also how other countries, in their turn, treated Japanese doctors. In this sense, this study provides bilateral and multiple perspectives in observing the transnational flow of medical personnel. It also attempts to shed light on the complicated interactive process of modernization of medicine, which has traditionally been considered a unilateral process of dissemination from the Western center to other peripheral parts of the world.

A New Medical Profession

In Japan today, all medical doctors trained outside the country have to pass a government qualification evaluation in order to receive a permit to practice.[7] The evaluation procedure is divided into three parts: (a) a document screening of the diploma, license, or other certificate issued by foreign authorities to prove an applicant's professional ability, (b) a Japanese language fluency test to ensure that the applicant can communicate with a patient in the language, and (c) a national licensing examination (which is the same examination for Japan-trained medical students). Based on the results of the document screening and language examination, the Ministry of Health, Labor and Wellness will determine whether an applicant's competence is equivalent to that of graduates of Japanese medical schools and hence qualified to take the licensing examination. No one can circumvent the examination requirement and obtain a medical license in Japan, not even those trained and licensed in medicine in developed countries such as Germany or the United States.

Needless to say, the evaluation system is designed to ensure the quality of the practitioner,

[7] For more details, see relevant information on the website for the Ministry of Health, Labour and Wellness of the Japanese government. "Qualifications for the Medical Licensing Examination." http://www.mhlw.go.jp/topics/2012/05/tp0525-01.html

an essential prerequisite for good medical service. But it needs to be emphasized that the notion that people's health is a responsibility of the state is a relatively recent one. Before the Meiji period, medicine was by and large independent of state control. With few exceptions, such as the trade in toxic materials, neither central nor local governments showed much interest in intervening in medical affairs. Even control of epidemics, arguably the most important medical issue during the pre-modern era, was managed by families and villages rather than the government.[8]

In the absence of a licensing system for practitioners, anyone could present himself as a medical doctor, irrespective of the training he possessed. Most doctors learned medicine through apprenticeships or in private schools run by established practitioners.[9] But self-trained physicians were also quite common, especially among Confucian scholars, since they had ready access to the classics of traditional medicine that were mostly written in classical Chinese in that period.[10] In either case, medical education was not standardized and there was no systematic training.

In contrast to previous Japanese reigns' *laissez faire* attitude towards medical practice and practitioners, the Meiji government had a very different vision of the state's role in medicine. The new political leaders were convinced that a stronger and healthier citizenry was an imperative for the creation of a wealthy and powerful nation. Hence, it was the state's responsibility to safeguard the health of its citizens (and thus the nation). From the very outset of its reign, the government was deeply concerned that the majority of doctors were in fact

[8] Akihito Suzuki, "Smallpox and the Epidemiological Heritage of Modern Japan: Towards a Total History," Medical History 55: 3 (July 2011): 313–318.

[9] Ellen Gardner Nakamura, Practical Pursuits: Takano Chōei, Takahashi Keisaku, and Western Medicine in Nineteenth-Century Japan (Cambridge, Mass: Harvard University Asia Center, 2005), 45–46.

[10] Fuse Shōichi, Ishi No Rekishi : Sono Nihonteki Tokuchō (Tokyo: Chūō Kōronsha,, 1979), 54–72.

positively incompetent when judged by modern standards, and they feared that this would hamper the state's capacity to defend the national body. In an ordinance in 1868, the first year of Meiji rule, the Cabinet stated, "Being a doctor is a difficult job, because people rely on doctors to save their lives. Recently, however, many ignorant and incompetent healers recklessly practice medicine. Their behavior often resulted in the patient's death, thereby impairing the benevolence of the Emperor (i.e., the state)."[11] Accordingly, the ordinance mandated all local governments to encourage ill-trained practitioners to study in schools of Western medicine, which were burgeoning all over Japan at that time.

From the 1870s onwards, the Meiji government enacted a series of laws and institutions to regulate the training and licensing of medical doctors. In 1874, the state issued the Regulations on Medical Practice (*Isei*), which mandated direct state qualifying examinations and licensing of practitioners.[12] Western medical science was the only knowledge system acknowledged under the newly introduced scheme. Therefore, no alternative paradigm, not even classical Chinese medicine that had for long been the most powerful medical tradition in Japan, could be taught in medical schools or tested for under the new licensing examinations. As per the regulations, examinations for practitioners were initially held by local governments in Tokyo, Kyoto, and Osaka, respectively.[13] But, since the standards of examinations in these various places were not identical, in 1878 a united national licensing examination was instituted by the Home Ministry (later transferred to the Ministry of Education) to replace the old system. The Rule on Medical Schools in 1882 set minimum academic standards for pre-medical education, required a specific number of years of medical training, and determined the quality and quantity of the teaching

[11] Quoted in Sugaya Akira, Nihon Iryō Seidoshi (Tokyo: Hara Shobō, 1976), 39.
[12] Koseisho Imukyoku, Isei Hyakunenshi, vol. 1(Tokyo: Gyosei, 1976), 61-63.
[13] Kawakami Takeshi, Gendai Nihon Iryōshi; Kaigyōisei No Hensen (Tokyo: Keisō Shobō, 1965), 124.

faculty. It also divided all medical colleges (excluding universities) into two ranks.[14] Graduates from Class A schools and universities would be directly granted a license, but graduates from Class B schools had to take the licensing examination in order to obtain permission to practice. A registration system was established in 1884, requiring all licensed doctors to register their names and legal domiciles on Home Ministry records.[15]

As a consequence of the legislation, after the 1880s the path to becoming a medical doctor was to a large extent fixed. A person could acquire a medical license either through a formal medical education in a certified institution or by passing the licensing examination. In the first track, the route to becoming a doctor entailed four or five years of middle school education, followed by four years of Class A medical school or five years of medical course work in a university. Class A medical schools were later replaced by or transformed into the medical departments in the higher schools (*kōtōgakkō*) and then special schools for medicine. There was no minimum educational requirement for candidates for the medical licensing examination. Usually, examinees learned medicine through apprenticeship and/or in Class B medical schools and preparatory cram schools for licensing examinations, like *Saisei Gakusha*.

From 1878 to its abolition in 1916, the licensing examinations produced more than 20,000 practitioners, making it the primary path for individuals to become licensed doctors. Only after 1910 did school-trained doctors outnumber the "examined physicians (*shikeni*)."[16] Superiority in numbers notwithstanding, it was difficult for the "tested physicians" to rise within the medical profession. Most of them worked as general practitioners and seldom rose into management

[14] Koseisho Imukyoku, Isei Hyakunenshi, vol. 1, 78.

[15] Sugaya Akira, Nihon Iryō Seidoshi (Tokyo: Hara Shobō, 1978), 44.

[16] Hashimoto Koichi, Senmonshoku Yōsei No Seisaku Katei: Sengo Nihon No Ishisu O Megutte (Tokyo : Gakujutsu Shuppankai, 2008), 109.

positions.[17] However, the hierarchical status that divided the graduates of medical colleges and universities from the "tested practitioners" was really merely social, but not legal, since the two groups of doctors received identical licenses and were included in a single medical register.

It is well-known that the medical institutions of Meiji Japan were deeply inspired and influenced by the West, especially Germany. However, in a sense the Japanese licensing system was more "national" than that of many Western countries. Medical licenses were issued and granted exclusively by the state, and were valid throughout the state. It should be noted that both these two characteristics were rather rare at the time and only a few countries imposed a single, strict and uniform national licensing system as Japan did. As Ramsay has pointed out, although every Western state in the nineteenth century had enacted some form of regulation for medical practitioner qualifications, in most countries the legislation contained critical loopholes that tolerated the practice of unlicensed doctors.[18] Among the major Western countries, Germany had the most stringent bureaucratic control over its medical profession—"everywhere the state controlled the licensed physician's activities to some degree."[19]

Like its German precursor, the Meiji government monopolized the licensing power and created a direct compulsory licensing of practitioners. The qualifications of medical doctors, consequently, had to be supervised and endorsed by the state. This was vastly different from the prevailing situation in Britain and the United States, where such power was controlled by multiple licensing bodies (e.g., guilds, universities, or local governments); each with its own

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[17] Nagao Setsuzo, Aa Ihei, rev. ed. (1908; repr., Tokyo : Shunjusha, 1982), 43.

[18] Matthew Ramsey, "The Politics of Professional Monopoly in Nineteenth-Century Medicine: The French Model and Its Rivals," in *Profession and the French State 1700-1900*, ed. Gerald L. Geison, 242-243 (Philadelphia: University of Pennsylvania Press, 1984).

[19] Ibid., 255.

rights and privileges.[20] France was another centralized country where the state was the only licensing authority, but the French government conferred two kinds of licenses—one national and one regional—to medical doctors. Practitioners with a doctorate from a medical school were qualified to practice anywhere in France, while their colleagues with more limited and practical training could only practice in an assigned (rural) area.[21]

Such regional licenses were also available in Meiji Japan, but only for a short period of time and the number of the licensees was extremely limited—less than one percent of all the practitioners.[22] By and large, Japanese medical licenses did not come with restrictions on geographic locality, so licensees could practice anywhere within the national boundaries, as well as in overseas territories, such as Taiwan and Korea.

Thus, the state-medicine nexus was much closer in Meiji Japan than in most countries. Given the unrestricted situation just two decades prior, surprisingly, the Japanese government's exertion of control over the medical profession did not evoke great resistance or petitions from the medical community. There were some serious criticisms of the government's regulation strategies, but none about the government's regulation on medicine itself. The major opponents of the state's medical reforms, not surprisingly, were the practitioners of classical Chinese medicine (*kanpō*) who comprised an overwhelming majority of the medical personnel in the Meiji period. As people untrained in Western medicine, they bore the primary brunt of the reforms. To counter the monopoly of Western medical science, many *kanpō* leaders and supporters tried to seek ways to incorporate Chinese medicine into the new medical system in the

[20] For a brief description of the licensing system in Britain, Germany, the United States and Meiji Japan, see Hashimoto Koichi, Senmonshoku Yōsei No Seisaku Katei: Sengo Nihon No Ishisu o Megutte , 29-34; 106-112.

[21] Toby Gelfand, "The History of the Medical Profession" in Companion Encyclopedia of the History of Medicine, vol. 2, ed. W. F. Bynum and Roy Porter, 1132 (London; New York: Routledge, 1993).

[22] Meijiki Eiseikyoku Nenpō, vol. 9 (Tokyo: Tōyō Shorin : Hatsubai Hara Shobō, 1992), 89.

1880s and 90s.[23] Several petitions were presented to the authorities seeking permission to include Chinese medicine among the test subjects of licensing examinations. Some famous *kanpō* physicians appealed to the government to have the efficacy of *kanpō* therapy tested in the new medical institutes, such as laboratories and hospitals. There was also a movement to build a school of Chinese medicine. The strategies *kanpō* practitioners employed suggest that they did not oppose the state's intervention in medical profession and were only trying to win state support in order to ensure a position for classical Chinese medicine in the emerging new system. Unfortunately for them, all their efforts were in vain.

Within less than two decades, medical practitioners in Japan transitioned from a policy of *laissez-faire* to a strict state-sanctioned licensing system, thereby creating a new perception of the medical doctor. The term *ishi* (medical doctor), legally speaking, no longer meant any person who practiced medicine but specifically referred to a professional certified and sanctioned by the state. Hence, although the practice of Chinese medicine and other traditional therapies remained prevalent throughout the Meiji and later eras, these healers were not identified as medical doctors in official documents, and consequently were not eligible to claim to be medical doctors. In other words, they were legally excluded from the newly emergent medical profession.

The Medical Border and the Evaluation of Foreign Certificates

In this sense, the Meiji government's regulation of medicine made the title 'medical doctor' a documentable status, since the membership in the medical profession was established on the basis of and determined by the eligibility and validity of several crucial certificates—diplomas, licenses and registration in particular. The documents functioned as a tangible link between the

[23] Kawakami Takeshi, Gendai Nihon Iryōshi: Kaigyōisei No Hensen, 155–161.

state and an individual, a palpable manifestation of the state's recognition of a particular doctor whose qualifications met the requirements of the state. Moreover, because the documents made a doctor's qualifications visible, they also facilitated the state's suppression of unlicensed (read as unqualified) practitioners, which advanced the government's goal of protecting people's health.

These documents, however, were not invented solely for domestic purposes. They were also simultaneously addressed to a global audience. In a study of the regulation of migration, McKeown has argued that the modern passport came into being with the emergence of an international society of nation states. "The efficacy of the [modern passport] depends on recognition of the issuing entity as part of an interlocked order of nation states;" at the same time, "the ability and willingness to produce such documents has become one of the many qualifications necessary for recognition as a state within the international system."[24] We could thus consider the medical license to be analogous to a visa that allowed a foreign doctor to enter and practice in Japan. The practice of issuing national medical licenses, like the parallel developments of the passport and visa, functioned as a 'gate-keeper' regulating the flow of qualified personnel by both simultaneously and systematically enclosing and opening the national boundaries of medicine. On the one hand, state certification for doctors controlled the medical professionals' border crossing, because to practice without a local license would render a doctor illegal and irregular and could hence be barred. On the other hand, since the Japanese government generated its certificates in accordance with the standards of "advanced" countries, these documents were manifestations of the state's attempt to integrate into the larger world. Consequently, the transnational flow of medical personnel was not only made possible, but also

[24] Adam McKeown, Melancholy Order: Asian Migration and the Globalization of Borders (New York: Columbia University Press, 2008), 1–2.

strictly regulated.

From the outset, Japan's medical reforms were carried out under an acute consciousness of (Western-centered) international society. To ensure the "authenticity" of the new education, the Meiji government hired foreign (mostly German) doctors to teach in medical schools, and man the public and military hospitals at very high salaries. At the same time, select young students were sent abroad to study medicine. One of them was Nagayo Sensai. As a member of the famous Iwakura Embassy, the first diplomatic mission sent by the Meiji government in 1871, he was assigned the task of investigating the medical schooling and licensing system in Europe.[25] On his return to Japan, Nagayo was appointed the first director of the newly founded Sanitary Bureau and became the chief architect of the government's regulation of medical profession. Obviously, Nagayo's first-hand observations and Western experience was one of the primary reasons for his appointment. Both these moves, the "import" and "export" of physicians, served the same purpose—to make Japanese medical men, institutions and hospitals as "civilized" as those of the West. Accordingly, Japan could both claim to be and hence be accepted as an equal partner in international society, thereby abolishing the unequal treaties between Japan and Western countries. The Westernization (read as modernization) of medicine, in other words, was an important step in achieving Japan's independence.

The increasingly frequent transnational exchange of personnel between Meiji Japan and the West was also reflected in the recently created licensing system. In the Rule of Medical Licensing in 1883, the Meiji government recognized the qualifications of foreign practitioners. According to the Rule, holders of foreign medical degrees or licenses were qualified to practice

[25] Nagayo Sensai, Shōkō Shishi (Tokyo: Ishiyaku Shuppan Kabushiki Kaisha, 1958), 24.

in Japan (Article IV)[26] and as long as their certificates could pass the Home Ministry's screening, they could obtain a Japanese medical license without having to take the licensing examination.

The recognition of foreign medical certificates, on the one hand, showed the Meiji government's eagerness to be a part of the international society of medicine. However, since in the article the government retained the right to evaluate these documents and the power to grant (or refuse) permission to practice in Japan, it also reflected the Meiji state's intention to control its national border of medicine. This intent, however, was self-styled at best. As per the unequal treaties Japan had signed with Western imperialist countries in the late 1850s and 60s, Westerners were subjected to the legal jurisdiction of their respective consular courts rather than the Japanese government. Hence, Western doctors were exempt from the jurisdiction of the Japanese licensing system. Passing the qualification evaluation of the Home Ministry, consequently, was not a prerequisite for foreign doctors to set up business in Japan. Although in theory they were only permitted to practice within their settlements,[27] it was not uncommon for them to do business outside these areas. For example, Duane B. Simmons, an American practitioner in Yokohama, also practiced in his Japanese friend's hospital in Tokyo twice a week and made house calls in the city.[28] The names of Simmons and his hospital (in Yokohama) appeared in several newspapers in Tokyo and were claimed to enjoy a great popularity among Japanese and Westerners alike. Generally speaking, the Meiji state's legislation of medicine had little impact on foreign doctors, for the local rules could not compel foreign practitioners to apply for a Japanese license or enforce those who were without any license or otherwise unqualified to cease

[26] Koseisho Imukyoku, Isei Hyakunenshi, vol 2, 56.

[27] The Archives of the Ministry of Foreign Affair of Japan (MOFA hereafter), "Gaikokujin nishite igyō ni itonamu mono toriatsukaikata ni kanshi Hakodate kenrei ukagau ikken (Inquiry from the governor of Hakodate prefecture about foreigners' practice of medicine)," 1883. File no.:3-11-1-3.

[28] Kodama Junzō, Bakumatsu Meiji No Gaikokujin Ishitachi (Tokyo: Ōzorasha Shuppanbu, 1997), 87–89.

business. In reality, any foreigner could practice medicine in Japan, irrespective of his legal and professional status in his fatherland. This situation continued until the institution of the Regulations on Medical Doctors in 1906 (see Chapter Three for fuller discussion.).

Hence, most people for whom the fourth article of the Rule of Medical Licensing applied and who obtained a permit to practice in Japan were not foreign practitioners but Japanese doctors trained outside the country. The precursors of overseas trained Japanese physicians can be traced back to the late Tokugawa era and their numbers grew considerably throughout the Meiji period. According to Donzé's survey, the number of Japanese medical students abroad multiplied more than thirteen times during the four decades of Meiji: from 32 in the 1870s to 81 in the 1880s, 150 in the 1890s, and ultimately 437 in 1912.[29] The statistics from another study is even more impressive; it reveals that between 1865 and 1914 Europe's German language region alone had a total of 1,150 Japanese medical students, of whom more than six hundred were studying in Berlin.[30] In addition to Germany, Austria-Hungary and Switzerland, other major countries that enrolled many Japanese medical students included the United States, the United Kingdom, and France.

Current studies on Japanese medical students abroad almost solely focus on the physicians in Germany, while very little attention has been paid to the situation in other countries. This is understandable, since Germany was the primary destination for Japanese students to study medicine. However, focusing on German-trained Japanese doctors is not the best way to study the Meiji government's evaluation of foreign medical certificates for two reasons. First, most

[29] Pierre-Yves Donzé, "Studies Abroad by Japanese Doctors: A Prosopographic Analysis of the Nameless Practitioners, 1862-1912," Social History of Medicine 23: 2 (2010): 248.

[30] Kim Hoi-eun, "Physicians on the Move: German Physicians in Meiji Japan and Japanese Medical Students in Imperial Germany, 1868-1914" (PhD diss., Harvard University, 2006), 96-97.

Japanese medical students in Germany had already earned their first medical degrees and licenses in Japan and went overseas for graduate education and training.[31] Since they had been certificated before they went abroad, there was no need for them to go through the Home Ministry's qualification evaluation on return. Second, it was much easier to pass the evaluation with German diplomas and licenses because there was a uniform and mandatory national licensing system in Germany that was easy to track, since, as mentioned earlier, very few countries in the nineteenth century had established such a strict legislation for medical education and licensing. In this sense, the German certification system was an exception and thus not the representative case for such a study.

When faced with problems in screening foreign medical certificates, the Home Ministry usually sought the assistance of overseas diplomatic missions; as a result, the Diplomatic Archives of the Ministry of Foreign Affairs of Japan is a rich source of primary materials on the subject of the evaluation of foreign-trained Japanese doctors. Interestingly, although Germany was the chief destination for Japanese studying medicine abroad, only one case found in the Diplomatic Archives pertaining to the qualification of a German-trained Japanese practitioner who studied medicine in Chicago before going to Europe has implications for the present study.[32] Since the doctor had finished a three-year doctorate program in less than two years, the Home Ministry wanted to ensure that he had not falsified his educational record or whether the German university had waived some required courses as he already possessed an American medical

[31] Kim, "Physicians on the Move," 100-101; also see Donzé, "Studies Abroad by Japanese Doctors: A Prosopographic Analysis of the Nameless Practitioners, 1862-1912," 248–49.

[32] MOFA, "Kanagawa kenmin Satō Kazuo gakureki torishirabekata eiseikyokuchō yori irai no ken (A request from the director of the Sanitary Bureau to investigate the educational records of Satō Kazuo, a resident of the Kanagawa Prefecture)," Gaikoku igakukō ijyutsu kaigyo menkyo kafu oyobi iyaku seido nado ni jikō kansuru torishirabekata, 1904. File no.:3-11-1-12.

degree. In other words, the investigation of the doctor's qualifications involved not only the validity of his German degree, but also the legitimacy of his education in the United States.

Unfortunately, because the Diplomatic Archives only preserves records of disputed cases, we cannot determine the total number of physicians who received the Home Ministry's qualification evaluation for medical licenses, not to mention the success rate. Nonetheless, the archive still provides useful material for studying seemingly suspicious doctors. Although they were certified by a foreign authority, for some reason the Meiji government was dubious about the reliability of their certification. The material on the doctors not only reveals the difficulties and complexities in evaluating foreign certificates; more importantly, it also opens a window through which to view the tensions between the national licensing system and the transnational movement of medical personnel. In other words, how the globalization of modern medical science had to confront the emerging national boundaries for the control of the medical profession.

America as a "Gray Area" for the Japanese Licensing System

A significant characteristic of the disputed cases in the Diplomatic Archives is that almost all the seemingly suspicious doctors were trained in the United States, a primary destination for Japanese medical students abroad second only to the German-speaking Europe. Why did the Meiji government take a more cautious attitude toward these doctors? In a sense, American-trained Japanese physicians were alienated from other members of the Japanese medical community, as most of them had their entire training solely in the United States.[33]The

[33] Donzé, "Studies Abroad by Japanese Doctors: A Prosopographic Analysis of the Nameless Practitioners, 1862-1912," 254.

regulation of these doctors, consequently, was completely outside the purview of the Japanese government's control. This was very different from the situation of Japanese doctors in Germany, since most of them were graduates of Japanese medical universities and colleges.

Hence, studying medicine in America functioned more as an alternative rather than a supplement to Japanese medical education—"a second choice for those unable to make it into the first-choice track," to put it in Kinmonth's words.[34] What were the advantages of studying in the United States? To answer this question, we have to understand the difficulties of becoming a doctor in Meiji Japan. To be sure, education was a luxury for most people at that time. Only one third of school-age children were able to complete an elementary education.[35] Of these, only one tenth of the luckier few could continue to study in middle schools.[36] The door for higher education like medicine could only be narrower still. The licensing examination was often considered a shortcut to become a physician, for it did not require a candidate to get medical training at school. However, passing the examination was not an easy task either. It was said that it took an average of ten years (three years for the first phase and another seven years for the second phase) for a candidate to pass the examination.[37] Few people could afford such long-term investment of time and money.

Compared to the situation in Japan, it was relatively easy for Japanese students to get into an American medical college. Thanks to a proliferation of proprietary medical colleges, the United States experienced a rapid expansion of medical education during the second half of the

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[34] Earl H. Kinmonth, The Self-made Man in Meiji Japanese Thought: From Samurai to Salary Man (Berkeley, Calif: University of California Press, 1981), 204.

[35] Amano Ikuo, Shiken No Shakaishi: Kindai Nihon No Shiken Kyōiku Shakai (Tokyo: Heibonsha, 2007), 123.

[36] Andrew Gordon, A Modern History of Japan: From Tokugawa Time to the Present (New York: Oxford University Press, 2003), 106.

[37] Nakayama Shigeru, Noguchi Hideyo (Tokyo: Iwanami Shoten, 1995), 57.

nineteenth century. Because tuition was the chief financial pillar of the schools, the increasing competition for students forced the schools to open their doors to people who were previously almost entirely excluded from medical education—Jews, women, blacks, and new immigrants including Japanese.[38] It should also be noted that because even the best universities lacked a strict requirement of preparatory education for medical students, any person aspiring to study medicine had the opportunity to get admission.[39] To finish the program was also not too difficult, since the curriculum and requirement for graduation had no unified standard and the teaching faculty had no control over their students, even when they were completely inadequate in training.[40] In this context, from the 1880's onward some Japanese youth started to go to the New Continent for medical education. Famous examples include Watanabe Kanae, preceptor to the later famous bacteriologist Noguchi Hideyo and Ōishi Seinosuke, who became a leftist and was sentenced to death in the High Treason Incident in 1911.

Partly because of the fever of migration to America, the study-abroad trend reached a peak in the first decade of the twentieth century when the success stories of the first generation Japanese graduates from American colleges made awareness of American higher education more widespread and appealing in Japan. A major advocate of the trend was Katayama Sen, whose book *A Student's Guide to Studying in the United States* was a bible for Japanese youth dreaming of studying in American colleges. Katayama frankly claimed this book was not written for university graduates, students from rich families, and government scholarship holders (members of these three groups often overlapped with each other),[41] but for students with financial

[38] Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982), 124.
[39] Ibid., 113
[40] Ibid., 114.
[41] Katayama, Gakusei Tobei Annai, 37–38.

disadvantages and had little chance of receiving a higher education in Japan. According to Katayama, America was a land of opportunity for them. Since Americans believed in the dignity of labor and the country was full of work-study opportunities, it was not difficult for a student from impecunious economic conditions to work his way through college as long as he had a firm resolution, fierce ambition, indefatigable perseverance, and a healthy body.[42] Katayama was his own best example, since he worked as a house servant, school caretaker, and waiter to pay for his high school and college education in America and eventually received a graduate degree at Yale.[43] Needless to say, his personal experience made his book more appealing and persuasive. *A Student's Guide to Studying in the United States* was an instant bestseller in Japan upon its publication in 1901. It was reprinted fourteen times in six years, and claimed over 100,000 readers.[44] Given the great popularity of this book, Katayama and other people produced a series of similar guidebooks in subsequent years.

Medicine was not the only discipline Katayama recommended to his readers, but it was marketed as the best job-worthy college major for Japanese students in American universities. The reason was simple and practical: because the Japanese government recognized American medical diplomas, holders of medical degrees could open a practice directly upon returning to Japan.[45] Their career opportunities, in other words, were secure and guaranteed by Japanese laws and institutions. No other profession had similar legal privileges.

However, the real process was not as simple and easy as Katayama claimed, because the Home Ministry's document screening process not only verified the authenticity of the certificates

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[42] Ibid., 9–10.

[43] Ibid., 58–63.

[44] Katayama Sen, Tobei no Hiketsu (Tokyo: Tobei Kyōkai, 1907), 1.

[45] Ibid.

issued by a foreign institution, but also the credibility of the institution and the quality of medical education in that country. While it was relatively easy to verify whether a person had been really certified by some foreign authority as he claimed, to evaluate whether a foreign diploma or license was comparable to its counterpart in Japan was a much more difficult task. To precisely evaluate foreign medical certificates, the Home Ministry frequently requested the Foreign Office to conduct a survey of the medical education and licensing system in major countries all over the world at the turn of the twentieth century.[46] The subjects of investigation included all major Western states and even some Latin American countries such as Brazil and Peru.

The United States was the only country for which investigations of its medical institutions was repeatedly sought in all the surveys. The repeated requests for information on the American medical system, on the one hand, was a reflection of the large number of American medical certificates awaiting license screening in the Home Ministry. On the other hand, it revealed that the information the Foreign Office provided in one specific case was often not sufficient for the Ministry to determine the qualifications of an American-trained doctor in another case, so the

[46] MOFA, "Ijyutsu kaigyo menkyo kafu ni kansuru jikō torishirabekata naimushō eiseikyokuchō yori irai no ken (A request from the director of the Sanitary Bureau of the Home Ministry to investigate the licensing of practitioners," 1895; "Ijyutsu kaigyo menkyo kafu nado ni kansuru jikō torishirabekata naimushō eiseikyokuchō yori irai no ken (A request from the director of the Sanitary Bureau of the Home Ministry to investigate the licensing of practitioners and other matters)," 1898; "Burajiru Peru Aruzenchin kyōwakoku hokube gasshūgoku kashu to kanada kashu ni okeru igaku kyōiku no teido oyobi ijyutsu kaigyo shiken kisoku torishirabekata namu jikan yori irai no ken (A request from the vice home minister to investigate the level of education and regulations for medical licensing examination in Brazil, Peru, Argentine Republic, the United States of America, and Canada)," 1898; "Beikoku oyobi Aruzenchin kyōwakoku ishi seido torishirabekata namu jikan yori irai no ken (A request from the vice home minister to investigate the medical licensing system in the United States and Argentine Republic)," 1899; "Hokubei gasshūgoku Karifonia shu ni okeru ijyutsu kaigyo menkyo ni kansuru kaisei hōrei torishirabekata naimushō eiseikyokuchō yori irai no ken naimushō eiseikyokuchō yori irai no ken (A request from the director of the Sanitary Bureau of the Home Ministry to investigate the revision of the rules for medical licensing in California, the United States)," 1901; "Gaikoku ni okeru iyakuseido sonohoka torishirabekata maimu chōkan (A query from the chief of the general affairs of the Home Ministry to investigate the system of medical and pharmaceutical care in other countries)," 1902. All files are in Gaikoku igakukō ijyutsu kaigyo menkyo kafu oyobi iyaku seido nado ni jikō kansuru torishirabekata. File no.:3-11-1-12.

Ministry kept seeking further information.

What made the evaluation of American-trained physicians so difficult was the lack of a centralized authority regulating medical education and licensing in the United States. In a comparative study of the legislation of medicine in major Western countries in the nineteenth century, Ramsey states that the United States had "the freest medical field in the Western world."[47] In America, the license for a practitioner was essentially honorific rather than mandatory, and not all states had licensing legislation or anti-quack laws.[48] Penalties for freewheeling healers, moreover, were either light or non-existent. As a result, the distinction between licensed doctors and illegal or irregular physicians was rather blurred. America was also a country that truly enjoyed the freedom of medical education. The lack of regulations and standards encouraged the number of medical schools to dramatically multiply by over threefold during the second half of the nineteenth century, from 52 in 1850 to 160 in 1900.[49] The schools, however, varied considerably in curriculum, level of courses, and years for graduation, and some schools were notorious diploma mills. As a result, it was extremely difficult to standardize the qualifications of graduates from American medical schools.

Given the fact that there were numerous American medical schools and the quality of these schools never was guaranteed, the Meiji government did not have a standardized policy toward the American-trained Japanese physicians and tended to examine each applicant on a case by case basis.[50] Therefore, the Japanese consulates in the United States often received requests

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[47] Ramsey, "The Politics of Professional Monopoly in Nineteenth-Century Medicine," 251.

[48] Ibid., 250-251.

[49] Starr, The Social Transformation of American Medicine, 112.

[50] MOFA, "Zai Beikoku Karihonniashu honpōjin Ōkubo Tsukunori yori Gaichi ni okeru honpō mushiken ishi menkyo wo ebeki igakkōmei shijikata negaide no ken (A request from Ōkubo Tsukunori, a Japanese in California, the United States, for a list of American schools with which medical diploma a graduate can waive the licensing

from the Home Ministry to investigate certain medical schools.[51] And in some cases, the Home Ministry during its correspondences probed deeper asking further questions in order to obtain further details. In addition to some general information about a medical school, such as its type (public or private), curriculum, level of courses, and years of training, the Ministry was particularly curious about the standing and legal status of the school: was it recognized by the American Medical Association (AMA) or another association of medical professionals; could its graduates directly receive a medical license after graduation, and was its status equivalent to a Japanese university or special school of medicine. Based on the consuls' report, the Home Ministry would decide whether to grant a license to a physician.

In the ensuing discussion, I will take three physicians as examples to demonstrate how difficult and complex the evaluation procedure could be. The cases, on the one hand, reflect the "freedom" of American medical fields, but they also reveal the precautions taken by the Meiji government against the entry of (seemingly) problematic doctors across its national border.

The first example is a typical case demonstrating how the Japanese government would evaluate the validity of a physician's diploma. In 1901, the Home Ministry requested that the consul in Chicago investigate the educational records of Miyoshi Yasunosuke, who claimed to be a graduate of the Kansas City College of Dental Surgery and had applied for a medical license in Japan.[52] The Ministry wanted to know whether Miyoshi had really completed the program at

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examination in Japan),"1906, Ijutsu kankei zakken (2). File no.:3-11-1-13.

[51] For some examples, see MOFA, "Ijyutsu kaigyo menkyo kafu ni kansuru jikō torishirabekata naimushō eiseikyokuchō yori irai no ken (A request from the director of the Sanitary Bureau of the Home Ministry to investigate the licensing of practitioners," 1895; "Beikoku Indeana shikadaigaku no gakka tedo nado torishirabekata (An investigation of the course level and other matters of Indiana Dental College)," 1902. Both in the folder Gaikoku igakukō ijyutsu kaigyo menkyo kafu oyobi iyaku seido nado ni jikō kansuru torishirabekata. File no.:3-11-1-12.

[52] MOFA, "Hokubegasshūgoku kansasushu shikaidai gakkō katei no taigai torishirabekata naimushō eiseikyokuchō

that school, and if so, how long the training was, and whether his diploma entitled him to a license in the state of Kansas? The consul could not find a medical school by that name, so he wondered if the Kansas City College of Dental Surgery was a typographic error for the Kansas City Dental College and wrote to the school. According to the school secretary's reply, no Japanese student had ever attended the Kansas City Dental College. It turned out that Kansas City College of Dental Surgery had intentionally adopted a similar sounding name so people might confuse the diploma mill for the more famous Kansas City Dental College. A crucial difference between the two schools was that while the diplomas of the Kansas City Dental College were accredited by the National Association of Dental Examiners, as well as Kansas and the other states, the graduates of the Kansas City College of Dental Surgery were not recognized or licensed by any State Board of Dental Examiners in the United States. Moreover, the Kansas City College of Dental Surgery had been closed during the period Miyoshi claimed he studied at that school. During the investigation that followed the consul learned from the head of the local association of dentists that the endorser of Miyoshi's diploma was notorious for selling fraudulent diplomas. Obviously, Miyoshi bought the document and sought to secure a Japanese medical license by fraudulent means.

The second case deals with the evaluation of a valid but "unorthodox" medical certificate, which serves to illustrate the Meiji government's view of nonconformist strands in Western medicine. Inoue Tomo was a female physician who graduated from the Cleveland Homoeopathic Medical College, whose degrees were recognized by the Ohio State Board of Medical

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yori irai no ken (A request from the director of the Sanitary Bureau of the Home Ministry to investigate the general information of the courses of the Kansas City College of Dental Surgery, the United States," 1901, Gaikoku igakukō ijyutsu kaigyo menkyo kafu oyobi iyaku seido nado ni jikō kansuru torishirabekata. File no.:3-11-1-12.

Examination and Registration[53] and was qualified to be a licensed doctor in the state of Ohio. However, after she returned to Japan she had trouble securing a medical license from the Japanese Home Ministry. To be sure, while the Meiji government acknowledged the authority of Western medicine in Japan, there were many unorthodox trends in Europe and North America at that time, such as homeopathy and Eclectics, that challenged orthodox medicine and had numerous followers in many countries, especially in the United States, where they received official recognition in certain states, such as Ohio and Michigan (as we will see in the third case).[54] The Meiji government, however, was less tolerant of unorthodox physicians and hesitated to award Inoue Tomo permission to practice in Japan. As a result, Tomo asked her alma mater to contact the Japanese legation in Washington D. C. to confirm the legal standing of the school. Unfortunately, the Diplomatic Archives does not contain the Home Ministry's decision. My search of Inoue Tomo's name in the medical register yielded no results. As far as I know, there were also no reports about homoeopathy in Japanese medical periodicals of that time. Very likely, Inoue Tomo did not clear the Home Ministry's document screening.

If it is obvious that the applications from Miyoshi Yasunosuke and Inoue Tomo were turned down by the Home Ministry because their diplomas were either fraudulent or issued by an unorthodox medical school, then the third example reflects some concerns other than the certificate verification when another female physician, Inoue Tomoko,[55] a graduate from the

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[53] MOFA, "Honpō gakusei Inoue Tomo no Beigoku ni okeru igaku kenkyū syōmei ni kensuru ken (Matters on the medical certificates of Inoue Tomo, a Japanese student in the United States)," 1902, Ijutsu kankei zakken (1). File no.:3-11-1-13

[54] Starr, The Social Transformation of American Medicine, 100; Norman Gevitz, "Unorthodox Medical Theories" in Companion Encyclopedia of the History of Medicine, vol. 1, ed. W. F. Bynum and Roy Porter, 615-616 (London; New York: Routledge, 1993).

[55] In some material her first name was recorded as Tomo instead of Tomoko. To distinguish her from the homoeopathist Inoue Tomo, I mention her name exclusively as Tomoko.

University of Michigan with reliable certificates was nonetheless initially turned down by the Home Ministry. It was because her alma mater, the University of Michigan, had two medical divisions—one for orthodox medicine and the other for homeopathy—the Home Ministry wanted to ensure which of the two programs she had enrolled in and whether the graduates from the latter program could receive a medical license in the state of Michigan.[56] The local diplomat's reply was quite positive: Inoue Tomoko had completed the full course in the Department of Medicine and Surgery (i.e., the program in orthodox medicine); and the graduates of the university were entitled to practice in the state of Michigan by virtue of their diploma without any further examination and accordingly she should be qualified to be licensed in Japan. However, the Home Ministry still doubted the creditability of Inoue Tomoko's certificates and requested the consul to reinvestigate her educational records and the legal standing of the University of Michigan. Like the physician in our second case, Inoue Tomoko asked her alma mater for help. The president of the university wrote a letter to the American ambassador in Tokyo and requested him to testify that it was a renowned university. However, the Home Ministry replied saying they preferred to conduct an investigation on their own and in the meantime refused to grant Inoue Tomoko permission to practice.

Although the Ministry claimed they could not license Inoue on the grounds that they did not know whether the standing of the University of Michigan was good enough, Inoue and her alma mater could not accept this decision. In a letter written to the Japanese consulate in Chicago, the chair of the medical department of the University of Michigan explained his disappointment

[56] MOFA, "Inoue Tomo naru mono Mishigan daigaku futsūigakubu wo sotsugyō mono naru ya nai ya nado torishirabe no ken (The investigation of whether Inoue Tomoko was a graduate of the regular medical program of the University of Michigan)," 1902, Gaikoku igakukō ijyutsu kaigyo menkyo kafu oyobi iyaku seido nado ni jikō kansuru torishirabekata. File no.:3-11-1-12.

at learning that the standing of his university was questioned in Japan. To prove the creditability of his words, the chair particularly mentioned the name of some prominent alumni including Toyama Masakazu, a former president of the Tokyo Imperial University and later the Minister of Education. The president of the University of Michigan articulated his discontent even more explicitly, "If your Government refuses her permission to practice because she is a woman, that is your own affair; but there is no good ground why they should refuse her because of the standing of the University at which she was graduated."

Inoue and her school were probably right that gender was the real reason the Home Ministry doubted her qualifications. The number of female doctors was still quite small during the Meiji era (less than 200) and because Japanese medical schools at that time accepted only male students, the licensing examination was the only track for women to become doctors. Hence, a woman with a Bachelor of Medicine like Inoue Tomoko was extremely rare and unusual. It was not by chance that Inoue chose to study medicine in America, because the United States was far ahead of European countries in terms of the number of female physicians and medical colleges for women.[57] According to the records of Japan Medical Women's Association, there were at least six female doctors who obtained their degrees from American medical colleges, making the United States the chief destination for Japanese female medical students abroad.[58] Inoue Tomoko eventually obtained her license in 1903, but that was two years after her return to Japan.[59] She was an active member of the Japan Medical Women's Association.

[57] Starr, The Social Transformation of American Medicine, 117.

[58] Akiyama Chōzō, Nihon Joishi (Tokyo: Nihon Joikai Honbu, 1962), 177-198; 301-306.

[59] Ibid., 191.

The Evaluation of Japanese Medical Doctors and Certificates in America

Knowing that the Meiji government screened the documents of Japanese doctors trained in America, the next obvious question is the converse: How were Japan-trained physicians evaluated in the United States? This was not really an issue before the twentieth century, since the laws for medical licensing were not rigorously enforced in the US. For instance, although California and New York legally required all practitioners to pass a state examination, given the dramatically increasing number of Japanese immigrants in the states, the governments waived the requirement for Japanese doctors if they had been licensed in Japan.[60] At the same time, given inadequate local medical resources, some states had laxer regulations or lower standards for medical licensing, so it was sometimes easier to become a doctor in the U.S. than in Japan. Rumors about loopholes in the American medical licensing system circulated widely among Japanese communities in the United States and were disseminated back to the medical society in Japan. For example, one rumor had it that Japanese practitioners were not required to take the licensing examination in California. As long as a Japanese doctor could pass an English language fluency test, he could set up business in the state.[61] It was also said that the licensing examination in Idaho was not as strict as elsewhere and did not require the applicants to have a medical degree in hand.[62] There were already three or four Japanese who had never learned medicine but nonetheless successfully obtained medical licenses in Idaho. Since American licenses were recognized by the Home Ministry, they were granted Japanese licenses, too. A visit

[60] MOFA, "Kaigai kakkoku ni okeru ishi seido oyobi nihon ishi taigū nado torishirabekata naimushō yori irai ikken (A request from the Home Ministry to investigate the regulations for medical doctors and the treatment of Japanese doctors)," 1904, Kakkoku no ishi seido oyobi honpō ishi taigū nado torishirabe zakken (1). File no.:3-11-1-19

[61] MOFA, "Kashū ni okeru Ijyutsu kaigyo shiken kanshi Kuboki Hōju yori shōkai no ken (A query from Kuboki Hōju about the medical licensing examination in California)," 1910, Ijutsu kankei zakken (2). File no.:3-11-1-13.

[62] MOFA, " Beikoku shikaigyō menkyojō o asuru honpōjin no honpō kaigyō ni kansuru ken (The practice of Japanese dentist with American license in Japan)," 1917, Ijutsu kankei zakken (3). File no.:3-11-1-13.

to Idaho, in other words, was a shortcut to a permit to practice in Japan.

However, conditions began to change gradually yet profoundly at the beginning of the twentieth century, as a movement for stricter licensing control developed throughout the United States. As a result, the privileges of Japanese doctors in New York and California were cancelled in 1902.[63] From then on Japanese physicians also had to pass the licensing examination in the United States. To qualify to take the examination, candidates were required to have a diploma from a medical college in good standing. Examinees were rejected if the school they had attended was judged below par by the board of medical examiners. The new statute, consequently, created a need in the United States to evaluate the quality of Japanese medical schools.

Verification of Japanese diplomas was not an easy task for the authorities concerned, because it required knowledge of the rankings of Japanese medical schools and different legal statuses; namely, universities ranked at the top, followed by special colleges of medicine, and other medical schools. As chartered schools of the Ministry of Education, universities and medical special schools enjoyed the privilege of exemption from the licensing examinations. Accordingly, their students were directly licensed after graduation and referred to as *igakushi* (for university graduates) or *igaku tokugyōshi* (for graduates of medical specialty colleges). Graduates of other medical schools were not asfortunate. Although the schools were also legal institutions, their faculty and level of training were considered inferior to the standards of special medical schools and medical colleges of universities by the Ministry of Education. Hence, graduates of the schools were not honored with a specific title and had to pass the licensing

[63] MOFA, "Beikoku taiheiyō engan ni okeru honpō ishi ni kansuru ken torishirabe hōkoku (A report of Japanese medical doctors in the west coast of America)," 1903, Ijutsu kankei zakken (1). File no.:3-11-1-13.

examination in order to earn a permit to practice. Their professional qualifications, in other words, were not fully recognized in Japan.

Noguchi Hideyo's case provides an interesting example of the American medical society's lack of knowledge of Japanese medical certificates and of Japanese medical men taking advantage of this ignorance. In the world of medical history, Noguchi is well-known for his discovery of an agent of syphilis as the cause of the progressive paralytic disease, which won him a nomination for the Nobel Prize. In Japanese history he is more famous as a successful self-made man, an incarnation of the cult of "self-advancement *(risshin shussei*)" in pre-war Japan. Born to a poor peasant family, Noguchi could not afford higher education beyond elementary school, and started apprenticeship at a hospital run by Watanabe Kanae, one of the earliest Japanese surgeons trained in the United States. Noguchi passed the licensing examination at the unusually young age of 21, worked temporarily in Japan and in 1900 decided to go to America as a research assistant at the medical school of the University of Pennsylvania.

Although Noguchi received only an elementary-level formal education, in his curriculum vitae to the University of Pennsylvania he claimed he had studied at Tokio Medical College between the years 1894 to 1897, and obtained a diploma from the school.[64] Accordingly, Noguchi titled himself as an MD (doctorate of medicine) in his research papers published in America.[65] To be sure, there was no school called Tokio Medical College in Japan. Even if there were one, a graduate from that school could at best get a title of *igaku tokugyōshi*, since *igakushi* (Bachelor of Medicine or MB) and *igaku hakushi* (Doctorate of Medicine or MD) were reserved for graduates of universities. Noguchi did indeed enter a medical school in Tokyo in 1894, but

[64] Nakayama, Noguchi Hideyo, 109.

[65] Ibid., 115.

the name of the school was *Saisei Gakusha*, which was the largest preparatory cram school for the medical licensing examination. Obviously, Noguchi misrepresented his academic record in order to make it appear that his qualifications were higher than they actually were.

In a sense, Noguchi was an exceptionally successful or fortunate man. Although the American medical society gradually became familiar with Japan's multilevel medical educational and licensing system and took a more guarded attitude in screening Japanese certificates, Noguchi's falsification of his educational records during the years he worked for the University of Pennsylvania and later the Rockefeller Institute of Medical Research, remained undiscovered throughout his life. Other Japanese doctors who entered the United States in the same period were not as lucky. Files in the Diplomatic Archives suggest that many physicians, even some of them who had obtained a Japanese license, had difficulty persuading American medical schools or state boards of medical examiners that their certificates were valid and issued by a school in good standing,.[66] The situation was particularly harsh for the "examined doctors" and graduates of private medical schools, since their level of training was considered inferior, even in Japan. In these cases, local Japanese consuls were often called to testify about the reliability of the documents. Unfortunately, because not all diplomats were familiar with the medical system in Japan, they sometimes gave incorrect testimony.[67]

In order to assist in the screening of Japanese diplomas, in 1915 the American Medical Association published a list in the *Journal of the American Medical Association* and *The*

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[66] MOFA, "Tōkyō Takayama shikaigakkō ni kansuru torishirabekata zai shiyatō ryōji yori irai no ken (A request from the consul in Seattle to investigate Takayama Dental College in Tokyo)," 1907; "Hasegawa moto Tōkyō Saisei Gakusha shachō shōmeisho ni kansuru ken (Matters on a certificate granted by Hasegawa Tai, the former president of Saisei Gakusha, Tokyo)," 1908. Both files are in Ijutsu kankei zakken (2). File no.:3-11-1-13.

[67] See the letter written by Dr. Naide Saburō to the Foreign Ministry of Japan. MOFA, "Beikoku no igaku wo ronshiaete kokoku tōkyoku ni kyofu (A written opinion to the authority in the homeland about American medicine)," 1915, Ijutsu kankei zakken (3). File no.:3-11-1-13.

American Medical Directory introducing the nineteen medical colleges in Japan, including the two schools located in her overseas territories (Taiwan Medical School and South Manchuria Medical School).[68] Although the list's function was supposed to solve the difficulties in evaluating Japanese physicians, it eventually further complicated the situation because it revealed a gap between American and Japanese traditions of medical education. In AMA's opinion, only five Japanese medical schools—the medical colleges of four imperial universities and Osaka Prefecture Special Medical School—were in equal standing with American medical colleges. The educational requirements of other Japanese medical schools were deemed not as high as their American counterparts. Accordingly, American colleges and state boards of medical examiners declined to fully recognize diplomas issued by any Japanese medical school other than these five institutions.[69] This rejection, needless to say, provoked many Japanese physicians, since the legal status of their degrees was beyond question in Japan. Under their pressure, the Home Ministry put out an explanatory booklet on the Japanese medical institutions and educational institutes and distributed it to all Japanese consulates in the United States.[70]

After the 1920s, few disputes about the qualifications of Japanese doctors were reported to the consuls, a fact that seems to suggest that the efforts of the Home Ministry had accomplished their purpose. It should also be noted, however, that America gradually lost its attraction for Japanese medical men and women over this time period, since the increasingly severe examination of foreign certificates made their border-crossing much more difficult, and the rapid

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[68] MOFA, "Nihon teikoku isei no genjō to daisuru insatsubutsu okuritsuke no ken (Matters on sending the booklet The Present State of the Medical Administration of the Japanese Empire)," 1915, Ijutsu kankei zakken (3). File no.:3-11-1-13.

[69] Ibid.; MOFA, "Beikoku no igaku wo ronshiaete kokoku tōkyoku ni kyofu (A written opinion to the authority in the homeland about American medicine)," 1915, Ijutsu kankei zakken (3). File no.:3-11-1-13.

[70] MOFA, "Nihon teikoku isei no genjō to daisuru insatsubutsu okuritsuke no ken," 1915, Ijutsu kankei zakken (3). File no.:3-11-1-13.

burgeoning of anti-Japanese movements across the country made America no longer a friendly society for Japanese immigrants. At the same time, medical schools in the colonies of the Japanese empire became the new popular "study-abroad" destination for Japanese medical students, as well as a new easier track to become a doctor (for detailed discussion see Chapter Four).

Conclusion

This paper traces the evolution of Meiji Japan's legislation of medical profession and the emergence of a new modern concept of the medical doctor as a state certified and licensed professional. The government tried to monopolize the right to issue and examine the necessary documents that made someone a legal physician—diploma, license, and record on the medical register. The certificate verification directly determined who could practice in Japan. This practice thus created a new status for medical practitioners, casting them as members of a recognized national profession. That is to say, the Meiji state tried to assume her sovereignty in the medical domain over the national territory, even though physicians from Western countries enjoyed extraterritorial jurisdiction and not all of them followed the regulations even then.

At the same time, the emerging medical profession was also an international profession. In a sense, it was built on the belief in a universal medical science and required the newly imported professional expertise in medicine. This characteristic of the medical profession encouraged and opened a possibility for medical men and women to transcend the national borders, since their knowledge and specialties were supposed to be infallible in any corner of the world. In reality, however, this transnational flow of medical doctors had to confront the national boundary in the form of the Japanese licensing system.

The Meiji state's evaluation of foreign certificates provides an interesting window through which to observe how the government managed its national medical boundary. The verb "manage" applies in this case because this procedure involved both the opening and closing of the border gates. It endorsed but also restricted the transnational movement of medical personnel. The development of a national medical profession and the global spread of cosmopolitan medicine, though ostensibly two simultaneous yet antithetical trends, were actually two sides of the same coin.

The section on the screening of Japanese medical certificates in the United States is included to highlight the fact that it is important to study the medical history of modern Japan within a global and reciprocal context. For the same reason, the United States, rather than the well-documented Germany, is used as an example to analyze the medical exchange between Meiji Japan and the Western countries. Many current studies portray the modernization of medicine in Japan (and the rest of the non-Western world) as Japan's one-sided learning from the more advanced West. I coin the term "Germany oriented model" to describe this interpretation, because it is largely formulated based on the (hierarchical) relationship between Germany and Japan in terms of state monopoly and government control over the medical field. To balance such an approach, I introduce an "America oriented model" that treats medical modernization as a simultaneous and reciprocal global movement and emphasizes that the initiatives of individual professionals are equally important factors.

A major blind spot of the "Germany oriented model" is that it ignores the point that when the Meiji government was carrying out medical reforms, the modernization of medicine was still an incomplete and on-going process even in the West, and that Japan did not lag behind in every major aspect of medical modernization. At least in realm of the legislation of medical education

and licensing, Meiji Japan was far more advanced than many Western countries at that time.

The “America oriented model” emphasized here tries to place Japan on equal footing with Western countries. Therefore, it does not seek to replace the previous “German oriented model.” Instead, they could be understood as the two ends of a spectrum, since at the turn of the twentieth century no other country had a legislation of medicine as strict as Germany or possessed markets for medical care and medical education as free as the United States. For Meiji Japan, and most of the other countries in the late nineteenth century, their trajectories of medical modernization were in between these two models. Studying the individual pursuit of foreign medical degrees, even through legal loopholes, and the government’s quality control of medical practice and verification of foreign certification in Meiji Japan and her foreign affairs in the medical field, provides a more sophisticated understanding of the newly emerging class of modern medical professionals, who though nation-bounded yet from the very outset had transnational potential.

Chapter Two

Embarking a Medical Career Abroad: The Migration of Japanese Physicians and the Dynamics of Japanese Colonial Medicine

The outflow of Japanese medical practitioners began around 1900 and kept accelerating in the four decades that followed. Ironically, this was exactly the same period when Japan's hinterland suffered from unequal distribution of medical resources and increasing shortages of medical doctors. This paradoxical phenomenon—for many Japanese physicians, pursuing a career in a foreign land (in most cases even backward, hazardous, and hostile countries) was more promising than opening a rural clinic at home—has not yet been studied. What factors in the Japanese hinterland disappointed these doctors? Or, to put the question in another way: what attracted doctors about going abroad even if they barely had any knowledge of the language, society, and culture they were going to face?

This paper aims to demonstrate the forces that pushed and pulled the emigration of Japanese independent medical practitioners in the first half of the 20th century, as well as to illustrate the dreams they carried and the realities they faced before and after their emigration. By making the independent medical practitioner the center of my study, I seek to balance the prevailing state-centered, large-hospital-oriented narrative in colonial/imperial medical history. Over the past two decades, a considerable body of research has been conducted on Imperial Japan's medical enterprises in her colonies and other parts of Asia. Most of the literature focuses on a specific policy, institution, or medical figure (usually an eminent scientist, educator, or administrator) and discusses the subject's association with or contribution to the development of the Japanese empire.

The national interest and the will of the government, consequently, are often described as a major, decisive—and sometimes sole—impetus of the empire's medical missions, while individual agency or profit motivation is neglected or discounted. Little attention is granted to small clinics, which formed the front line of Japanese colonial medicine. While there is no doubt that the state power played a significant role in Japan's empire-building process, as the studies of popular imperialism pointed out, civil society and common people played an equally important role in the process.[1] Accordingly, this paper attempts to demonstrate the interplay between the participants that shaped the pattern of migration for medical doctors—the imperial government, the individual practitioners, the professional medical society in the metropolis, and the immigrant communities in the colonies and other overseas areas.

Doctor's Plight of Opening a Clinic in Japan

The increasing number of doctorless villages (*muison*) was one of the most serious social problems in pre-war Japan—a problem that, ironically, coincided with a continuous growth of the total number of (licensed) doctors. The kernel of the problem was thus not a shortage of but rather the distribution of physicians. The situation went from bad to worse in the first two decades of the 20th century. After 1882, the Meiji government stopped granting licenses to kanpō physicians, who comprised the majority of the medical providers at the village level. As a result, the overall number of rural doctors was gradually depleted by the death or retirement of existing healers. In the meantime, a severe long-term economic depression in rural Japan obstructed the inflow of medical practitioners with modern training. Poor villagers tended to seek help from

[1] Louise Young, *Japan's Total Empire: Manchuria and the Culture of Wartime Imperialism* (Berkeley: University of California Press, 1998).

patent medicines rather than medical doctors, and even if they went to see a doctor, they were very likely to default on their medical bills. As a result, most physicians unsurprisingly chose to open a practice in the city rather than the country, and in many areas, it became increasingly difficult for villagers to find a doctor nearby. On the other hand, it was also not easy to set up a business in urban districts, where medical markets were usually very competitive. The resulting high medical fees were beyond the affordability of lower income urban residents, so urban doctors actually competed over a lucrative but limited market share. For many people during that period (including some physicians), the urban concentration of physicians and the unequal distribution of medical resources marked the moral degeneration of medical professionals, who pursued personal profits rather than the ideal of the Hippocratic Oath—a "pollution" of medicine by capitalism and commercial culture. To fight the dilapidating current, many methods were adopted by the state and enthusiasts—charity or low-expense hospitals were established, and a nationwide health care system was launched in 1927 when the first Employee Health Insurance plan was created. The essence of these solutions, as the medical historian Kawakami noted, was to "shift the **increasingly high medical expenses that resulted from the advance of medical technologies** from poor citizens to doctors"[2] [emphasis added]. Accordingly, he claims the heyday of Japanese medical practitioners ended in the 1910s.

Hence, the first half of the twentieth century was an era of anxiety for both doctors and patients. Patients' worries about unaffordable medical costs and physician shortages have long been explored by historians. These two problems have been widely acknowledged as the growing pressure that encouraged the development of a modern social welfare system in Japan. On the other hand, the doctors' dissatisfaction with their worsening economic situation has not

[2] Kawakami Takeshi, *Gendai Nihon Iryōshi; Kaigyōisei No Hensen* (Tokyo: Keisō Shobō, 1965), 332.

been adequately discussed. From 1910s onward, or even earlier, many physicians expressed deep concerns about their shrinking incomes, which they believed were mainly caused by overproduction of doctors and the consequent destructive competition between medical practitioners. “Today the number of practitioners has reached the upper limit,” claimed Nota Tadahiro, a physician and a sanitary official, in 1917.[3] Because of the rapid increase in medical practitioners in the prior decade (from 35,850 to 43,813), the doctor-population ratio in Japan (1:1266) had actually surpassed the ratio in Germany (1:2038), Britain (1:1730), France (1:2273) and Austria (1:2222). If the trend of the producing of doctors had continued to increase, the poor economic situation of practitioners would have only been exacerbated. To alleviate the oversaturation of the medical market, Nota offered two solutions. The first was to recruit practitioners into doctorless districts by providing financial and other support from the government, and the second was to encourage the emigration of medical doctors.

To be fair, physicians may well have overstated their business difficulties. Hashimoto’s analysis on the series *Who is Who in Japan* (*nihon shinshi roku*), a biennial directory of prominent individuals in Japan, suggests that doctors’ financial situation was not all that bad in the 1910s.[4] Despite the wage disparities between elite and ordinary doctors, practitioners in general enjoyed a handsome income. Ikai’s study on local tax reports in 1920s and 30s also reveals that doctors’ earnings did not fall significantly even in the years surrounding the Great Depression.[5] This suggests that the claim that medical practitioners during this period experienced straitened circumstance was a myth. But we should also take note of the limitations

[3] Nota Tadahiro, “Honbō no ishisu ni tsuite (On the number of Japanese doctors),” *Tokyo iji shinshi* 2005-7 (1917), 57-61; 16-18; 21-23.

[4] Hashimoto Koichi, *Senmonshoku Yōsei No Seisaku Katei: Sengo Nihon No Ishisu o Megutte* (Tokyo: Gakujutsu Shuppankai, 2008), 114–115.

[5] Ikai Shuhei , *Byoin No Seiki No Riron* (Tokyo: Yuhikaku, 2010), 187–194.

of the primary sources used by the two scholars. Since *Who is Who in Japan* tends to highlight successful doctors, their not-so-successful colleagues might have been excluded from the data. And the data from the local tax reports recounts the amount of "gross profit" rather than "net revenue," so the costs of running a medical practice are not included. It is possible, then, that the conclusion of the two scholars was overly optimistic. Nevertheless, it is hard to deny the fact that medical doctors belonged to the Japanese upper class, and that becoming a doctor was widely considered a short cut for economic and social success.

Even if medical doctors' economic difficulties were exaggerated, as suggested by Hashimoto and Ikai, many practitioners of that time truly believed they were in straitened circumstances. How can the doctors' sense of crisis be explained? What gave rise to their feelings of relative deprivation? To answer these questions, it is necessary to have some understanding of Japanese medical society's composition and its transformation in the early twentieth century. As in many other countries, the medical profession in Japan had a hierarchical structure. At the summit were those with regular medical degrees—doctors of medicine (*igaku hakushi* or MD) were crème de la crème, followed by bachelors of medicine (*igakushi* or MB), and graduates of medical specialty schools (*igaku tokugyōshi*) or other medical schools (who did not have a specific title). The second stratum comprised the "tested physicians (*shiken i*)" who obtained permission to practice by passing the licensing examination. Many of the tested doctors did not receive any formal medical education. They learned medicine through apprenticeship and/or in preparatory cram schools for the licensing examination, such as *Saisei Gakusha*. At the bottom of the medical society was so-call "pre-existing doctors" (*jūrai kaigyōi*), physicians who had practiced medicine before the institution of the licensing system. Most of them were healers of kanpō medicine and had little knowledge of or training in modern medical science.

To a great extent, a doctor's career was shaped by his position in this hierarchy.[6] The first-tier physicians were usually academics and hospital-based specialists, while the second and third tier doctors were often general clinic practitioners or in the lower positions at hospitals. These different career opportunities, furthermore, caused a wage disparity between different rankings of doctors. According to the observation of Nagao Setsuzo, a practitioner and a famous medical critic in late Meiji and Taishō era, a doctor's income were correlated closely with his or her level of education.[7] The average annual income was 2000 to 3500 yen for a MD, 1000 to 3000 yen for a MB, and 300 to 400 yen for a MB under internship. By contrast, *igaku tokugyōshi* (graduates of special medical schools) were paid only 360 to 1200 yen a year, and "test physicians" received 100 to 1200 yen. Obviously, the more advanced an educational background a physician had, the more he or she could earn.

This tired structure of the medical profession remained in place throughout the years of pre-war Japan, but the proportions of doctors in each stratum fluctuated considerably. In the early years of the Meiji period, pre-existing physicians and examination practitioners comprised the overwhelming majority of doctors, but their numbers decreased gradually in later decades because the government stopped issuing new licenses to pre-existing doctors after 1882 and abolished the licensing examination in 1916. At the same time, the expansion of higher education caused a rapid growth of the number of bachelors (and to a less extent also doctors) of medicine. After 1910, medical degree holders became the largest strata of doctors.[8] The job market for MBs, nonetheless, continued to be weak because of the long-term business downturn in public

[6] Ibid., 113–115; Ikai Shuhei, *Byoin No Seiki No Riron* (Tokyo: Yuhikaku, 2010), 75–78.
[7] Nagao Setsuzo, *Aa Ihei*, rev. ed. (1908; repr., Tokyo : Shunjusha, 1982), 42-43
[8] Hashimoto, *Senmonshoku Yosei No Seisaku Katei*, 114–115.

hospitals, their largest employers.[9] As a result, instead of employment as a hospital-based expert, more and more MBs, and even MDs, chose to open their own businesses, while in previous years, only their less-trained colleagues would take such an option. This trend began in the 1890s and accelerated after the 1900s.

Table 1 A correlation between a doctor's education background and career and income in late Meiji

Education	Jobs	Income (yen)
Doctor of Medicine	Faculty of universities and medical special colleges	2000-3500 per year
Bachelor of Medicine	Intern in university hospitals	300-400 per year
	Professor at a special medical college	1000-2500 per year
	Director of a local (public) hospitals	2000-3000 per year
	Medical official	2000-3000 per year
Graduate of Foreign Medical Colleges	Faculty of public medical schools (rare case)	1000-1500 per year
igaku tokugyōshi	Doctors in public hospitals	30-100 per month
	Local sanitary official	50-100 per month
	Doctor working for insurance companies	40-80 per month
Examination Doctors	Doctors in public hospitals	8-40 per month

Source: Nagao Setsuzo, *Aa Ihei*, 1908

At the turn of the century, many doctors abandoned stable and financially-secured jobs in the public sector to join the competitive (private) medical market. Private practice could be quite profitable, to be sure, but it was also a source of economic pressure. The cost of investment in a

[9] Ikai, *Byoin No Seiki No Riron*, 78–88.

clinic, equipment, and medical supplies was fixed, but the future income was uncertain and depended on the doctor's appeal to patients. This stress of practitioners prompted the appearance of a special new genre of books providing the "know-how" to run a private medical practice. The publication of this kind of books, in turn, reveals a demand and a market for such knowledge.

One of the popular books of this type was *Tricks of Building up a Successful Business for Medical Doctors* (*ishi kaigyōjutsu*) written by Tatsugami Masao. An active practitioner, Tatsugami had rich first-hand experience running a private hospital, and was thus able to give more concrete and comprehensive advice than other authors of similar books. According to the preface, written by Tatsugami himself, the book originated from an series of articles in the alumni journal of his alma mater (which was of course a medical school), to which he and others had contributed[10]. One of his friends, another physician, saw the usefulness and marketability of the articles and urging him to organize them for publication. Thus, the book not only presented Tatsugami's point of view, but also voiced the opinions of many other anonymous doctors.

The aim of *Tricks of Building up a Successful Business for Medical Doctors*, as suggested in the title, was to help its readers become popular physicians (*ryūkōi*). According to Tatsugami, the first step was to give up naïve optimism and understand the harsh reality of the medical career. "Life is difficult, but the career of practitioner is gloomier and extremely grave," Tatsugami said in the very beginning of the book.[11] To maximize the opportunity for success he advised his reader to be cautious in selecting where to practice.[12] Both rural and urban settings have their respective pros and cons, and a common mistake for novice doctors was to open a practice in a less competitive district, but such places often have serious shortcomings that

[10] Tatsugami Masao, *Ishi Kaigyōjutsu* (Tokyo: Tohōdō Syoten, 1913), 7–8.
[11] Ibid., 1.
[12] Ibid., 159-176.

become immediately apparent. Hence, a wise general principle in establishing a medical practice was to go to the areas that already have a dense population of doctors. But how does one succeed in direct competition with other practitioners? Tatsugami's suggestion was to "enlarge the pie;" namely, to create new demands for medical services by highlighting the need for medical specialists. "The coming of an ENT will cause numerous children to have tonsillectomies, and the establishing of a new obstetrics hospital will awaken female patients to receive thorough treatments which they did not think they need at all. Therefore, do not fear to practice in areas which have had a lot of practitioners."

In addition to the location of the practice, another concern is the design of the hospital.[13] Tatsugami admitted that patients prefer to be treated in big hospitals rather than small clinics, and advocated that novice practitioners should make a costly investment in hospital construction. But he also understood that not every physician is from rich family or able to get a large loan from an investor, so Tatsugami suggested his readers adjust the scale of their building based on what they could afford and pay attention to indoor space arrangement. A hospital should have a waiting room, a consulting room, a treatment room, a pharmacy, and a laboratory, according to Tatsugami. The waiting room should be cozy, spacious, and well-decorated. The consulting room could be relatively small but must be equipped with a manikin, organ models, and "brand new, splendid medical instructions" in order to "threaten rowdy patients." The pharmacy should be clean and have a prescription counter, shelves, jars, cupboards for drugs to prevent contamination, and other implements. And a laboratory is "a facility every practitioner today must have;" it not only facilitated patient examination but also "pushes them to realize the advance of medical science and it displays the attentiveness of the therapeutic services so that a

[13] Ibid., 176-188.

physician could easily win the trust of patients (i.e., customers)." For these purposes, the laboratory should be sunny and partitioned by a glass-fitted shoji so that patients can clearly see inside of the room. In contrast of Tatsugami's stress on such "public" spaces, he does not talk much about the treatment room. Ironically, the actual room where medical treatment is practiced was the least notable space in a hospital.

Tatsugami's advice to his fellow practitioners confirms an important statement Ikai made in his recently published book. That is: the inflow of bachelors (and doctors) of medicine into private practice resulted in a boom of private hospitals owned by medical specialists.[14] Compared with their public counterparts, the hospitals were small and less well-equipped, but they still had all the modern medical implements necessary for a special hospital, and thus were able to provide advanced therapeutic services. The development of the hospitals, in return, facilitated the career pattern change of MBs, because the cost of opening and running a business could be controlled in a reasonable range.

Though Ikai's argument is insightful, he likely underestimates the financial burden of establishing a proprietary hospital. He may be right that in the pre-war period hospital construction costs were not particularly high, in part because people at that time emphasized medical equipment and instruments more than the physical hospital. Even so, the cost was still daunting for a new practitioner. Medical equipment and instruments were expensive, but a hospital could not be a commercial success if it was not well-equiped. The table below was made by a urologist of the estimated and actual cost for setting up a modest clinic in the Kanda area of

[14] Ikai, *Byoin No Seiki No Riron*, 194–197. Also see Suzuki Akihito' review of the book in Suzuki Akihito, "Shigekiteki de chōsenteki na riron: nihon no iryō no atarashii seitōteki na kaishakuni" *Shukan dokushojin* (August 13, 2010): 4.

Tokyo in 1910.[15]

Table 2 A practitioner's estimated and real cost for building an urological clinic in Tokyo in 1910

	Estimated Cost (yen)	Real Cost (yen)
Rent for House and Furniture	600	750
Medical Instruments	700	More than 700
Pharmacy Equipment	200	150
Various Tools	150	250
Advertisement Expenditure	600	400
Telephone Installation	400	200
Sundry Expenses	600	450
Operating Expense	400	150
Total Amount	3,650	3,000

Source: Kanda Kozō, "Kaigyō man ichinen " *Juntendō iji kenkyukai zasshi*, 448 (1910).

It should be noticed that, according to Nagao, a junior MB could only earn 300 to 400 yen every intern year. Although the urologist chose to rent a house as his office and thus saved considerably on construction cost, the total expanse was still as high as 8 to 10 times his annual income. Since the intern salary of Japanese doctors was notoriously low, it was very difficult for them to start a private practice relying solely on personal savings. The doctor in this example was lucky enough to receive a loan for 3,000 yen, which he had a hard time getting, but the money was only barely enough to support the initial expanses and could not cover the consequent maintenance costs of the clinic.

It goes without saying that the urologist's case does not present the whole picture, for the

[15] Kanda Kozō, "Kaigyō man ichinen " *Juntendō iji kenkyukai zasshi* 448 (1910): 55-62.

exact expense of building a proprietary hospital would vary from person to person, place to place, and specialty to specialty. Nevertheless, this example provides a significant hint as to why many doctors wanted to know if it was possible "to start as a practitioner with nothing but a stethoscope" overseas,[16] and why ready-made hospitals and financial aid for medical equipment purchases provided by the Imperial government and associations of Japanese immigrants were considered favorable enough terms to attract physicians to either leave Japan or stay in settlements, as we shall see in the following discussion.

Desire to Embark on a Medical Career Overseas

During the first decade of the twentieth century, many doctors aspired for a career overseas or encouraged their colleagues to pursuit one. Medical doctors' desire to "spread their wings overseas" (*kaigai yūhi*), a catch-phrase that frequently appeared in medical books and journals, was part of the migration fever present in Japanese society at large. Millions of Japanese left their homeland for the United States, Latin America, Southeast Asia, China, and the empire's overseas territories in Taiwan, Korea, and Manchuria. These diasporas created a new demand for Japanese practitioners abroad because the immigrants wished to have a physician with whom they could communicate conveniently in their mother tongue. Settlements of Japanese immigrants were often the places where Japanese physicians started their practice in foreign countries.

If the mass migration of Japanese citizens created overseas job opportunities for Japanese physicians, the constant and keen anxiety shared in Japanese medical circles about the

[16] For example, see the Archives of the Ministry of Foreign Affair of Japan (MOFA), "Ijutsu kaigyō no jiyū naru kokumei no torishirabe he ni kansuru ken (Inquiry about countries where Japanese doctors could practice without restraint)," 1918, Ijutsu kankei zakken (3). File no.:3-11-1-13.

oversaturation of the market gave them reason to answer the demand. The individuals who most avidly sought to embark on a career overseas were the young practitioners. Age may partially explain their passion to explore the world, but it should also noticed that as late-comers to the increasingly competitive medical business, they were in a particularly disadvantaged position, since they had to compete with established predecessors. Going abroad was considered a way to avoid the increasing difficulties of doing business in Japan or a method to accumulate money in a short time period to build their own hospital later on. "It is an uncontroverted fact that recently there is a growing tendency to launch a career in other countries among young doctors, and the cause, obviously, is the overproduction of medical professionals," stated by Iijima Hiroshi, an MB who practices in Hawaii for five years.[17] Nagao had similar observation. He noticed that Japanese practitioners in Manchuria and Korea were very often novice physicians who had just graduated from school and would not have been able to achieve commercial success in private practice, as their training and clinical experience were usually insufficient. Nagao lamented that it was too bad that the empire's medical missions were trusted to such disrespectable people who went the continent only for making money.[18]

Nagao pointed out a cruel and unpleasant fact: although many medical men and women talked about the ideal of *kaigai yūhi* in a high-minded manner, practicing overseas was only their second choice. Had they been able to set themselves up in Japan, these practitioners would not have gone to foreign countries. In other words, the option of starting a medical career overseas was more attractive to doctors who were less competitive in Japanese medical society. Much evidence demonstrates that low-ranking healers—test physicians, physicians of oriental medicine,

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[17] Iijima Hiroshi, *Hawai ni okeru eisei jōtai* (Tokyo: Naimushō Eiseikyoku, 1921): 2.

[18] Nagao Setsuzo, "Dōjinkai mankan haken ishi no sentei ni tsuite (The selection of assigned doctors to Manchuria and Korea by Dōjinkai)" *Nihon oyobi nihonjin* 487 (1908): 17.

unlicensed practitioners, quacks, and drug sellers—constituted a considerable portion, or even the majority, of the emigrating medical workers. For example, a Japanese diplomat reported in 1902 that "recently a lot of Japanese practitioners came to work in China and Korea. Many of them are failures at home or quacks."[19] The consul in Harbin also observed an inflow of poorly-trained doctors. [20] Among the ten Japanese practitioners in the city only two or three had graduated from medical special colleges (i.e. the lowest medical degree holders). The others had never received any education in modern medicine (i.e., examination doctors, pre-existing physicians, or unlicensed healers). In both case, the practitioners did not have the necessary skill and clinical experience to start a practice in Japan.

A petition to the Ministry of Foreign Affairs written by Kan Yoshihoko(?), an test physician in the Dutch Indies, provides direct evidence of the how increasing competition in Japanese medical society prompted the outflow of low-ranking doctors.[21] In the letter, Kan vividly stated the disadvantages of non-MB practitioners at home and abroad. Because of their inferior training, it was difficult for them to survive in the fierce domestic medical market. As a result, he and many other physicians in a similar situation were compelled to seek employment in Southeast Asia as unlicensed doctors. Although Japan and Britain signed a reciprocal agreement with Japan for medical qualifications in 1905, only bachelors of medicine were allowed to practice legally in British colonies. Most Japanese practitioners in Southeast Asia did not have a degree, and physicians with a degree rarely came to work in the area since they had good career opportunities

[19] MOFA, "Shifu nihonjin eiseikai ni oite Kaneta ishi yōhei no ken (The hiring of Dr. Kaneta by Japanese sanitary association in Shifu)," 1902, Ijutsu kankei zakken (1). File no.:3-11-1-13.

[20] MOFA, "Harubin ryōjikan tsuki iin shōhei he ni kansuru ken (Matters on the recruitment of an attached doctors of the consulate in Harbin)," Ijutsu kankei zakken (2), 1908. File no.:3-11-1-13.

[21] MOFA, letter written by Kan Yoshihoko(?) to the Ministry of Foreign Affairs of Japan. Ijutsu kankei zakken (2), 1908. File no.:3-11-1-13.

in at home, though this is not always true. The reciprocal agreement thus did not benefit the physicians who really needed it. Accordingly, Kan requested that the Imperial government amend the treaty with Britain and commence negotiations with Netherlands for recognition of the Japanese medical license.

It would be wrong, however, to consider the pursuit of the dream of "spreading wings overseas" as a phenomenon that existed only within low-ranking medical circles. Bachelors and doctors of medicine also eagerly embraced employment opportunities abroad. In 1917 several newspapers and journals carried the news that the government of Romania sought to employ one hundred Japanese doctors for six months to assist the state's campaigns for epidemic control.[22] The government sought applicants could speak either Germany or English, but did not have many educational requirements, as long as the applicants were trained in a medical school. The number and quality of interested people exceeded their expectations. More than two hundred medical practitioners applied for the job, and among them, more than ninety had graduated from Tokyo Imperial University, the top medical school in Japan. Given the high qualifications of many applicants, the person in charge explained that applicants without a bachelor's degree would likely be eliminated. In the end, the project to send Japanese doctors to Romania did not succeed because the state lost most of its territories to Germany and Austria in the First World War. Nevertheless, this episode demonstrates how avid even elite doctors wanted a chance to work abroad.

To some extent, obtaining information about opportunities overseas was not a problem at

[22] "Romani no honbō ishi shōhei (An invitation for Japanese doctors to go to Romania)"*Tokyo iji shinshi* 2030 (1917): 36-37; "Rogoku shōhei ishi no jinsen (The choice of medical personnel to Romania)" *Tokyo iji shinshi* 2033(1917): 35-36; "Rogoku shōhei ishi no tokō chūshi (The cancel of Japanese doctors' passage for Romania)" *Tokyo iji shinshi* 2038(1917): 34; "Rogoku iku ishi manin (Applications of doctors for Romania are filled up)" *Yomiuri Shimbun*, July 22, 1917 (morning edition), 2.

all for interested physicians. Relevant information was frequently introduced in medical periodicals, which addressed topics such as local medical legislation, procedures for applying for the permission to practice, the subject and levels of local licensing examinations, and the popularity of Japanese practitioners in the locales. Many of the reports were written by physicians themselves. Some were temporary visitors of the observed countries and some had first-hand experience of practicing there. There is also evidence that the medical journals intentionally collected this information, which suggests that such articles were popular among readers, namely, medical professionals. For example, Tanaka Giichi, the chief editor and publisher of *Ikai Jihō,* requested that the Foreign Office provide a list of Japanese physicians practicing overseas so that he could ask them to serve as correspondents for his journal.[23]

In addition to print media, other important and even more authoritative sources of information for Japanese medical doctors were the Minister of Foreign Affairs and the diplomats abroad. The consuls in Brazil, Mexico, and Nanjing (China), for instance, reported that the consulates often receive queries about how to open a medical practice in their respective countries.[24] The Japanese diplomatic archives also include a significant number of letters written to the minister by individual practitioners who raised questions related to their plan for migration.[25] Their questions were multifarious, but in most cases, physicians were curious about

[23] MOFA, "Gaikoku ni oite kaigyoseru nihon ishi no jūsho shimei torishirabe zakken (Investigation of the names and address of Japanese practitioners practicing overseas)" in folder with the same title. 1905. File no.:3-11-1-23

[24] MOFA, "Nankin chihō ni ijutsu kaigyo shibōsya no umu nado dōchi deikoku ryōjikan bunkan yori kikiawase no ken (Is there any applicant who want to practice in Nanjing; a query from the local consulate)," (1905) Ijutsu kankei zakken (1) File no.:3-11-1-13; "Hakoku chihō ni oite honbōjin ijutsu kaigyo ni kanshi sono juken zai deikoku kōshi kikiawase no ken (the licensing examination for Japanese practitioners in Brazil; a query to the Brazilian minister in Japan)" (1909) and "Honbō ishi nishite Mekishiko kyōwakoku ni oite kaigyo sentosuru mono ni taisuru chūi no ken (advices to Japanese doctors who want to practice in Mexico)" (1911); both in Ijutsu kankei zakken (2) File no.:3-11-1-13.

[25] To give just several examples, see "Manira shi ni oite ijutsu kaigyō ni kansuru jikō toiawase ni taisuru kaitō no

the local climate, the size of the population of Japanese immigrants and Japanese doctors, the prices of commodities, average medical expenses, and the popularity of Japanese practitioners in the local medical market. Another question many doctors raised concern over was the possibility of treating native patients without any knowledge of the local language or with the assistance of translators. What the practitioners longed to know, above all, was their legal status in the area where they hoped to practice: would their degree and certificates be recognized by the local authority, or did they have to take the local licensing examination to obtain permission to practice. Indeed, the qualification issue was so central that some physicians even directly asked the minister to inform them in which countries they could practice medicine without any legal restraint.[26]

Medical schools also sought out information related to practicing overseas to provide vocational guidance for students. Nagasaki Medical Special College, for instance, had asked the Foreign Office about whether graduates of Japanese medical special colleges could practice in Brazil with the license of Japan; if not, what was the requirement to obtain permission to practice

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ken (Replies for inquiries about opening a medical practice in Manila)" (1901), "Katayama Kikumatsu negaide manira shi ni okeru ijutsu kaigyō ni kansuru torishirabe kaitō no ken (Replies for Katayama Kikumatsu's inquiries about opening a medical practice in Manila)" (1903), "Gifu kenmin Iwasa Motoichiro honkon ni oite ijutsu kaigyō ni kansuru ken (Matters about opening a medical practice in Hong Kong, a query from Iwasa Motoichiro, a resident in Gifu Prefecture)" (1905) in Ijutsu kankei zakken (1) File no.:3-11-1-13; also see "Kashū ni okeru ijutsu kaigyō shaken kanshi Kuboki Houju yori syōkai no ken (Matters about the medical licensing examination in California, to reply the query from Kuboki Houju)" (1910), "Amoi chihō ishi kaigyō ni kanshi Mieken Tanno Hanzō yori toiawase no ken (Matters about opening a medical practice in Amoy, to reply the query from Tanno Hanzō, a resident in Mie Prefecture)" (1913), "Hagoku ni okeru honbōjin ijutsu kaigyō ni kansuru ken (Matters about Japanese practitioners' practicing medicine in Brazil)" (1913) in Ijutsu kankei zakken (2) File no.:3-11-1-13.

[26] MOFA, "shina sonota manmō taiwan karafuto nado ni okeru ishi shaken ni kansuru ken (Matters on the examinations of doctors' qualification in China, Manchuria, Mongolia, Sakhalin and other places)," 1917, Ijutsu kankei zakken (3). File no.:3-11-1-13. Also see "Ijutsu kaigyō no jiyū naru kokumei no torishirabe he ni kansuru ken (Inquiry about countries where Japanese doctors could practice without restraint)," 1918, Ijutsu kankei zakken (3). File no.:3-11-1-13.

in that country.[27] Tokyo Imperial University had very similar inquiry. The university wanted to know if its graduates could waive the Japanese licensing examination and directly obtain the medical license for British colonies and the United States.[28]

Another school that had a keen interest in "exporting" its graduates was Tokyo Women's Medical College, the first female medical school in Japan founded by an energetic female physician Yoshioka Yayoi. In 1916 a Burmese millionaire explained an attempt to employ female Japanese doctors in his hospital Yangon, where local women hesitated to receive treatment from male physicians, and asked Yoshioka to recommend appropriate candidates.[29] Yoshioka accepted the request and sent four of her students—two physicians and two midwives—there. The recruitment of Japanese female doctors proved to be a great commercial success, and they were welcomed by indigenous patents, both male and female, because they were more reliable than native practitioners and more kindly than British doctors.[30] Their monthly income was reported to be as high as two thousand yen. With the demand for Japanese medical women in Burma, another two doctors and three midwife-nurses were sent to the country in 1919 and 1920.[31]

To Yoshioka and her school, sending students to Burma meant more than just a job

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[27] MOFA, "Hagoku ni okeru honbōjin ijutsu kaigyō ni kansuru ken (Matters about Japanese practitioners' practicing medicine in Brazil)," 1914, Ijutsu kankei zakken (2). File no.:3-11-1-13.

[28] MOFA, "Tokyo teikoku Daigaku yori ei ryōchi oyobi beikoku ni oite honbō ishi kaigyō he ni kikiawase no ken (Query from Tokyo Imperial University on Japanese doctors' practicing in British colonies and the United States)" (1906). Ijutsu kankei zakken (1) File no.:3-11-1-13.

[29] "Futsuryō Indo he joi no haken (The dispatch of female doctors to French India)" *Yomiuri Shimbun*, March 22, 1916 (morning edition), 4; "Nihon joi no Biruma yuki (The dispatch of Japanese female physicians to Burma)" *Yomiuri Shimbun*, April 17, 1916 (morning edition), 3.

[30] "Biruma he itta joi no daiseikō (The great success of Japanese female physicians in Burma)" *Yomiuri Shimbun*, April 19, 1917 (morning edition), 4.

[31] "Joi sanba kangofu ga matamo Biruma ni yuku (Female physicians, midwives and nurses go to Burma again)" *Yomiuri Shimbun*, July 20, 1919 (morning edition), 4; "Joshi isen de no wakai joi Rangun he shōheisaru (The invitation of young graduate of female medical college to Rangoon)" *Yomiuri Shimbun*, September 23, 1920 (morning edition), 4.

placement. They used it as a proof of female physicians' contribution to the Japanese empire and, accordingly, justified the value of higher education of women. Thanks to the flourishing of girls' education and women's careers at the turn of the twentieth century, more and more women developed careers in medicine. But the trend did not stop adverse criticisms of female doctors.[32] Some people blamed them for spending too many years at school and thus delaying marriage and child-bearing, a behavior that would cause the depletion of the population (read as manpower) of Japan. As "women that could coolly handle the bloody scenes of operations," female physicians were also accused of lacking sensitivity, softness, and many other ladylike qualities. In short, they were disqualified from being "good wi[ves] and wise mother[s]," the idealized role for Japanese women during the pre-war period, and it was implied that the increase of such ignoble women would eventually result in the ruin of the Japanese nation.

To counter reprobation of female doctors, Yoshioka demonstrated how the cultivation of female physicians would benefit Imperial Japan.[33] She was one of the first medical educators that encouraged students to pursue careers in other Asia countries. "I have long had an enterprise for sending Japanese female physicians to overseas. Many graduates of my school are practicing in neighboring countries especially China and Korea. As far as I know, all of them make good there."[34] Like many of her male colleagues, Yoshioka asserted that the "export" of Japanese practitioners to underdeveloped neighboring countries would not only elevate the local standard of medical care, but also bring fame and influence to the empire. What made her views unique was her stress on the irreplaceable position of female doctors in the promotion of Japanese

[32] Yoshioka Yayoi, *Yoshioka Yayoi: Yoshioka Yayoi Den* (Tokyo: Nihon Tosho Sentā, 1998), 270-272.
[33] "Futsuryō Indo he joi no haken" *Yomiuri Shimbun*, 4; "Nihon joi no Biruma yuki" *Yomiuri Shimbun*, 3.
[34] "Joi no kagai hatten (female doctors' advance to overseas)" *Yomiuri Shimbun*, November 6, 1913 (morning edition), 3.

medicine. She claimed that because of the custom in many Asian societies of avoiding all physical contacts with members of the opposite sex who were not family members, ill women often could not receive treatment from doctors, since most of them were men. Japanese female practitioners could attract native female patients and fulfill their medical needs. Female doctors' practicing overseas, moreover, would help to fix the indelible stigma upon Japanese women in Asian countries that female Japanese were very often prostitutes. To encourage her graduates to embark on careers abroad, Yoshioka held big send-off parties for students going abroad and welcome receptions for students returning to the school[35] asked the students share their ambitions or experiences with other students, invited guests, and the media. These events and the consequent detailed reports in the newspaper, in return, made a good advertising for the school and its contribution to the Japanese Empire.

While the fever of *kaigai yūhi* in the medical society was an undeniable phenomenon, the total number of doctors who traveled overseas is unclear. There is indeed much material on how many Japanese practitioners practiced in a specific place and time, but the information is too scattered to piece together the entire picture of pre-war Japanese physicians' transnational moves. At the request of the Sanitary Bureau of the Home Ministry, the Ministry of Foreign Affairs conducted a survey of Japanese doctors residing abroad in 1917 and 1921, which was one of the very rare investigations into overseas Japanese doctors with a global scope and thus became a

[35] "Nihon joi no Biruma yuki" *Yomiuri Shimbun*, 3; "Biruma kara kichōshita joi to kangofu (Dispatched female doctor's and nurse's returning home from Burma)" *Yomiuri Shimbun*, May 15, 1919 (morning edition), 4; "Joi gakkō no atsumaru de joi tachi no kien (Female doctors' high spiritedness showed in a gathering in Tokyo Women's Medical College)" *Yomiuri Shimbun*, May 30, 1919 (morning edition), 4; "Biruma saisho no nihon joi Minato Masayo san kaeru (Minato Masayo, the first Japanese female doctor in Burma, has returned to Japan)" *Yomiuri Shimbun*, December 14, 1921 (morning edition), 4.

valuable resource in the study of these doctors's demographics (Table 3 and 4).[36]

Table 3 The number and distribution of overseas Japanese doctors in 1917

Area	Number of Japanese Doctors	Number of Japanese Dentists	Number of Japanese Emigrants
Manchuria	187	43	309,981
China	176	33	27,770
South(east) Asia and Oceania	137	81	26,733
North America	218	31	213,662
South America	7	3	6,763
Europe and Siberia	147	15	5,246
Total	872	206	590,195

Source: *Tokyo iji shinshi* (data originally from the Foreign Office)

Table 4 The number and distribution of overseas Japanese doctors in 1921

Area	Number of Japanese Doctors	Number of Japanese Dentists	Number of Japanese Pharmacists
Korea	601	92	144
Taiwan	351	40	86
The Kwantung Leased Territory	291	48	94
Sakhalin	55	23	14
Qingdao	78	10	24
China	225	31	61
Russia	13	1	1
U.S.A	74	39	13
Hawaii	37	3	15
Philippines	6	0	0

[36] "Zaigai no honbō ishi (Overseas Japanese doctors)" *Tokyo iji shinshi* 2022 (1917), 35; "Zaigai honbō ishi nado no chōsa (A survey of overseas Japanese doctors)" *Tokyo iji shinshi* 2299 (1922), 31-32.

Table 4 (*Continued*)

Area	Number of Japanese Doctors	Number of Japanese Dentists	Number of Japanese Pharmacists
Canada	3	1	1
India	11	1	0
Straits Settlements	19	2	1
Hong Kong	4	0	0
Australia	1	0	0
Mexico	16	0	0
Brazil	6	0	1
Dutch East Indies	4	1	1
Siam	4	1	1
Peru	5	1	1
Total	1,804	294	458

Source: *Tokyo iji shinshi* (data originally from the Foreign Office)

However, this data obscures as much as it reveals. Because the Foreign Office only targeted legal doctors, unlicensed healers were not included in the statistics. Given that the client of the survey was the Home Ministry, doctors who obtained their original licenses in Taiwan, Korea, and other overseas territories were also excluded, because they were not in the Japanese medical register. The surveys, furthermore, did not distinguish between physicians who went abroad to practice medicine from doctors who ventured overseas for other purposes. For example, many Japanese doctors in Europe were MD students and were not practicing there. Most importantly, it should be noted that the doctors in the 1917 survey and those in 1921 investigation were likely different groups of people. Physicians often practiced overseas for set periods of time since many of the work opportunities abroad for these doctors were short-term positions. The position at the women's hospital in Yangon, for instance, was a three-year appointment, and the Japanese physician project in Romania was a six-month assignment. Most

of these employment contracts were for a one- to three-year term. Because of the temporary nature of their jobs, Japanese practitioners overseas moved around frequently. The impermanent nature of these positions may explain why so many Japanese doctors did not hesitate to accept jobs in other countries.

Of course, not all Japanese medical practitioners went abroad as contract doctors. There were also doctors who left their homeland with the ambition of opening their own hospitals. Some of them succeeded, but more doctors failed or gave up the plan. For example, there were more than 220 Japanese practitioners staying in Manchuria in 1906, but only 71 of them were able to start a business; the others were looking around to see if there was a chance.[37] Since the doctors had not really settled down in their destinations, they were likely not counted in the surveys of the Foreign Office, as they may have decided to return to Japan after a short period of time. In short, the data of these surveys did not fully explore the scale of the Japanese doctors' migration.

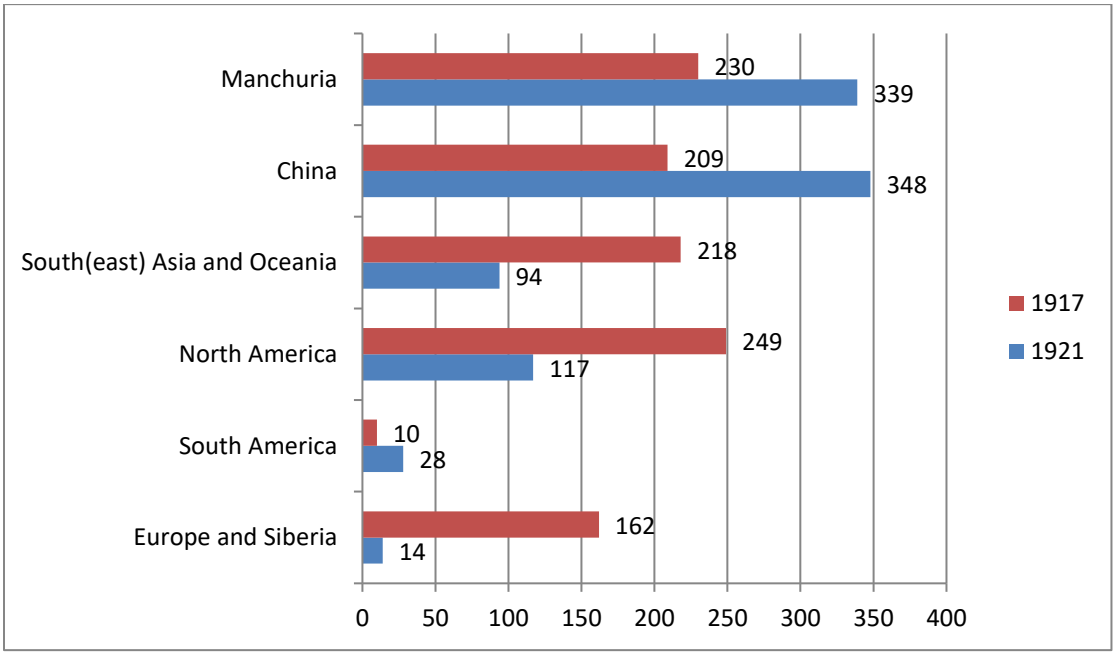
Despite these limitations, the surveys provide an important source for examination of the distribution of overseas Japanese doctors. To meaningfully compare the two surveys several adjustments must be made, because their categories, research subjects, and coverage areas were not uniform. I remove the data on pharmacists, Taiwan, Korea, and Sakhalin from my analysis because they were not available in the 1917 survey. I also redistributed the data of 1921 survey to make its geographical categories identical with those of the 1917 investigation.

If we juxtapose the adjusted data of the two years based on geographical categories, it is quite obvious that the spatial distribution of overseas Japanese doctors changed considerably (Figure 1) during this period. In the 1910s, North America had the most overseas Japanese

[37] "Manshū no wa kaigyōi (Japanese practitioners in Manchuria)" *Dōjin* 5 (1906), 26.

practitioners, but the differences between areas were not remarkable. Regional disparities, however, grew in the late 1910s and early 1920s. The number of Japanese doctors in Manchuria and China increased substantially, while its counterpart in North America, South(east) Asia and Oceania (Hawaii in particular) shrunk dramatically.

Figure 1 The increase and decrease of overseas Japanese practitioners in different areas



Source: *Tokyo iji shinshi* (data originally from the Foreign Office)

The geographical redistribution of overseas Japanese doctors, on the one hand, reflected the changing character of Japanese migration on the whole. North America and Hawaii had long been major destinations for Japanese emigrants, but the situation changed in the late 1900s.[38]

[38] Japanese American National Museum, *Amerika Tairiku Nikkeijin Hyakka Jiten: Shashin to E De Miru Nikkeijin No Rekishi* (Tokyo: Akashi Shoten, 2002), 68–69.

Because of Japan's expansion in Asia and a swell of Japanese in the internal population of the United States, the U. S. government sensed a threat from Japan and instituted much stricter immigration policy and laws for Japanese immigrants, which soon were also adopted in Canada. In the new system, only re-entering immigrants and familial dependents of current residents were allowed to enter the country. Japanese migration to North America, consequently, was practically halted. At the same time, thanks to the victories in the wars against China (1895) and Russia (1905), Japan became the new hegemonic power in East Asia. This stimulated emigration from the Japanese Archipelago to the Asian continent on an unprecedented scale. Korea, Manchuria, and China were important destinations for Japanese emigrants., and the presence of these Japanese communities created and secured a niche for Japanese practitioners.

An even more direct factor impacting the direction of Japanese doctors' transnational movements was the adoption of more complete regulations on the evaluation of foreign medical doctors' qualifications in the United States and Southeast Asia (fuller discussion will be presented in the fourth chapter), while medical legislation in China and Manchuria remained underdeveloped. There were no laws or authority to effectively regulate medical practices, including that of foreign practitioners. The laissez-faire liberal condition, needless to say, was a plus for would-be medical emigrants. Moreover, the newly established Japanese hegemony also gave Japanese doctors a psychological edge over their professional brethren in other Asian countries. Many had absolute faith in the advances of Japanese medicine and the superiority of Japanese practitioners, regardless their training and education background. There were even voices in Japan that encouraged medical candidates who had failed the Japanese medical

licensing examination several times to go to China.[39] No matter how inadequate these practitioners were, they were still more competitive than the native physicians because they had more knowledge of and skill in modern medicine. Emigrating to China would not only solve their predicament but also benefit the Chinese people, as well as potentially furthering Japanese cultural influence.

Setting up Practice in a Foreign Land

When moving to the Asia continent, Japanese practitioners had little doubt that they would enjoy popularity and quick success among the Chinese and Korean people, given the greater therapeutic efficacy of Japanese (i.e., modern) medicine than that of traditional kanpō medicine. But they quickly found that soliciting native patients' patronage was far more difficult than they had expected. This is not to say that the patients did not seek Japanese doctors' help. Rather, many Japanese practitioners treated Korean and Chinese patients, but in most cases their visits were too infrequent and brought too little profit (for further discussion see Chapter Three). As a consequence, the Japanese doctors had to rely on the custom of their fellow countrymen to maintain their practice. To be sure, there were some Japanese physicians who were able to acquire favor with non-Japanese patients. For example, Surgeon Ideta Takiba had a hospital in Shifu (today Yantai, North China) that solely targeted Chinese patients,[40] and it was reported that some Japanese doctors in Harbin were favored by Russian and Chinese but unpopular within

[39] MOFA, "Nihon teikoku ishi kaigyō menkyo o shoji sezaru mono ni shite sei kan ryōkoku he toko shi kōzen ijutsu kaigyō tameshi eru ya nai ya toriawase no ken (a query about whether a Japanese healer without the medical license of Japan can publicly practice in China and Korea)" 1903, Ijutsu kankei zakken (1). File no.:3-11-1-13.

[40] MOFA, "Shifukō ni oite moppara shinajin o mokuteki toshite kaigō shitaru honbō ishi ni kansuru hōkoku," 1902.

Japanese residents because their treatments were relatively inexpensive but poor.[41] But generally speaking, not many Japanese doctors were able to drum up business outside the Japanese immigrant communities. The correspondence between the change in the geographical distribution of overseas Japanese doctors and that of Japanese emigrants in general, to some extent, revealed the doctors' strong dependence on the Japanese communities. It should also be noted that before Ideta established his own hospital in a Chinese district, he was a contract doctor of the local Japanese association and had many Chinese patients during that time. The Japanese community, in other words, paved the way for Ideta's career in China.

For communities of Japanese immigrants, Japanese practitioners were an asset as well as a burden—a solution as well as a problem. Their presence in the immigrant settlements was considered a good thing for it meant the immigrants did not have to trust their lives to (presumably) unreliable native physicians or return to Japan for medical treatment of serious illnesses. But their arrival also brought trouble. The incoming doctors, as mentioned earlier, were a mixture of physicians with different training and educational backgrounds, and it took time to learn whether a practitioner was legal and trustworthy, usually at the cost of some settlers' bad experiences. Medical disputes between Japanese doctors and non-Japanese patients sometimes also caused a tension with the native ethnic group. For instance, in 1908 a Japanese physician in Harbin was accused of malpractice by Russian physicians, who performed a post-mortem on the body, in a case which had resulted in the patient's death.[42] Because the deceased was a daughter of the vice-consul of Spain in Harbin, this incident was widely reported in the local press and aroused animosity toward the Japanese immigrants. Moreover, because practicing medicine on

[41] MOFA, "Harubin ryōjikan tsuki iin shōhei he ni kansuru ken," 1908.

[42] Ibid.

the Imperial frontier was difficult and not always profitable, doctors moved around frequently. Instead of settling down in a place after practicing for some time in a place, many doctors returned to their homeland or moved to another place. Japanese practitioners in these communities were thus transient and the population unstable.

To ensure there would be a dependable Japanese physician in the settlements, many Japanese communities decided to use public money to support a doctor's residency and service in their community. Local residents' associations provided one- or two-year (renewable) contracts to recruit practitioners, and doctor waived or reduced medical treatment fees for members of the associations—namely, the Japanese immigrants—in return, although they still had to pay the cost of drugs. These doctors were also required to assist in medically–related public affairs such as autopsies, vaccinations, and epidemics control. In many cases, the communities would provide a house as the doctor' office and accommodation and pay his transportation expenses, but that was not always the case. Rental of medical instruments, or subsidy or no-interest loan for purchases of the equipment, were provided in some cases as well.

In primary sources, this sort of practitioner was often referred to as an "employed doctor" (*koyōi*) of local Japanese association or Chamber of Sanitation, but the term somewhat misrepresented the relationship between the association and the physician. It would be more appropriate to consider them "chartered doctors," who ran a private practice but received financial aid from the residents' association. The association grant, to be sure, was a subsidy for, rather than the salary of, the doctors. Although the money to some extent gave the doctors a steady income, it was not handsome enough to support the doctors' livelihood or the complete operation of the hospitals. Instead of relying on the associations' support, practitioners were expected to draw most of their earnings from the practice. They were also required to assume

responsibility for the costs of running the hospitals, from the salaries of medical assistants and nurse-midwives to medicines and medical equipment. Given the relatively limited amount of financial aid and small size of the Japanese communities, the physicians were allowed, if not encouraged, to drum up business from the indigenous population. Once the doctors solicited native patients' custom, the profit of their practice increased, thereby strengthening a desire to settle down in that location. Some Japanese associations also requested the "chartered doctors" to consider of the non-profit value of their job. When recruit a practitioner to work in Shifu, the local residents' association explained they needed someone who did "not take profit-making as the first concern."[43] Rather, applicants should consider the employment as an opportunity to do fieldwork for the study of endemic diseases in China.

In a sense, both encouraging treatment of native patients and de-emphasizing profit-making revealed that the Japanese immigrant communities did not have the financial resources to give full support to the doctors' business. But, even though the financial aid from the residents' associations was not as generous as the doctors may have liked, it was a huge economic burden for the settlers. In 1885, the revenue of the Japanese association in Inchon was 1600 yen, which was barely enough to pay the cost for sanitation, public transportation, fire control, plague fighting, and the maintenance of well and other common facilities,[44] but association leaders estimated they would need 1000 yen to have a Japanese physician practicing in the community. The money for "hiring" a practitioner seized 62.5 percent of the total budget of the association, by far the largest single disbursement of the community.

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[43] MOFA, "Shifukō ni oite moppara shinajin o mokuteki toshite kaigō shitaru honbō ishi ni kansuru hōkoku," 1902.

[44] MOFA, "Jinsenkō ryōjikan tsuki iin wo haishi kaigyōi he hojokin wo tashi dōkō he hashutsu no ken (The close of the affiliated hospital of the consulate in Inchon and the granting of subsidy for practitioners in the city)" 1885, Zai Chōsenkoku Jinsen Genzan Keijō Heijō. File no.:3-11-1-7.

If the employment of a Japanese doctor was particularly financially burdensome for Inchon and other small settlements, was it less of a problem for those places that had larger Japanese populations and thus wider fiscal bases in the communities? To some extent it was less difficult, but the problem is that very few settlements were large and prosperous enough to bear the expenses of having a "chartered doctor" on their own, especially in their early years. With approximately 600 residents, the Japanese community in Inchon was much smaller than it was after 1890s, but at that time it was already the third largest Japanese settlement in Korea. Seoul and Pusan were the only communities in which the number and wealth of Japanese immigrants was greater than in Inchon. Furthermore, Japanese doctors in those two cities also received financial aid from the Foreign Office. In Manchuria, the Japanese settlers at Mukden (a.k.a. Fengtian, Shenyang today) constituted the biggest single community. In 1906 the city had more than two thousand Japanese residents, and yet the local Japanese association still could not afford to recruit an experienced Japanese practitioner with a monthly salary of about 200 yen.[45] Since the Japanese communities Inchon and Mukden could not afford a "chartered doctor," smaller and less wealthy settlements could not be expected to bear the cost.

Aside from the high expense of hiring a Japanese doctor, we must also acknowledge the weak fiscal base of Japanese communities. By the mid-1900s, the numerous overseas Japanese residents' associations still did not have any legal status or authority to compel local residents to pay taxes or other fees.[46] The association revenue, consequently, was largely based on the immigrants' voluntary contributions, and was thus inconsistent. Another factor in the instable

[45] MOFA, "Hōten sōryōjikan tsuki iin secchi ni kansuru ken (the addition of a physician to the staff of the consulate general in Mukden)" (1906). Ijutsu kankei zakken (1) File no.:3-11-1-13.

[46] Peter Duus, *The Abacus and the Sword: The Japanese Penetration of Korea, 1895-1910* (Berkeley: University of California Press, 1995), 359.

fiscal base of the associations was the occupational structure of the Japanese communities. As Duus precisely noted, one characteristic of the Japanese imperialism was the relative disinterest of large-scale firms in investing in the colonial territories, as opposed to the middle or lower middle class' avid and restless ambition to exploit economic opportunities overseas.[47] The majority of Japanese immigrants in continental Asia were skilled labors, small businessmen, petty capitalists, and those engaged in service occupations.[48] In other words, they were people who did not have much capital, and their income would fluctuate considerably with a business boom or slump. Their inconsistent income, needless to say, affected their willingness to pay membership fees or make donations, which consequently affected the funds available to residents' associations.

State involvement played a key role in helping the Japanese doctors to settle down and establish their businesses because of these circumstances. The Ministry of Foreign Affairs, as the superintending authority over the Japanese residents' associations that kept settler communities afloat, was naturally the government department most engaged in the process.

The aid offered by the Ministry of Foreign Affairs took two main forms: recruiting proper physicians and offering subsidies for the hired physicians. As mentioned above, the quality of many Japanese physicians in the "Imperial frontier" areas was highly doubtful, and most overseas settlers were unable to tell the good from the bad. Hence, instead of recruiting a physician by their selves, many immigrant communities asked the Ministry of Foreign Affairs to recommend reliable doctors to them. Usually, a Japanese residents' association first set the recruitment conditions, such as expected qualifications of the prospective physician, the clinic's

[47] Ibid., 429–431.

[48] Ibid., 334–342.

potential income, the amount of the association stipend and other plausible subsidies. Then they would ask the nearest Japanese consulate to submit these conditions to the Ministry of Foreign Affairs, which would forward it to the related governmental bureaus or other semi-official institutions, such as the Ministry of Domestic Affairs, the Ministry of Education, medical schools, and the *Dōjinkai* (a non-profit Japanese medical philanthropic organization in Asia, particularly China), and ask them to recommend proper candidates. Although some Japanese residents' associations would later complain about the quality of the recommended physician, immigrant communities seldom refused the candidates dictated by the Ministry of Foreign Affairs—after all, they rarely had any other better choices. In other words, the immigrant communities, especially those in peripheral areas, depended heavily on the Ministry of Foreign Affairs' state authority, network of personnel and information, and, most importantly, subsidies to recruit Japanese physicians for them.

The Ministry of Foreign Affairs' medical subsidies for overseas Japanese communities can be traced back to the short-term medical support given to seasonal Japanese migrant fishermen in the U.S. and Canada, though that was exceptional and seasonally limited. The earliest regular subsidies were for Japanese physicians in Korea in the 1880s. Before that, the Japanese consulate had its own subsidized hospital or medical attaché offering medical service for Japanese immigrants, but it was closed because of the tightening budget. Therefore, Japanese residents' associations in Korea had no choice but to establish their own cooperative hospitals or clinics. Due to their limited economic capacities—most of the immigrants were petty businessmen and labors—they asked for aid from the local consulates. In Inchon, for example, the Ministry of Foreign Affairs agreed to contribute 1000-1500 yens per year for 6 years (70 yens per month for the doctor) to the newly found cooperative hospital, as well as cover round-trip

travel and a moving stipend for the doctor.[49] Furthermore, the Inchon consulate not only lent the building and the pricy major medical equipment of the old subsidized hospital to the clinic for free, but it also sold minor tools and medicine from the old hospital's inventory to the new doctors at discounted prices (40-70% off) in five-months installments. Similar cases in Korea include Keijō (Seoul today), Busan, and Wonsan. Nominally, those cooperative hospitals and clinics were established and managed by the Japanese residents' associations, but in reality, they were patronized and supervised by the local Japanese consulates. Those doctors were obligated to do publicly-mandated investigations for the local courts and police, such as autopsies, as well as other medical services ordered by the consulates.

Ideally, the interaction between the state (the Ministry of Foreign Affairs), the society (the Japanese residents' association), and the doctors was symbiotic and contributed to a win, win, win situation for all parties. For the clinical doctors, the stipend from the Japanese residents' association and the subsidies from the Ministry of Foreign Affairs guaranteed a certain level of income and relieved them from the financial tensions of fluctuating clinic incomes. For example, the income of the director of the Busan cooperative hospital came from three sources—a 50-yen monthly subsidy from the Ministry of Foreign Affairs, a 50- to 60-yen monthly stipend from the Japanese residents' association, and his own clinical income.[50] For the Japanese residents' associations, establishing their own cooperative hospitals or clinics and hiring "trustworthy" Japanese doctors greatly improved the settlers' health. Without the initial funding, annual subsidies, and the other uncompensated support provided by the Ministry of Foreign Affairs,

[49] MOFA, "Jinsenkō ryōjikan tsuki iin wo haishi kaigyōi he hojokin wo tashi dōkō he hashutsu no ken" 1885

[50] MOFA, "Wonsanrsu ryōjikan tsuki iin wo haishi kaigyōi he hojokin wo tashi dōkō he hashutsu no ken (The close of the affiliated hospital of the consulate in Wonsan and the granting of subsidy for practitioners in the city)" 1986, Zai Chōsenkoku Jinsen Genzan Keijō Heijō. File no.:3-11-1-7.

those Japanese residents' associations could not afford to fund the hospitals and clinics, even though the stipend they pay for the doctors is still a substantial amount of money.

Japanese hospitals and doctors were considered beneficial to the development and governance of a colony, and it was hoped that they would win local people's trust and support for Imperial Japan. For the Ministry of Foreign Affairs, the amount of the subsidies paid to cooperative hospitals and clinics was far less than the budget needed to run a subsidized hospital at each consulate. In Inchon, for example again, the Japanese consulate actually had to spend 4500 yen each year to run its own subsidized hospital.[51] But, as mentioned before, it only cost one third of that to support the Inchon cooperative hospital. Therefore, from the Ministry of Foreign Affairs' point of view, two thirds of the cost was passed onto the Japanese residents' associations and the doctors themselves. And if the immigrant community and the hospital thrived in the future, the consulate could gradually cut the amount of the subsidies. For instance, the government subsidy for the Inchon cooperative hospital ended on 1890 (though the building and equipment of the hospital were still lent without compensation). Another successful example was Sanka Hospital in Keijō (Seoul today). The owner-practitioner of the hospital, Kojō Baikei, opened for business business in 1886 and received subsidies in the first five years that allowed him to build his fame and accumulate enough customers to succeed on his own.[52] After his subsidies ended, he remained there and became one of the most renowned doctors in Korea.[53]

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[51] MOFA, "Jinsenkō ryōjikan tsuki iin wo haishi kaigyōi he hojokin wo tashi dōkō he hashutsu no ken" 1885.

[52] MOFA, "Keijō koshikan tsuki ikan wo haishi Beikoku ishi ni shokutaku oyobi kaiyaku to kaigyōi hojō hashutsu no ken (Matters on the dissolution of medical attaché of the Legation in Keijō, cancellation of an contract with American doctor, and sending a subsidized practitioners)" 1885-6, Zai Chōsenkoku Jinsen Genzan Keijō Heijō. File no.:3-11-1-7.

[53] Ishida Sumio, "Meiji jūku nen igo keijō de katsudōshita ishi Kojō Baikei to sono kyōdai ni tsiite—sanka byōin wo cyōshin ni (The first Japanese doctor Kojō Baikei who stayed at Keijō from 1886 and his brothers—on Sanka Hospital in Keijō 1891-1942)" *Yōgaku* 18 (2009), 81-102.

His hospital stayed open until 1942.

However, in reality, the relation between the immigrant communities and the doctors hired by the Japanese residents' associations did not always go so well, and the local consul had to function as both the coordinator and negotiator between the two sides. Okubo Masaharu, a physician hired by the Japanese residents' association in Jiujiang, South China, had a long history of quarreling with the association. When Okubo assumed the job in Jiujiang, he came with nothing but a physician's bag. However, the association expected the recruited practitioner to bring not only necessary medicines and equipment, but also an experienced nurse and midwife to start the clinic.[54] Instead, the association was forced to spend extra funds to buy medicine and equipment for Okubo's clinic. Later, although the Japanese immigrants complained about the quality of Okubo's medical care, they endured him because it was difficult to recruit a good physician. Meanwhile, Okubo complained to the Ministry of Foreign Affairs and *Dōjinkai*, the broker of his post, that the local Japanese residents were unfriendly and sarcastic to him, and even asked him to quit, though the local consul denied that. When endemic disease struck in the summer of 1925, Okubo quit his job before his contract expired, outraging the Japanese immigrants there.[55] A similar dispute also occurred in Qiqihar, North Manchuria,[56] where the local Japanese association discharged Dr. Uehara Kenzō because both his skills and equipment were disappointing. To attract a better-trained and better-equipped practitioner to come to the city, the association increased the monthly subsidy from 80 to 300 rubles (due to the geographical

[54] MOFA, "Kyūkō Nihonjinkai ni oite ishi shōheini kansuru ken (The recruitment of doctor for the Japanese association in Jiujiang)" 1922, Iji Kankei Zakken (1). File no.:3-11-1-30.

[55] MOFA, "Nihonjinkai shokutaku ishi jinin (The resignation of the commissioned doctor of the Japanese association in Kyūkō and request for recruiting a successor)" 1925, Byoin Kankei Zakken: Dōjinkai no Bu. File no.:3-11-3-6.2.

[56] MOFA, "Chichiharu kōritsu iin kaisetsu no ken (The opening of Qiqihar Public Hospital)" 1909, Zaigai Honpōjin Keiei Byoin no Bu. File no.:3-11-3-6.

affinity between Russia and North Manchuria, the ruble circulated in Qiqihar) and spent more than 300 yen purchasing and renovating a hospital. These expenditures, however, constituted an heavy, additional burden on the association budget and eventually caused a serious debt problem for the group.

The conflicts between Japanese residents' associations and the "chartered doctors" in Jiujiang and Qiqihar not only reflected the flood of ill-qualified physicians to the frontiers of the empire, they also revealed a tension between the Japanese emigrants and practitioners stemming from the two sides' differing expectations of the practice of Japanese medicine on the Asian continent. For the practitioners, practicing in settlements was a means to start a business with limited capital—a chance to carve a career "with nothing but a stethoscope"—but in the emigrants' point of view, since they spent a fortune aiding the doctors' practice, they had every right to ask for satisfactory medical service—treatment from a skilled doctor using modern medical appliances.

Conclusion

After the 1910s, most of the cities mentioned above no longer needed subsidies from the Ministry of Foreign Affairs to ensure they recruited qualified Japanese medical practitioners. With the annexation of Korea into Japan, the Korean Government-General replaced the foreign ministry as the main sponsor of Japanese medicine on the peninsula. Seoul, Pusan, and Inchon were put in the care of public medical institutions established by the colonial government. In Manchuria, hospitals were built in Mukden and other major cities by the South Manchurian Railway Company (SSRC) along the railroad lines. The Governor-General of Taiwan erected Hakuaikai Hospitals in Amoy, Fuzhou, Guangzhou and Shantou; and *Dōjinkai* opened hospitals

in Qingdao, Jinan, Beijing and Hankou. Although many Japanese doctors were hired by these hospitals, unlike the "chartered doctors" of the Japanese immigrant associations, they did not run the hospitals.

Since the hospitals mentioned above were all owned and operated by official or quasi-official institutions, did their establishment indicate a decrease in the number of self-employed Japanese doctors aboard? The answer is probably no, as these hospitals were built in large cities where there was already a dense and prosperous Japanese immigrant population that could also support independent physicians open private practices. In fact, these cities usually had a good number of Japanese private practices. As Tatsugami advised his contemporaneous doctors, it was always safer to set up a business in a well-developed medical market. At the same time, the semi-independent "chartered doctor" model remained prevalent in places outside the large Japanese settlements. Actually, Japanese immigrants who struggled from lack of medical resources were not in the urban areas, but in the peripheral areas. From the strategic point of view of the Japanese Empire, it was most important to build and maintain immigrant strongholds and outposts in the hinterlands of the Asian continent. Therefore, the numerous small Japanese hospitals and clinics in the hinterland played an equally important role as the large urban hospitals.

The Ministry of Foreign Affairs continued to provide or channel financial aid and other assistance to Japanese medical practitioners in the hinterlands of Manchuria, where support from the Imperial government and Japanese residents' associations were still essential for doctors to maintain their businesses. SMRC and *Dōjinkai* also adopted the "chartered doctor" mode to build small affiliated clinics in secondary cities. The SMRC Tōyō Hospital in Jilin, for example, was owned and operated by Dr. Ishibashi Saburō rather than the railway company and was also

partially subsidized by the foreign ministry,[57] as was the Jiujiang branch of the Hankou Dōjinkai Hospital, which received financial aid from the foreign ministry and local Japanese immigrant association.[58] The owner-practitioners were expected to be responsible for the profits and losses of these hospitals. Therefore, even though these two hospitals were found and sponsored by SMRC and *Dōjinkai* and named after their founders, they were never fully funded by those organizations and operated on their own.

The semi-public, semi-private practitioners' wide and active involvement in the frontiers of the Empire urges us to reconsider the dynamics of Japanese colonial and Imperial medicine. Current scholarship often highlights the great significance of state and quasi-governmental institutions like SMRC and *Dōjinkai* in introducing and promoting Japanese medicine. The dissemination of Japanese medicine throughout the empire, consequently, has been portrayed as a state-driven process completed for the sake of territorial expansion. While it is true that Japanese imperialism also motivated the medical doctors' desire to "spread wings overseas" and that financial aid and other assistances from the Imperial government enabled the doctors to set up practices aboard, but, as demonstrated in previous discussions, the state was not the only force facilitating the outflow of Japanese medical techniques and personnel. The entrepreneurial spirit individual doctors, the efforts of the medical community in Japan, and the immigrant associations in the colonies were also very important. The front line of Japanese colonial and imperial medicine was not pushed forward by an omnipresent state power, but gradually shaped in the interplay between governmental, societal, and individual forces.

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[57] MOFA, "Kirin tōyō iin setsuritsu no ken (Matter on the establishment of Tōyō hospital in Kirin)" 1913, Byoin Kankei Zakken: Zaigai Honpōjin Keiei Byoin no Bu. File no.:3-11-3-6.

[58] MOFA, "Kyūkō Nihonjinkai ni oite ishi shōheini kansuru ken" 1922.

Chapter Three

Drawing the National Boundaries of Medicine:

Migrant Doctors in Domestic and International Politics

By the end of the first decade of the twentieth century, Japan had transformed itself from a dependent semi-colony to a full-fledged member of the international community. Through a series of diplomatic negotiations, the Meiji government successfully regained tariff autonomy and legal jurisdiction over both the treaty ports and foreign nationals, the two essential ceded rights that had made Japan a political and economic subordinate to Western powers. The victories in the wars against China (1894-95) and Russia (1904-05) further confirmed the rise of Japan as a new regional hegemon. Consequently, Japan became a major competitor to Western imperial forces in the Far East. The new international position encouraged Japan to adopt a more resolute stance in dealing with foreign affairs. If the chief diplomatic goal of Japan in the late nineteenth century was to win the acceptance and approval of Western powers, in the first half of the twentieth century the paramount diplomatic goal of Japan was to demonstrate Japan's equal status with other (advanced) nation states in the world. The emergence of a powerful Japan, however, caused great anxiety among both Western imperialists and neighboring Asian countries, alerting them to keep a cautious eye on Japanese migrants, including medical doctors.

Regulating Foreign Doctors, Legitimating the State

It is under these circumstances that foreign-trained doctors emerged as an issue at debate in the domestic and international policies of Japan. Earlier in Chapter One, I have discussed how Western doctors were exempted from the jurisdiction of Japanese medical licensing laws.

Although all physicians in Japan were legally required to be licensed by the state, in reality European and American nationals could set up a medical practice without any government permission because they enjoyed extraterritoriality. At the turn of the twentieth century, there were several dozens of foreign practitioners in Yokohama, Kōbe and other areas of Japan patronized by both Japanese and foreign clients. Although small in number, the presence of the (unlicensed) foreign doctors humiliated the sovereignty of Japanese state, for they eluded the surveillance of local administrative and jurisdictional authorities.

The revision of the treaty in 1899 put an end to the extraterritoriality of foreign nationals. Prior to that, the Japanese government had been preparing to bring foreign doctors under the purview of state regulation. Between 1895 and 1904, the Ministry of Domestic Affairs had entrusted the Ministry of Foreign Affairs the authority to investigate foreign medical licensing systems of not only the Western Powers, such as Britain, France, Germany and the United States, but also of the newly established nations similar to Japan, such as Mexico, Peru and Brazil.[1]

The Ministry of Domestic Affairs collected this information prior to drafting the Medical Practitioners Law. In 1897, Gotō Shinpei, the director of the Public Health Bureau, explicitly pointed out at a Diet hearing that a major difference between the newly drafted Medical Practitioners Law and the current Rule of Medical Licensing (in effect since 1883) was in the way of qualifying foreign-trained doctors.[2] Under the current rule, though anyone who possessed a foreign medical diploma or license, the credentials of which was verified by the Ministry of Domestic Affairs, could directly acquire a Japanese license with no further

[1] All relevant files are collected in a folder named "Gaikoku igakukō ijyutsu kaigyo menkyo kafu oyobi iyaku seido nado ni jikō kansuru torishirabekata (Investigations into foreign medical schools, licensing system, and other medical institutions: Request from the Ministry of Home Affairs)" at the Diplomatic Archives of Japan (MOFA) . File no.:3-11-1-12.

[2] Ikai jihō sha, ed., *Ishikai Hō Sanpi Ron* (Tokyo: Ikai jihō sha, 1900), 123.

examination, however, there would be some adjustments under the newly drafted law. And when a Diet member asked Gotō whether the foreign-trained medical personnel's privilege of exemption from the medical licensing examination would be rescinded, he did not respond directly, but only replied that it was under investigation by the government and no change would be made in the near future. But since at that time, Japanese government was still in the process of diplomatic negotiations with Western nations to abolish the extraterritoriality, Gotō's evasive reply is understandable. Nevertheless, the message he conveyed was also very clear: sooner or later, the special treatment of foreign physicians would be abolished.[3]

The proposed Medical Practitioners Law provoked considerable debates in Japan's Diet, medical society and beyond. Despite the range of opinions, there was consensus that foreign doctors should be placed under stricter state oversight. For example, Suzuki Manjirō, a practitioner and a Diet member, claimed a stricter law would help to regulate both Japanese and foreign doctors. He asserted that a substantial number of foreign doctors would come to Japan after the rescission of extraterritoriality, since once foreign nationals were no longer confined to reside and conduct businesses exclusively in treaty ports, foreign doctors could set up medical practice anywhere in the country. Suzuki predicted that the in-coming medical migrants would pose a grave peril to the Japanese government and society in general, because presumably many of them would neither be well-trained, trust-worthy, nor respect Japanese laws. The enactment of the Medical Practitioners Law, he declared, must be a preemptive measure to forestall these potential problems.[4] In order to place foreign doctors under more rigorous state control, Suzuki suggested that the new law should increase the regulating power of the medical society. He

[3] Ibid., 125.

[4] Ibid., 8.

proposed that every prefecture organize a monopolized medical association, which demanded all doctors in that area (including foreign ones) to join it, and only its member could practice in that region and every practitioner was to be supervised by the association. Suzuki's proposal was supported by medical practitioners and officials in the Ministry of Domestic Affairs, but was opposed by non-clinical doctors, such as university medical professors and military physicians, as they feared that the local practitioners would control the prefectural medical association because of their numerical superiority.[5]

Suzuki's concerns about foreign doctors as potential threats was very representative, for similar apprehensions frequently surfaced in discussions and debates over the draft of the Medical Practitioners Law. Even those who opposed Suzuki's version of the act argued in the same vein and concurred that the mass presence of foreign physicians within the national boundaries would infringe Japanese doctors' interests and threaten public health in Japan. For instance, in an editorial in *Tokyo Daily News* (*Tokyo nichinichi shimbun*) the author stated he agreed with Suzuki that "in order to protect public health and human rights (in Japan), it is necessary to regulate the practice of foreign physicians," he nevertheless criticized the proposed act as it did not specify the basic qualifications of foreign doctors and necessary requirements for them to set up practice in Japan. He argued that Japan up to now has had no law to regulate foreign doctors, and the upcoming Medical Practitioners Law would lay the foundation for further legislations and hence must be carefully drafted after thorough investigation and discussion. He opined that the current act, though initiated with good intention, was drafted in a rush, and if enacted would cause considerable problems. He therefore called on Diet members to

[5] Kawakami Takeshi, *Gendai Nihon Iryōshi; Kaigyōisei No Hensen* (Tokyo: Keisō Shobō, 1965), 234-237.

return that act and re-draft it.[6]

Historians of medicine have suggested that the debates surrounding the Medical Practitioners Law was a factional dispute, with clinical practitioners and officials from the Ministry of Domestic Affairs in one camp and university medical professors and military physicians in the other, vying for the leadership of Japan's medical society.[7] They contend that the reason why foreign doctors' issue became so controversial was because both camps took it as an opportunity to justify and insist on their rightful positions and claims to power. But it nonetheless reflected the fact that Japanese medical community in general considered foreign doctors as a potential national threat and therefore ought to be policed by the state. In hindsight however, the immense interest and popularity this discourse drew and people's alert and watchful attitude toward migrant medical doctors was a tad hysterical. As a matter of fact, the predicted mass exodus of foreign doctors into Japan never happened: their numbers actually had never even exceeded one hundred at the end of the Second World War. Nonetheless, the attention the discourse gained reveals that a public anxiety struck Japanese society at the turn of the twentieth century: the fear that the abolishment of extraterritoriality would ironically only further Western invasion and encroachment. Many people believed once the Westerners were set "free" from the treaty ports and permitted to enter Japan's hinterland, they would eventually enlarge their share in the Japanese domestic market, as they possessed both capital and technological advantages over their Japanese competitors. Similar worries frequently surfaced in public opinion at the time.[8] Concerns about the immigration of foreign doctors were, however, only the tip of the

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[6] Ibid., 35-40.

[7] Ibid.

[8] Asano Toyomi, *Teikoku Nihon no Shokuminchi Hōsei: Hōku Tōgō to Teikoku Chitsujo* (Nagoya: Nagoya Daigaku Shuppankai, 2008), 15.

iceberg.

After the rescission of extraterritoriality in 1899, foreign doctors were brought under the jurisdiction of Japanese licensing system. At the time, the bills of Medical Practitioners Law were still in the legislative process at the Diet and was not enacted until 1906. Consequently, the regulation of foreign doctors was still based on the 1883 Rule of Medical Licensing. The doctors were legally required to register at the local police office, who superintended all healthcare providers in the district.[9] All foreign physicians were also required to submit credentials for evaluation as per Japanese Home Ministry by laws.[10] All Westerners successfully passed the screening and obtained Japanese medical licenses, while the applications of Chinese doctors — who practiced traditional herbal medicine— were turned down. Community leaders in Yokohama Chinatown presented a petition to the ministry asking permission to allow the doctors to keep their practice in the district, but the request was rejected. The ministry insisted they could not license the Chinese doctors unless they could pass the licensing examination. Accordingly, the Japanese government was able to demonstrate its sovereignty as an independent modern state while respecting the vested interests of those Euro-American citizens who had resided and had businesses in Japan before the revision of the treaty and abolishment of extraterritoriality. The aforementioned statement by Gotō Shinpei represented Japanese government's promise to the western countries: no major changes would be made in the near future.

The 1906 Medical Practitioners Law kept the door open for holders of foreign medical degrees and licenses to acquire a Japanese license through verification of their credentials by the

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[9] "Eikyō gaijin he chūi (Attention! Foreigner who are doing business in Japan)" *Asahi Shimbun*, June 21, 1899, 2.
[10] "Jōyaku jisshi to gaikoku ishi (Treaty revision and foreign doctors)" *Asahi Shimbun*, April 14, 1899, 7; "Gaii no kaigyō shūtsugan (The applications of foreign doctors for practicing in Japan)" *Yomiuri Shimbun*, August 2, 1899 (morning edition), 2; "Gaikoku ishi kaigyō (Foreign doctors set up practice)" *Asahi Shimbun*, August 24, 1899, 1.

Ministry of Domestic Affairs. However, after a stricter Imperial Ordinance No. 244 was passed later that year, only Japanese nationals, who had studied medicine abroad, and medical license holders from countries that had signed the medical license reciprocity agreements with Japan, were allowed by the Ministry of Domestic Affairs to exchange their medical licenses and practice in Japan without further examinations.[11]

The modification of medical licensing system marks Japan's reorientation of its position in international society. Before the 1899 treaty revision, the primary diplomatic goal of Japan was to win the recognition of the West in order to abolish extraterritoriality through diplomatic negotiations in order to be accepted by the West as "one of us." Japan had not only adopted the Western medical science as the only officially recognized knowledge system for its medical administration and education, but also allowed foreign physicians, who received qualified Western medical trainings with proven credentials, to practice medicine within its borders. In doing so, as a newly built modern nation state, Japan tried to emphasize its commonality with the other advanced countries in the world. The abolishment of unequal treaties signaled Japan's acceptance as a more or less equal partner of the Western powers. As a country that had just gotten rid of its semi-colonial status and become a fully independent state, Japan re-oriented its diplomatic priority to protect its sovereignty. Placing foreign doctors under state regulation and supervision was an important step to demonstrate Japan's administrative and judicial independence.

The new licensing requirement considerably raised the barriers for foreigners to obtain a Japanese medical license, and a major challenge was language. Because the licensing examination in Japan was conducted in Japanese, proficiency in the language was a necessity to

[11] "Gaikoku ishi menkyo rei (Ordinance on licensing foreign doctors)" *Asahi Shimbun*, September 13, 1906, 2.

succeed in the test. In 1907, the year following the promulgation of the Medical Practitioners Law, an American petitioned the concerned authorities requesting permission to answer the examination questions in English, and it was granted. This case soon attracted the attention of foreign diplomats in Japan. The German ambassador wrote to Japanese government querying if examinees could also take the medical licensing examination in German language, and the response was positive. According to the reply from the Ministry of Education, which was in charge of the licensing examination, foreigners were at liberty to write their answers for the examination in English, German, or French. If necessary, the candidates could even take the examination with the assistance of a translator, who would be selected and assigned by the Committee of Medical Licensing Examination.[12]

The response of the ministry aroused great disputes. On being asked for an explanation, the chair of the Medical Licensing Examination Committee responded that although the usage of Japanese was the norm, there was no rule that prohibited the candidates from answering the examination in other languages. To permit foreign examinees to use their own languages in the licensing examination, he explained, was a good way to demonstrate to the world that Japan had become a modern country as civilized as the West — our examination committee members could review the answer sheets in three foreign languages![13] Some medical personnel and other intellectuals supported the decision of the Ministry of Education. They argued it was unrealistic to require foreigners to take the licensing examination in Japanese, since Japanese had not been

[12] MOFA, "Ijutsu kaigyō shiken ni dokubun wo mochiiru no kahi kikiawase no ken (Query about if German language can be used in the medical licensing examination)," Ijutsu kankei zakken (2), 1907. File no.:3-11-1-13.
[13] "Gaijin ijutsu juken Eikyō gaijin he chūi mondai ni tsuite (Questions about foreign candidates in the medical licensing examination)" *Tokyo Asahi Shimbun*, September 30, 1907, 4.

accepted as an international language of medical science.[14] They also pointed out that the purpose of the medical licensing examination was to test a person's familiarity with medical knowledge and technology, not his or her proficiency in Japanese language. Allowing a foreign examinee to answer in their mother tongues was a suitable way to test their professional capacities, because people articulate themselves best in their own languages.[15]

But there were more criticisms and doubts about the decision of the Ministry of Education. Some commentators noted that while this particular case in itself was harmless – only a single foreign doctor petitioned and he came from a country friendly to Japan – however, it would create an ominous precedent. Predictably, thousands of foreigners would follow the example and ask for similar treatment, including medical migrants from (less-friendly and backward) countries such as China and India.[16] Some others doubted whether the examination committee members were really competent to review the answers in three foreign languages, since Japan's medical education system at that time was modelled on Germany's, German was the first foreign language for most Japanese physicians and only a few of them had also mastered English and French.[17] Allowing foreign examinees write the examination with the help of translators was also questioned by many people, since to be a competent translator that person had also to have at least some knowledge of medicine, and hence it would be possible to cheat in the exam if the translators help the examinees answer the questions.[18]

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[14] Kōhara Akira, "Eigo tōan sawagu ni tarazu (No need to make a fuss on answering the examination questions in English)"*Ikai Jihō* 696 (1907), 4

[15] Nishiyama Hiroe, "Bekokujin no eigo tōan ha naze futsugō ka (Why to let American answer the examination questions in English is inconvenient)," *Ikai Jihō* 694 (1907), 2-4.

[16] "Shūchū hakuro," *Ikai Jihō* 694 (1907), 11.

[17] Bōgakurō shujin, "Gaijin no ijutsu kaigyō juken ni tsuite (Foreign candidates in the medical licensing examination)," *Ikai Jihō* 694 (1907), 4.

[18] "Bejin no jicchi juken (Practical tests for American examinees)," *Ikai Jihō* 696 (1907), 5.

Even the Ministry of Domestic Affairs disagreed with the Ministry of Education and worried that allowing foreigners to take medical examination in European languages would license migrant doctors who knew no Japanese language thus creating subsequent problems. For example, if a migrant doctor gave his patient a prescription in a foreign language and the patient handed it to a pharmacist who didn't understand that language, it would increase the risk of medication mistakes. Moreover, if a migrant doctor signed a legal document, such as death certificate or postmortem report in a foreign language, it was highly possible that a clerk in a local municipal office was not able to read that document. It was impossible to ask every government branch or every migrant doctor to hire a translator, and further it was impossible to guarantee a translator would be error-free. Furthermore, what if a migrant doctor used his inability to understand Japanese as an excuse to overlook the codes or resolutions made by Japan Medical Association? Consequently, the Ministry of Domestic Affairs claimed even though the American physician passed the examination, it still needed further discussions to determine whether to issue a license to him or not.[19]

As noted by many commentators, other than the substantial subsequent problems it would create, more importantly, allowing migrant doctors to take medical licensing examination in foreign languages would undermine the sovereignty of Japan in international society. They argued that even though there was no specific code to regulate it, as an independent sovereign state, Japan's national examination should definitely be conducted in Japanese. Otherwise, it would not only be contrary to international norm but also be a humiliation. "No first-class state in the world does not respect its own national language. Only countries like the neighboring Korea, which is nominally an independent state but in reality a protectorate of Japan, do not have

[19] "Gaikokujin no shaken to naimushō (Foreign examinees and the Home Ministry)," *Ikai Jihō* 694 (1907), 6.

the power to protect their national languages."[20] "If foreigners think it is painful to take examination in Japanese, then, it is equally torturous for overseas Japanese people who take examinations in French or Russian. Unless some country is willing to concede the right and removes the language barriers for our citizens there, our country need not ignore the precedents and international norms to ease the similar travails for their citizens in Japan. To win equal rights among all countries in the world on an equal basis should be our ultimate concern."[21] Some commentators criticized that it was a grave blunder for the Ministry of Education to let a foreigner take the examination in his own language. However, this was water that had already passed under the bridge. What mattered now was to urge the Ministry of Foreign Affairs to negotiate reciprocal rights from other countries.[22]

Despite the widespread criticisms, the Japanese government supported the arrangement of the Ministry of Education. Many people thought it was a friendly gesture made by the Japanese government deliberately in order to ease the rising anti-Japanese sentiment in the United States. Another suggestion was that Japanese government made this concession in exchange for the U.S. agreeing Japanese doctors to practice in Hawaii and the Philippines without qualification examinations.[23] In any event, the special treatment the American physician received in 1907 set a precedent. Hereafter, foreigners were permitted to use the English, French, or German language in the medical licensing examination and, with the pre-approval by the Chair of the Examination Committee, they might bring an interpreter for the examination. This continued till 1916 when the track of medical licensing examination was abolished. It should be noted that the

[20] Bōgakurō shujin, "Gaijin no ijutsu kaigyō juken ni tsuite," *Ikai Jihō* 694 (1907), 5.
[21] Gonsan Jyōjin, "Kōryō ronsha ni nobu (Message to the Pro-tolerance Group)," *Ikai Jihō* 698 (1907), 2.
[22] "Kintō no kenri wo kakushu (Go get the equal rights)," *Ikai Jihō* 698 (1907), 2.
[23] Hayakawa Shinjiro, "Eigo tōan ni tsuite (Answering the examination in English,)" *Ikai Jihō* 698 (1907), 3.

medical licensing examination was from the very beginning a transitional system designed by the Meiji government to grant medical licenses. Since in the early Meiji period, the quality and quantity of Japan's medical education system could not produce sufficient qualified physicians, it was necessary to create an alternative track to screen those medical practitioners who received a certain modern medical trainings outside medical schools. Although the medical licensing examination kept running up until 1916, there had been many voices in the 1900s suggesting it should be abolished and the government should grant license only to those who graduated from standard medical schools. In other words, when Japanese government gave the American examinee the convenience to take the medical licensing examination in English, this licensing track was expected to be abolished in the near future. From this point of view, the language accommodation was from beginning a temporary and transitional arrangement, not a permanent treatment to all the migrant doctors.

The language accommodation didn't mean Japanese government was giving up or loosening its licensing control over foreign doctors, on the contrary, it allowed the authorities concerned to supervise them more easily. For example, two American physicians were reported practicing in Japan without license initially, then took the medical licensing examination and got their permissions to practice.[24] The state regulation covered migrant doctors in Japan's colonies, too. In Korea for example, after 1913, only physicians who held medical licenses issued by the Japanese government or the Korean Governor-General had the right to practice in the Korean peninsula. Deeming it as a suppression of American medical missionaries, the American consulate petitioned to ask the Korean Governor General to issue licenses to those American

[24] "Beikoku jin no juken ni tsuite (American's taking the licensing exam)" *Ikai Jihō* 848 (1910), 2; "Nihon de sasho no gaikokujin fujin ishi (The first foreign female physician in Japan)" *Yomiuri Shimbun*, November 12, 1926 (morning edition), 11.

doctors who had been practicing medicine in Korea prior to1913, but this request was rejected.[25]

Nationalism, Professionalism and Racism

Japan rejected American consulate's request because it did not match the principle of international reciprocity: if Japanese doctors were required to take examination to obtain medical licenses in the U.S., American doctors should do the same in Japan.

This argument was very similar to the aforementioned criticism towards the language accommodation given to migrant doctors in Japan: both considered the treatment of foreign doctors was a matter of national prestige and reflected Japan's standing in the world. In their eyes, after the abolishing of unequal treaties, the relation between Japan and America (and the other countries) should be absolutely equal and reciprocal. This meant that what treatments foreign doctors in Japan received should be no different than what Japanese doctors were given in the foreign countries, otherwise, it was self-degrading.

In this context, the Japanese government made great efforts to establish a reciprocal recognition for practitioners with other countries. The first and the only major power that reached a reciprocal recognition for practitioners with Japan was Britain, the most important ally of Japan before the 1920s. The Anglo-Japanese Medical License Reciprocity Agreement was signed in 1902, just shortly after the establishment of the Anglo-Japanese Alliance, and thus could be regarded as a subsidiary treaty that sought to strengthen the cooperation between the two island empires.

The negotiations with other states were not as successful. Russia, for example, refused to

[25] MOFA, "Chōsen ni okeru Beikoku jin ishi kaigyō meikyō ni kansuru ken (Matters on licensing American physicians in Korea)," Honpō ni oite gaikoku ishi kaigyō kaikei zakken, 1914. File no.:3-11-1-18.

sign a similar agreement with Japan, worried that other European countries would ask for exchanging medical license without examination in Russia.[26] Japan reopened the negotiations with Soviet Union in 1920s, hoping the newly founded communist government could give Japanese physicians the permission to practice in the Russian Far East.[27] Unfortunately for Japan, the efforts proved abortive. Japan also failed to reach a medical license reciprocity agreement with the United States. The U.S. federal government claimed medical license in America was issued by each state and there was no national license, therefore, it was impossible to sign a nation to nation reciprocal agreement like Japan and the United Kingdom. Nevertheless, American government mentioned that on the principle that all physicians should be tested before practicing, it could be allowed as an exception to give some conveniences to doctors who held Japan's medical licenses in areas where Japanese immigrants were concentrated, such as Hawaii and the Philippines (especially Manila),[28] which basically meant Japanese doctors could take local licensing examinations with the help of translators. As aforementioned, at roughly the same time, Japanese government allowed an American physician to take licensing examination in English, therefore, even though there was no formal agreement between Japan and the United States, they must have had some kind of tacit understanding on the qualifications of medical doctors.

In addition to the pursuit for equal diplomacy, another reason that urged Japan to negotiate with other counties over the conversion of physician licenses was to foster the growth of

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[26] "Bei ro ryōgoku to ishi gokei jōyaku (Medical reciprocity agreements with the United States and Russia)" *Ikai Jihō* 696 (1907), 5.

[27] MOFA, "Kaigai ni okeru hōi jiyū kaigyō ni kansuru ken (Unrestricted medical practice of Japanese doctors overseas)," Iji kankei zakken (1), 1925. File no.:3-11-1-30.

[28] "Bei ro ryōgoku to ishi gokei jōyaku (Medical reciprocity agreements with the United States and Russia)" *Ikai Jihō* 696 (1907), 5.

overseas Japanese communities. Sometimes, the negotiations were initiated on the request of medical associations and overseas migrant communities. For many Japanese in the late nineteenth and the first half of the twentieth centuries, emigration was an important "peaceful method" for the building of Japanese state and empire.[29] Remittances of emigrants helped to solve the state's financial deficit, and the mass presence of Japanese in other countries enhanced the nation's influence and prestige in the world. In this context, the overseas practice of Japanese doctors was essential because it secured the growth of a stable population of Japanese migrants. In Chapter two, I have explored how overseas Japanese communities recruited practitioners from Japan in order to secure accessibility to a practitioner with whom they could communicate in the native language. Despite the high expense, the presence of a compatriot-doctor in the neighborhood helped to protect the health of Japanese migrants and enhanced their willingness to settle down.

Initially, the coming of Japanese migrant doctors was tolerated if not welcomed. Because most overseas Japanese communities were located in remote areas with scarce medical resources, local officialdom tended to take a lax attitude towards their practice. However, the situation gradually changed. Like Japan, many receiving countries of Japanese migrants started to impose more restrictions on qualifications of foreign practitioners through the design of licensing system. The development, in part, was a result of medical modernization and professionalization, but it was also closely associated the anti-Japanese movement that emerged in the first-half of the twentieth century. The rise of Japan as a major world power rang alarm bells in many

[29] Jun Uchida, *Brokers of Empire: Japanese Settler Colonialism in Korea, 1876-1945* (Cambridge, Massachusetts and London: Harvard University Asia Center, 2011), 9; Louise Young, *Japan's Total Empire: Manchuria and the Culture of Wartime Imperialism* (Berkeley: University of California Press, 1998), 312-17. Also see Eiichiro Azuma, *Between Two Empires: Race, History. And Transnationalism in Japanese America* (New York: Oxford University Press, 2005).

countries/regions about Japanese immigrants, worrying that they would become the vanguards of Japanese imperial expansion. As a result, Japanese migrant physicians were considered by receiving countries as potential trouble makers—not only their professional capacity, but also personal morality and loyalty to receiving country were doubtful, and hence they might also threaten the individual health, public hygiene, and national security. Accordingly, Japanese migrant doctors— if they should be permitted to practice, and if so how to regulate their qualifications— became a burning domestic problem in the receiving countries and a significant diplomatic issue for Japan.

The protest against the employment of a Japanese doctor in Broome offers an intriguing example of how the physician became a scapegoat in xenophobic White Australia. A small harbor in northwest Australia, Broome was the largest center of pearling industry in the world before the First World War. Due to the shortage of labor, the local pearling firms and ship owners recruited a large number of indentured workers from Asia and Pacific Islands, because they were cheap to hire and easy to replace. The contract laborers included Chinese, Malays, Filipinos, Amboinese, Timorese, and many others, but Japanese was the largest ethnic group.[30] At the peak of the industry, there were more than one thousand Japanese residents in Broome, while the white population was less than 700.[31] Most indentured Japanese were seamen working on pearling fleets, and they were particularly reputed as good divers. Compared to other occupations available for colored workers, pearling crews were relatively well-paid but the wage

[30] Pam Oliver, "The Japanese and Broome to 1942" in Stephen Alomes edited, *Outside Asia: Japanese and Australian Identities and Encounters in Flux* (Victoria, Australia: Japanese Studies Center Monash University, 2011), 121. Japanese constantly constituted one third of Asian indentured laborers, or a half of crews of pearling fleets in West Australia. See Mary Albertus Bain, *Full Fathom Five* (Perth, Western Australia: Artlook Books, 1982), 125.
[31] D. C. S. Sissons, "The Japanese in the Australian Pearling Industry," *Queensland Heritage* 3:10 (1979): 9; John Bailey, *The White Divers of Broome: the True Story of a Fatal Experiment* (Sydney: Macmillan, 2001), xiv.

came at a high price of loss of health, and sometimes loss of life. Many sailors got injured or died on the sea, and almost all crew members suffered from some sorts of infectious diseases, malnutrition, alcoholism, or mental illness, due to the insanitary, cramped, and isolated working condition on pearling boats. The job of divers was especially hazardous. Beside the risks shared by all seamen, they were also exposed to the danger of decompression sickness because they had to stay deep underwater for long periods of time.[32]

In the eyes of the Japanese seamen, medical services in Broome was far from satisfactory and trustworthy. The only practitioner in town was an (white) Englishmen who practiced in the local government hospital. Since the educational level of Japanese indentured migrant workers was low and the command of English poor, they faced difficulties in describing and explaining their illnesses and symptoms to British physician thus increasing the risks of misdiagnoses. Even worse, the British physician, who had a biased attitude toward colored people, often thought his Japanese patients were malingerers. There had been a case of a seriously ill Japanese laborer worked to death because he could not get a sick leave from the doctor.[33] Disappointed and upset, the Japanese decided to raise funds to establish their own hospital. By 1909, the Japanese Society at Broome had collected enough money to guarantee a salary for a physician from Japan, to buy him a residence and workplace, and to setup the necessary drugs and medical equipment for his practice. To staff the hospital, the society sought help from the Japanese government to find them a physician who graduated from an imperial university and spoke English. Mediated by the

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[32] Mary Albertus Bain, *Full Fathom Five*, 149-162.

[33] MOFA, "Nishi gōshū buru-mu nihonjin kai ni oite honpō ishi shōhei no ken (A job offer for Japanese physicians from the Japanese Society in Broome, West Australia)," Ishi shōhei kankei zakken, 1914. File no.:3-8-4-37. Also see JACAR Ref. B12082291000. The relationship between Japanese workers and the British physician was so bad that as late as in the 1950s, a Japanese migrant still recalled him as "an utter quack. He was so bad that his nickname was Dr. Murder." P. Stride and A. Louws, "The Japanese Hospital in Broome, 1910-1926," *The Journal of the Royal College of Physicians of Edinburgh* 45(2015): 158.

Ministry of Foreign Affairs and Ministry of Education, the society successfully employed Dr. Suzuki Tadashi, an eminent graduate from the renowned Kyoto Imperial University, who was recommended by the president of the school.[34] The Japanese Consul-General in Sydney also helped the medical man to obtain an Australia visa, which allowed him to stay in the country for three years for the purpose of practicing medicine.

Initially, the white community at Broome did not notice the plans. By the time they knew what was happening, Dr. Suzuki was preparing to leave Japan for Australia and the Japanese Society had purchased a house and was remodeling it into a hospital. The news outraged the white citizens. Protest petitions were circulated throughout the town, one organized by the Municipal Council and the other by the Pearlers' Association. People feared that the Japanese doctor would attract all the colored patients, and without the admissions of Asiatic labor, the white doctor and the government hospital would not be able to get adequate revenue to continue. This meant all the white people in Broome would have to consult with "a full-fledged medical practitioner of an alien race." Even women would need to expose their bodies for examinations to the Japanese physician. Pearling boat owners and other businessmen asserted that Dr. Suzuki's practice would cause them economic loss, since a malingering worker could easily obtain a sick leave from the Japanese doctor. They also believed their pearls must have been stolen by the indentured Japanese workers; otherwise, how could they afford the huge expanse of building a hospital and hiring a practitioner from Japan? Local politicians worried if the Japanese physician was allowed to come in, other ethnic communities would also desire to have the service of a medical doctor or other professionals of their own race. The Chinese and Afghans, for example,

[34] MOFA, "Nishi gōshū buru-mu nihonjin kai ni oite honpō ishi shōhei no ken," Ishi shōhei kankei zakken, 1914.

had been demanding Asian lawyers for a long time.[35]

The objection to the advent of the Japanese doctor "is unanimous and representative of the whole community," the mayor of Broome stated in a telegram to the federal government. He also guaranteed "the Japanese residents in Broome or employed on the pearling fleets are not and never have been under any disadvantage or disability through the absence of a Japanese doctor." Accordingly, he urged the government to take immediate steps to withdraw Dr. Suzuki's entry permit.[36]

The local conflict soon became a national controversy in Australia. The members of Commonwealth Parliament from different states inquired one after another why the government had granted a Japanese doctor the permission to reside and practice in Australia. Wouldn't it violate the Immigration Restriction Act and break the set White Australia Policy? Since Broome already had a highly qualified Caucasian practitioner who provided medical services to white people and the Japanese alike, there was no reason to admit an Asian doctor whose capacity was presumed to be inferior. Some members of the House of Representatives raised the question that even though the Japanese man was a licensed physician in Japan, could his qualification truly satisfy the requirements of the state of Western Australia for medical practitioners. A House of Representative's member, who was a medical doctor and obviously familiar with the fame of Kyoto Imperial University, admitted that Dr. Suzuki had graduated from a school with a very high academic standing. However, he pointed out that just because Dr. Suzuki was a distinguished physician, his immigration was a problem. "I know that the white man could not compete on equal terms with the Japanese. It is for the latter reason that I fear their entry into

[35] P. Stride and A. Louws, "The Japanese Hospital in Broome, 1910-1926," 157; John Bailey, *The White Divers of Broome*, 59-60.

[36] MOFA, "Nishi gōshū buru-mu nihonjin kai ni oite honpō ishi shōhei no ken," Ishi shōhei kankei zakken, 1914.

Australia." [37] The ostensibly Japan-applauding statement thus ironically ended in an anti-Japanese conclusion.

This event as a whole got national attention and news coverage. There were sympathetic voices, too. For example, an editorial described the petitions at Broome were "quite unnecessary." The intention of the White Australia policy, the author stated, was "to keep out those who might come in such number as to threaten our racial supremacy," not to block all immigrants. The coming of a highly-qualified Japanese doctor to minister to his countrymen would not endanger the whiteness of Australia.[38] Unfortunately, this opinion did not reflect the consensus of the majority.

It might be difficult to understand why the proposed introduction of a Japanese medical man at a small town would be conceived as "a most serious attempt to break down the provision of the Immigration Restriction Act," to borrow the words of a parliament member. After all, there were only a few thousands of Japanese residing in Australia, a much smaller number than that of Chinese immigrants (ten times more).[39] To consider it simply from the size of the population, Japanese immigrants could hardly bring any challenge to the European descendants. As a matter of fact, Chinese immigrants were the major target of the White Australia policy, not the Japanese.

However, this is not to say that Australians were less watchful over Japanese. Quite to the contrary, many Australians believed Japan had a secret plan to expand its power to the southern

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[37] A record of the parliamentary inquires is available in the Diplomatic Archive of Japan. See MOFA, "Nishi gōshū buru-mu nihonjin kai ni oite honpō ishi shōhei no ken," Ishi shōhei kankei zakken, 1914.

[38] A clipping of the report is available in the Japanese Diplomatic Archive. Unfortunately, the clipping does not include the information of the title of the newspaper and date of publication. MOFA, "Nishi gōshū buru-mu nihonjin kai ni oite honpō ishi shōhei no ken," Ishi shōhei kankei zakken, 1914.

[39] Takeda Isami, *Monogatari: Ōsutoraria no rekishi* (Tokyo: Chūō Kōron Shinsha, 2000), 65.

hemisphere and therefore posed a serious threat to their country. The fear of Japan was clearly revealed in the contemporary popular literature, in which Japanese invasion of Australia was a repeating theme since the 1900s.[40] For example, *The Australian Crisis*, a futuristic fiction published in 1909, depicted a scenario of Japan's conquest of the Australian continent: Japanese navy invades the northern Australia and occupies a vast territory, but the British navy is unable to dispatch sufficient number of battleships to fight against Japan's fleet. As a result, the British Empire is forced to concede territory and make peace with Japan. In the preface, the author states that his motivation to write this fiction was to depict "the dangers to which the neighbourhood of overcrowded Asia exposes the thinly populated Commonwealth of Australia." "The central idea of the book," he continued, is to portray "the possibility of a coloured invasion of Australian territory."[41]

Although the story of *The Australian Crisis* is fictional, it reflects the widely spread anxiety toward a rising Japan in Australian society in the early twentieth century. The year 1905 was a turning point for Australian-Japanese relations. Prior to that, the two countries had a good diplomatic relation in general, but after Japan's victory in the Russo-Japanese War, more and more Australians started to consider Japan as a foe rather than a friend. In their eyes, the military victory of Japan meant Japan was going to play a more important and aggressive role in Asia, and the development would endanger the interests of Australia in the Pacific.

The renewal of Anglo-Japanese Alliance in the same year further exacerbated the anxiety of Australia. Initially, the military cooperation between the two island empires was built to

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[40] David Walker, *Anxious Nation: Australia and the Rise of Asia, 1859-1939* (St Lucia, Australia: University of Queensland Press, 1999), 109-110; Takeda Isami, *Monogatari: Ōsutoraria no rekishi* (Tokyo: Chūō Kōron Shinsha, 2000), 137-138.

[41] C. H. Kirmess, *The Australian Crisis* (Melbourne: Lothian, 1909). A full-text of the book is available on-line at http://www.australianculture.org/the-australian-crisis/

defend the expansion of Russia in Asia. After Russia had been defeated by Japan, its threat to Asia, especially to India had drastically decreased. Germany became the next main opposing force to the British Empire. In order to counterbalance the rapidly expanding German navy, Britain transferred its Eastern Fleet's major warships to station in the North Sea, and left the waters of the Far East under the protection of Japanese navy.[42] This meant that the whole Pacific, including the waters adjacent to Australia were patrolled by the Japanese navy. To Australia, which did not have its own navy at the time, this was tantamount to putting its national security in the hands of Japan.

Needless to say, Britain's decision caused a great sense of insecurity among Australian citizens, which generated rampant rumors about the coming Japanese invasion. *The Australian Crisis* and other similar works were a result of this atmosphere. The anxiety about Australia's vulnerability to Japan stimulated Australia to strengthen its defense. In the decade after 1905, the expenditure on national defense increased five-fold in support of a series of military reforms: the introduction of compulsory boyhood conscription, the establishment of a military academy at Duntroon, and the formation of the Australian Navy.[43]

The emerging imagination of Japan as a threat significantly affected how Australians looked at and reacted to the Japanese migrants. More and more people came to believe the "Japs" were all vanguards of Japan's overseas expansion, and therefore, their activities had to be regarded with suspicion. This mentality clearly revealed itself in the aforementioned parliamentary inquiries on the introduction of a Japanese physician to Broome. Though the doctor was presumed to enter Australia solely for the purpose of practicing medicine, who could

[42] Takeda, *Monogatari*, 134-137.

[43] Walker, *Anxious Nation*, 108; Takeda, *Monogatari*, 140-144.

guarantee he would not in his after-hours "become the owner of a pearling fleet, or take up a grazing area"? The parliament member who made this statement did not accuse anyone in particular but he obviously suspected Dr. Suzuki would collect information for Imperial Japan in preparation for its future invasion of Australia.

It is not an accident that Dr. Suzuki was singled out as a prospective spy. Many Japanese indentured laborers had been accused of committing espionage for their father country in the decades after the end of the Russo-Japanese War, particularly between 1908 and 1912.[44] Japanese divers and crews of pearling luggers were frequently accused of fathoming the sea, marking the water ways, and mapping the coastlines because due to their jobs, they usually worked alone for long periods of time in the coastal waters of northern Australia, from Thursday Island to Broome. The government archives of Australia preserve a large number of reports on Japanese espionage activities filed by local people from many places, and the consequent investigation reports on the suspected figures.[45] On the other hand, researches on Japanese government archives suggest that in this time period Japan did not have any territorial interest in Australia. It was only after the outbreak of the Pacific War in 1941 that Japan manifested an intention to invade the Australian continent.[46]

Some characteristics of Broome contributed to the whole affair becoming more sensitive. First of all, since Broome only had a small population, the whole town could only support the business of a single practitioner. There was already a British doctor in town, who also served as

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[44] Pam Oliver, "Interpreting 'Japanese Activities' in Australia, 1888-1956," *Journal of Australian War Memorial* 36 (2002): available online at https://www.awm.gov.au/journal/j36/oliver.asp; Pam Oliver, "Espionage and Paranoia: Accessing Australian responses to 'Japanese Activities,' 1870-1947," *Ritsumeikan Journal of Asia Pacific Studies* 11 (2003): 27-56.

[45] Pam Oliver, "Espionage and Paranoia: Accessing Australian responses to 'Japanese Activities,' 1870-1947," *Ritsumeikan Journal of Asia Pacific Studies* 11 (2003): 27-56.

[46] Pam Oliver, "Interpreting 'Japanese Activities' in Australia, 1888-1956".

the forensic doctor and the quarantine officer. Had a Japanese doctor come and won all the colored clients in town, the British doctor would have no choice but leave Broome, then, the local government would be forced to hire that Japanese doctor to perform post-mortems and impose quarantines. Was it appropriate to hire a foreigner to be a Federal servant and have him represent a state of Australia? Would the magistrate accept a Japanese doctor's forensic report and other documentations without a second thought? Moreover, as a busy sea port at the northwestern coast of Australia, steamers were continually calling at Broome from Singapore and other Asian ports. Wouldn't a Japanese doctor abuse his power to assist the smuggling of illegal Asian labor that had been surfacing in various business locations? Steamers brought not just cargos and laborers but also diseases. At a time when racism framed everything that Australians thought about themselves and the world, many people believed that the rampant epidemics in Australia—smallpox, cholera, dysentery, syphilis, typhoid, and beriberi—all had come from Asia and all colored migrants were propagators.[47] It was too risky to entrust an important duty like defending Australia's medical border to an oriental doctor, who himself was also a new immigrant.[48]

Despite the huge opposition it stirred, the federal government rejected the demand to revoke Dr. Suzuki's visa. The reason, at least in part, was the intervention of the British Empire. The imperial government in London worried that the movement to block the Japanese doctor might result in the deterioration of the relationship between Japan and Australia and, in the worst case scenario, might even undermine the Anglo-Japanese Alliance. Yet, the dissenters did not give up. Since they could not stop Dr. Suzuki entry into Australia, they decided to hinder him

[47] Warwick Anderson, *The Cultivation of Whiteness: Science, Health, and Racial Destiny in Australia* (New York: Basic Books, 2003).

[48] MOFA, "Nishi gōshū buru-mu nihonjin kai ni oite honpō ishi shōhei no ken," Ishi shōhei kankei zakken, 1914.

from obtaining a local medical license. Again, the cooperation between the two island empires saved his case. As mentioned before, thanks to the medical license reciprocity between Japan and Britain, medical licentiates of Japan were qualified to obtain a reciprocity certificate in Britain, and as a dominion of the British Empire, Australia had to acknowledge a British medical certificate. The Japanese embassy in Britain helped Suzuki to obtain a certificate issued by the General Medical Council in London, then used it to apply a permission to practice from the state of Western Australia. The local government and Commonwealth Parliament did not welcome the arrival of Suzuki, but when he presented his British credentials to the state health department in Perth, the authorities could find no reason to turn down his registration.[49] Suzuki arrived at Broome in 1910 and continued medical practice until 1912, when his visa was to expire. He had tried to stay for a few more years in Broome, but the Australian government rejected his application for visa renewal due to the ferocious opposition from its white citizens and medical associations.[50]

Competing and Negotiating in an Internationalized Arena

On the other side of the Pacific Ocean, Americans were also anxious about the emergence of Japan as an aggressive military power in Asia and the Pacific. There were far more Japanese immigrants in America than in Australia; therefore, it aroused more suspicion and vigilance. As a matter of fact, the rise of the anti-Japanese movement in the United States immediately became the diplomatic background to the discourse on Japanese invasion. Australia worried that Japanese-American relationship would unravel rapidly and this might lead to war. If there were

[49] MOFA, "Nishi gōshū ni okeru gaikoku ishi no kaigyo shikaku ni kansuru ken (Qualification requirements for foreign practitioners in Western Australia)," Ishi shōhei kankei zakken, 1910.
[50] JACAR Ref. B12082291000

to be a war between the two countries, Britain too had to declare war with America, bound as it was by the Anglo-Japanese Alliance. That meant Australia as a dominion within the British Empire would be dragged into a war, too.[51]

The mass immigration of Japanese to America began in the late nineteenth century: they arrived in Hawaii in the mid-1880s and then in the West Coast a decade later. Despite the relatively late start, the growth rate of Japanese immigrants was tremendous. Between 1885 and 1924, 200,000 Japanese moved to Hawaii and 189,000 to the continental United States.[52] A great majority of the immigrants were young male laborers who came to America as contract workers. Due to the widespread impoverishment of the peasantry in Japan, many rural youth left for cities and abroad in search of livelihood. America was a popular destination for the young emigrants because wages in the U.S were much higher than in their home country. A common laborer in Hawaiian plantations could earn four to six times more than their counterparts in the major cities of Japan, and the wages in the West Coast were often twice as much as in Hawaii.[53]

In addition to the indentured laborers there was also a small group of more educated and urban originated middle-class migrants. Physicians were a representative of the elite migrants. Due to the language and cultural barriers as well as the racial prejudice, overseas Japanese physicians were in general rare to have clients other than the local Japanese immigrants; therefore, their presence indicated the presence of a Japanese immigrant settlement. Conversely, when a community of Japanese immigrants grew bigger, the need for Japanese physicians rose as well, because most of the Japanese immigrants were lower-class laborers with very limited

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[51] Takeda Isami, *Monogatari*, 136.

[52] Ronald Takaki, *Strangers from a Different Shore: A History of Asian Americans* (New York: Penguin Books, 1989), 45.

[53] See Eiichiro Azuma, *Between Two Empires*, 29; Yuji Ichioka, *The Issei: The World of the First Generation Japanese Immigrants: 1885-1924* (New York: the Free Press, 1988), 65.

foreign language abilities and they preferred to see a Japanese physician with whom they could easily communicate with.

The case of Hawaii illustrates well the symbiosis between the Japanese migrant doctors and the growing overseas Japanese communities mostly composed of indentured laborers. In a sense, the history of Japanese doctors in Hawaii parallels the history of Japanese settlement in the islands. The earliest Japanese, who came to Hawaii, were often referred as "government-contract emigrant." Their immigration was arranged by an official accord between Japan and the Kingdom of Hawaii in 1867. Later, according to a convention between the two states, the Hawaiian government was obligated to offer "good medical attendance and medicines free of cost." To fulfill the requirement, Japanese doctors were recruited to provide complimentary medical service to Japanese migrant workers. They were also responsible for conducting physical examination at the quarantine stations in Yokohama and Honolulu in order to monitor the health conditions of the exported/imported workers to prevent contagious diseases. Between 1885 and 1894, more than twenty Japanese doctors were introduced to Hawaii through this track.[54] The annexation of Hawaii by the United States in 1898 did not stop the emigration of Japanese physicians to the islands. Quite to the contrary, the rapid growth of the population of Japanese indentured workers increased the demand for doctors from home, and therefore drew more Japanese medical personnel to Hawaii for career opportunities. These migrant doctors basically did the same jobs as their predecessors, only switched their employer from Hawaiian government to private plantation owners. It also began to have self-employed Japanese doctors. By the turn of the twentieth century, a large number of Japanese indentured workers turned into

[54] Eriko Yamamoto, "The Evolution of an Ethnic Hospital in Hawaii: An Analysis of Ethnic Processes of Japanese Americans in Honolulu through the Development of the Kuakini Hospital" (PhD Dissertation, University of Hawaii, 1988), 47-48; 53-54.

free agent workers after their contracts ended. That meant they were able to leave sugar fields for better jobs in cities, but that also meant they no longer enjoyed free medical service. Their need for healthcare created a market for Japanese doctors. It encouraged some of the government/plantation commissioned doctors to practice privately after their contracts ended. There were a few Japanese physicians who even chose to go to Hawaii by themselves and open their own private clinics.[55]

By 1902, there were already thirty Japanese physicians in Hawaii and another six or seven new medical migrants, who had just arrived and were planning to start a medical career on the islands.[56] Advertisements of these private clinics often appeared in local Japanese newspapers.[57] In Honolulu, one street in a high-class residential neighborhood was nicknamed "the Doctors' Row" because many Japanese doctors lived there.[58] It should also be noted that many of the doctors, like their compatriot contract laborers, were sojourners rather than permanent migrants. Most of them never wanted to stay in Hawaii forever, they only planned to work a few years, earn some money, then go home. Due to the very high mobility, the number of Japanese physicians, who had once practiced in Hawaii, far exceeded thirty. This booming business also benefited from the lax medical licensing system in Hawaii. Although as early as in 1859 the Kingdom of Hawaii had legally required foreign practitioners to be sanctioned by the government, it was not difficult for Japanese doctors to obtain a Hawaiian license, as long as the candidates possessed similar credentials in Japan or other countries.[59] A more rigid system was

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[55] Ibid, 70-72; Michael M. Okihiro, "Japanese Doctors in Hawaii," *The Hawaiian Journal of History* 36 (2002): 56-57; 107-109.

[56] JACAR Ref. B12082223800.

[57] Yamamoto, "The Evolution of an Ethnic Hospital in Hawaii," 58.

[58] Ibid, 64.

[59] Robert C. Schmitt, "Health Personnel in Hawaii, 1820-1974," *Hawaii Medical Journal* 34:2 (1975): 53;

instituted in 1895, which required all practitioners in the islands to take a licensing examination written in English, regardless of their previous training and licensing credentials. However, due to the protests of Japanese diplomats and migrant leaders, the Hawaiian government agreed to give Japanese candidates a grace period and permitted them to use translators in the examination until July 1902.[60] The arrangement considerably eased the difficulties of getting a Hawaiian physician license for Japanese medical personnel, but only temporarily.

In a sense, the enactment of a mandatory medical licensing examination in Hawaii, now an American territory, reflected a call for a strict medical regulatory system that was sweeping over the United States. In the same time period, almost all continental states also mandated an examination as part of their medical licensure requirements.[61] However, since, by an unfortunate coincidence, the new system was enforced at a time when an antagonism toward the Japanese was rising, the regulation of Japanese doctors inevitably got involved with the local racial politics. This is what happened in Hawaii during the 1900s and 1910s.

At the turn of the twentieth century, there were more than 60,000 Japanese residing in Hawaii, which constituted about forty percent of the total population. In the rest of the population, Caucasians constituted a little less than one-third, which was lower than indigenous Hawaiians but a little higher than Chinese immigrants.[62] Although Caucasians were a minority, they definitely dominated the government and the upper class. As for the medical community,

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Yamamoto, "The Evolution of an Ethnic Hospital in Hawaii," 56.

[60] Yamamoto, "The Evolution of an Ethnic Hospital in Hawaii," 57; JACAR Ref. B12082223800.

[61] The only exception was New Mexico, see David A. Johnson and Humayun J. Chaudhry, *Medical Licensing and Discipline in America: A History of the Federation of State Medical Boards* (Lanham: Lexington Books, 2012), 66.

[62] The population of Hawaii in 1900 was 154,001, including 29,799 Hawaiian (19.3 %); 7,857 part Hawaiian (5.1 %), 61,111 Japanese (39.7%), 25,767 Chinese (16.7 %), 28,819 Caucasian (18.7 %), 233 Negro (0.2 %) and 416 other ethnic group (about 0.5%). Robert C. Schmitt, *Demographic Statistics of Hawaii, 1778-1965* (Honolulu: University of Hawaii Press, 1968), 120.

there were about ninety Caucasian physicians in Hawaii at that time. They controlled the main medical facilities and the government medical board in the islands. Most of them were Americans, partly because a lot of non-American Caucasian physicians had left during the turmoil of America's annexation of Hawaii, and also partly because an increasing number of American doctors came in after the annexation.[63] There were thirty Japanese doctors, who were either contract physicians working for plantations or as private clinical practitioners.[64] The number of Chinese and indigenous doctors are unknown, but were certainly less than the Japanese. This is to say, the number of Japanese physicians was only one-third of that of the Caucasian physicians, but in proportion to the number of their clients (i.e., Japanese immigrants) was twice as large as that of the Caucasian physicians. Considering that Chinese migrant workers were most likely preferred to see Asian doctors, Japanese migrant physicians certainly had an advantage over the Caucasian physicians. Not surprisingly, the presence of Japanese doctors exerted a huge pressure on their Caucasian competitors. They asked the Hawaiian government to strictly ban physicians who had not passed the mandatory licensing examination from practicing medicine in the islands. This request, which ostensibly aimed at ensuring the quality of medical care and protecting the prestige of the medical profession, seemed very appropriate and legitimate. However, in effect, it created an almost unsurmountable obstacle for its real intended target – the Japanese migrant doctors in Hawaii. In pre-war Japan, German was taught as a medium to learn medicine in most of the medical schools, because modern Japan's medical education system emulated the German model. As a result, most Japanese physicians only

[63] JACAR Ref. B12082223800.

[64] For a more detailed discussion about the private practice of Japanese doctors, see Leon Bruno, *The Private Japanese Hospital: An Unique Social Phenomenon on Hawaii, 1907-1960* (Hilo, Hawaii: Lyman House Memorial Museum, 1985).

learned German as their foreign language, and few of them could speak English fluently. Except for a few who had studied medicine in America, for most of the Japanese migrant doctors in Hawaii it was almost impossible to pass the licensing examination in English. Caucasian doctors also tried to hinder the practice of Japanese doctors in other indirect ways. For instance, they made all the major medical institutions in Hawaii (which were under their control) close their doors to the Japanese. That meant Japanese physicians could not only not get any position in these institutions, but also could not use the facility and equipment at these institutions, and hence they could not perform any major operation or advanced treatment.[65] This repression by white doctors strengthened the solidarity of Japanese medical personnel. Three Japanese practitioners decided to establish a small but fully equipped hospital.[66] A medical association was built in 1896 with the objective to promote "academic progress and *professional security*" of Japanese doctors.[67]

The confrontation between the Japanese and white doctors reached a climax in 1902, the last year in which a foreign examinee could bring a translator with him during the licensing examination. The Japanese appealed for an extension of the grace period, but the request was turned down by the medical board. The Hawaiian government, moreover, proclaimed to revoke the qualifications of sixteen Japanese doctors who had passed the licensing examination with the assistance of interpreters. Although these sixteen doctors appealed to the United States circuit court and won the case, the Hawaiian government refused to obey the court's order allowing them continue their practice.[68] The local Japanese community felt grievously injured, as it meant

[65] Yamamoto, "The Evolution of an Ethnic Hospital in Hawaii," 73-75.
[66] Ibid, 74-75.
[67] Ibid, 81, emphasis added.
[68] JACAR Ref. B12082223800.

more than half of their doctors would no longer be allowed to provide medical services. Upset and in panic, the migrants protested through their newspapers, which provoked the intervention of the Japanese government. In response to the inquiry by the Japanese consul, the Hawaiian government claimed that the enforcement of mandatory licensing examination was to prevent quackery, not to block Japanese doctors and furthermore, that it was difficult to evaluate an examinee through translation, and it was also hard to find suitable interpreters to do so. As a final point, the Hawaiian government questioned Japan whether foreigners were allowed to take Japanese medical licensing examination in their own tongues?[69]

After a long diplomatic negotiation, Hawaiian government finally agreed to let Japanese physicians take the licensing examination with the aid of an interpreter. The compromise was made partly because the United States used it to exchange similar privileges for American doctors in Japan as discussed previously. Another reason that caused Hawaiian government to yield was the support of plantation owners, who were mostly Caucasians.[70] Many Japanese doctors were hired by the sugar plantations. Other than providing medical treatment to the sick or injured Japanese migrant workers, they also examined the workers' health conditions regularly, preventing malingering or other excuses to shy away from work.[71] Moreover, as the only few educated among the Japanese immigrant community, they also played the role of negotiators whenever there were conflicts between Japanese laborers and their Caucasian managers, helping the plantation owners to resolve labor disputes.[72] Hence, they were important personnel for the plantation owners.

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[69] JACAR Ref. B12082223900

[70] Ibid.

[71] Yamamoto, "The Evolution of an Ethnic Hospital in Hawaii," 52-53.

[72] Ibid, 54-55.

The concession by the Hawaii government did not mean a victory for the Japanese doctors. Despite, or because of, the popularity of their private practice, they had escalating conflicts with the White practitioners. Caucasian doctors often wrote letters to the Sanitary Bureau about the dubious professional training and questionable medical conduct of Japanese physicians. The director of the bureau, who was a Caucasian, opined that because Japanese physicians usually did not speak English well this gave rise to misunderstandings when they treated non-Japanese patients. Rumors and scandals about Japanese examinees' cheating in the licensing examination circulated widely and were reported, which tarnished the image and reputation of Japanese physicians as a whole. The House of Representative of Hawaii, which had discussed several times the legality of using translators in medical licensing examination, proposed to enact a law to ban it, which gained the open support of the Territorial Governor of Hawaii.[73] Moreover, Japanese doctor's relationship with the white plantation owners, who had been their major allies in the past, gradually turned sour. Since the average wages in continental America was far higher than that in Hawaii, many Japanese indentured workers chose to move to the West Coast after their contract ended. At the same time, Japanese laborers in Hawaii started to organize their own unions to demand higher wages and better working condition from their employers. This gave rise to conflicts between the Japanese plantation workers and the white plantation owners. The social tension between the different classes eventually created a hostility among the white people toward Japanese immigrants in general in local society.[74]

In the 1910s, the call to cancel the privilege of taking licensing examination with the aid of a translator for Japanese physicians rose again. Since more and more Japanese migrant doctors

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[73] JACAR Ref. B12082223900; B12082224100

[74] Gary Y. Okihiro, *Cane Fires: The Anti-Japanese Movement in Hawaii 1865-1945* (Philadelphia: Temple University Press, 1991), 45-49.

had come into Hawaii to practice during this period, and most of them did not speak English well, Hawaiian government decided to re-evaluate this privilege for Japanese physicians. At that time, there were several Japanese medical personnel who had just arrived in Hawaii and were preparing to take the licensing examination. On hearing this, they decided to hire a local lawyer to submit a petition to the authorities, and Japanese government was again called upon to interfere. However, both of these efforts failed this time.[75] 1914 was the last year that the Japanese could take the examinations in their own language in Hawaii.[76] California, another state that used to allow foreigners to take the medical licensing examinations with translator assistance, also discontinued the privilege in 1920. The keynote of the amendment was clearly manifest in the title of a relevant newspaper report: "Japanese Must Speak English."[77] Since then, except for a few who spoke English fluently (most of them were second-generation Japanese American), Japanese physicians could no longer obtain an American physician license. Four years later, the U. S. federal government enacted a new immigration law which outright banned the immigration of Japanese.

Imperialism, Sovereignty, and Medical Regulation

If the Australian and American xenophobia toward the Japanese was hysterical and racist, China had good reasons for its hostility toward the Japanese. A bitter and direct rivalry had developed between the two countries since the late nineteenth century, and China, unfortunately, was the underdog. After losing the Sino-Japanese War of 1894-95, China surrendered Taiwan, the Liaodong Peninsula, and its most important client state Korea to Japan. After that, Taiwan

[75] JACAR Ref. B12082224000; B12082224100

[76] Bruno, *The Private Japanese Hospital*, 13.

[77] "Japanese Must Speak English," *California State Journal of Medicine* 18:9 (1920): 345.

and Korea became the two major colonies of Japan. The Liaodong Peninsula had been temporarily returned to China, thanks to the intervention by Russia, Germany, and France, but was ceded to Japan again in 1905 after the Russo-Japanese War. With the Liaodong Peninsula as a beachhead, Imperial Japan gradually encroached into the hinterland along the Manchurian Railways and eventually turned the whole Manchuria into its third colony. Moreover, in China proper, Japan also enjoyed concessions, extraterritoriality, and privileges for building railways and mining. To a considerable extent, Japan's hegemony in East Asia was built at the cost of China.

Chinese had a mixed feeling about Japan. On the one hand, with a continuing confrontation between the two countries, there was a strong anti-Japan sentiment in Chinese society in general, though it fluctuated depending on time and place. On the other hand, many Chinese people admired the accomplishments of modern Japan. To defend against Western invasion, both Chinese and Japanese government launched a series of political, military, and economic reforms in the latter half of the nineteenth century in order to build strong and prosperous states. By the 1900s, Japan had already become a modern state that enjoyed a status equal to the Western Powers, while China was still a semi-colony subordinated to the West, and now to Japan as well. This sharp contrast provoked Chinese intellectuals to think about what China could learn from its main rival Japan. Thousands of Chinese youth went to Japan to study advanced knowledge and technologies that could help strengthen and enrich their country. At the same time, a substantial number of Japanese books were translated into Chinese in order to learn from Japan's successful experiences. Indeed, on China's road to modernization, Japan not only played the role as a rival and opposing force, but also as a model to follow.

A significant lesson that China learnt from Japan was the importance of Western medicine

in modern state building. Lei Hsiang-lin has noted that the adoption of Western medicine in China underwent a sharp re-orientation at the turn of the twentieth century. In the nineteenth century, Western medicine was basically introduced into China by foreign missionary doctors, focusing on the treatment (especially surgery) on individual patients. But at the beginning of the twentieth century, when Chinese students started to study medicine in Japan, they realized Western medicine was not only about the individual treatment but also a whole set of institutions that facilitated the state's governance over medical personnel and affairs of public health. They thought the close relationship between state and medicine was one of the key factors in transforming Japan into a powerful modern state. Therefore, China started to follow Japan's model to develop its own infrastructure of modern medicine.[78] Rogaski has pointed out that China's understanding and imagination of the modern state was deeply influenced by Meiji Japan, therefore, both countries specifically emphasized the concept of the obligation of a state to protect the national body (i.e. the public hygiene).[79] The administration of medicine thus was considered as an essential part of modern state building.

Hence, after the establishment of the Republic of China, a Sanitation Bureau was incorporated under the Ministry of the Interior in 1914. Like its Japanese counterpart, the main responsibility of this government agency was to determine who was qualified to practice medicine in the country. The following year, the government promulgated that candidates in medicine must possess the "standards insisted upon by all progressive countries" and their qualifications must be recognized by the government. However, in reality the regulatory power

[78] Sean Hsiang-lin Lei, *Neither Donkey Nor Horse: Medicine in the Struggle Over China's Modernity* (Chicago: the University of Chicago Press, 2014), 46-50.

[79] Ruth Rogaski, *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China* (Berkeley and Los Angeles, California: University of California Press, 2004).

of the state was next to nonexistent, partly because of the political fragmentation and instability of the country and partly due to the shortage of funding and staff.[80] Consequently, any person could commence medical practice without much interference from the concerned authorities. It was only after the unification of China in 1928 that the enterprise of medical regulation was carried forward by a relatively strong and centralized Nationalist government.

The Nationalist government prioritized the medical administration by establishing a new Ministry of Health to replace the old Sanitary Bureau under the Ministry of the Interior. Immediately after the founding of the Ministry of Health in 1928, the ministry issued the Provisional Regulations on Medical Practitioners (1929), which stipulated the qualifications and registration of physicians. Like its counterpart in Meiji Japan, the newly enforced regulation issued medical license to the following personnel: diploma holders from a government-approved Chinese or foreign medical school, licentiates of a foreign country, and successful candidates in government-administered licensing examination based on the knowledge of modern medicine (Article III). Anyone who possessed one of the aforementioned qualifications, as long as the credentials were verified by the Ministry of Health, could receive a medical license in China, irrespective of his or her nationality. (Article IV). In the same year, the Nationalist government also issued an order that all doctors, including foreign nationals, must be licensed and registered with the Ministry of Health and the respective municipal government.

By 1920, it was estimated that there were about 600 foreigners practicing medicine in China, who constituted about forty percent of all modern physicians.[81] Most of them were foreigners who enjoyed extraterritoriality in China. The new regulation of medical doctor

[80] Ka-che Yip, *Health and National Reconstruction in Nationalist China: The Development of Modern Health Service, 1928-1937* (Ann Arbor: the Association for Asian Studies, 1995), 15.
[81] Ibid, 13.

licensure was one of the many efforts to abolish the unequal treaties. Like what Japan had tried to do twenty years earlier, the Nationalist government, by regulating foreign physicians in China, attempted to defend and strengthen China's sovereignty.

However, Japan was not sympathetic to China's efforts. From the point of view of the Japanese government and other Western countries alike, the Nationalist government was trying to infringe on their extraterritorial rights. As a matter of fact, Japan was the country that protested most vehemently. Britain and America held a passive stance, letting the physicians in China to decide for themselves whether to accept it or not. Only Germany, which had a very small number of immigrants in China and had lost its concessions after WWI, agreed to follow the new licensing and registration system. Japan, however, tried every means to block it. In Shantou and Changsha, Japanese consuls registered strong protest with the local governments and refused to provide the information about their compatriot physicians. In Guangzhou, Beijing, and Shanghai, Japanese doctors and hospitals were instructed not to obtain any Chinese licenses. The consuls explained to them that while the Provisional Regulations on Medical Practitioners might appear innocuous since it recognized the qualification of Japanese doctors, but in reality, the enactment of the regulation would undermine the extraterritorial privileges of the Japanese. "The (Japanese) government would not tolerate the attempt of Chinese authorities to impose a Chinese law on Japanese nationals. It is a matter of principle."[82]

Furthermore, Japanese government also worried that once a comprehensive list and contact information of Japanese migrant doctors in China had been gathered, the Chinese authorities would be more controlling and "oppress" them more effectively. For example, the government might demand them to take the licensing examination in Chinese, or set other obstacles to revoke

[82] JACAR Ref. B04012775100.

their right to practice.[83] They had good reasons to worry. In 1928, during the Nationalist Northern Expedition, Japan deployed troops in the Shandong Province to protect the local Japanese consulates and settlers. Conflicts between Japanese troops and the Nationalist army and patriotic Chinese crowds broke out that caused a casualty of thousands of Chinese citizens, nearly twenty Chinese officials, and hundreds of Japanese settlers. After the incident, anti-Japanese sentiment escalated all over China. Fearing China's patriotic agitation would threaten the interests of Japan in South Manchuria, Japanese military leaders plotted to expand their control over the region, and eventually occupied the entire Northeastern China in 1931. This further stirred up China's antagonism toward the Japanese.

As a result, attacks on Japanese settlers erupted in many cities, and Japanese doctors very often became victims in anti-Japanese movements, because by the nature of their occupation, they had to stay for long periods of time at hospitals or clinic-residences, and these locations were widely known among local Chinese. According to a report from the Hakuaikai Medical Association, its four hospitals in Southern China suffered collateral damage in anti-Japanese movements every year since their opening. Fearing damages caused by the frequent riots, Hakuaikai asked its hospitals to update their property inventory more often, prepare emergency funding, and conduct evacuation drills regularly. The association also pointed out the hostility towards Japan seriously affected the willingness of Chinese patients to see a Japanese doctor, and thus ruined the business of the hospitals.[84]

It should also be noted that, in comparison with the other imperial powers, Japanese government had more direct and deeper involvement in its citizens' medical enterprises in China.

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[83] JACAR Ref. B04012694700.

[84] Taiwan Sōtokufu Keimukyoku, *Nanshi Nanyō no Iryō Shisetsu* (Taipei: Taiwan Sōtokufu Keimukyoku, 1936), 38-39.

The three largest Japanese medical chains—Hakuaikai Hospitals in Southern China, Tōjinkai Hospitals in Northern and Central China, and the affiliated hospitals of the South Manchuria Railroad Company in Northeastern China—were private institutes in name but behind the scenes, Japanese government was their biggest financial sponsor. While it is unclear how many of the Chinese who vandalized these hospitals in anti-Japanese movements were aware of this fact, from Japanese government's point of view, these attacks were definitely open provocations toward Imperial Japan.

Conclusion

In the previous two chapters, I have explored a rather laissez faire style overseas migration of medical doctors. Because there were no set standards and strict regulations governing the qualifications of foreign-trained physicians, doctors could easily spread their wings abroad without encountering any legal problems. This chapter discusses how the situation ended in the early twentieth century, when the presence and practice of foreign doctors came to be regarded as a legal, social, and national security problem. More or less simultaneously, many countries in the world started to institute more rigid requirements and controls over foreign physicians through the design of the licensing system. The hitherto free international movement of medical personnel thus could not avoid state interference anymore.

This development was a part and a parcel of a global wave of modern state construction. Some countries, such as Japan and China, imposed licensing control over foreign doctors within their territory in order to proclaim their sovereignty. Some countries, like Australia and America, used the regulation of foreign doctors as an important security mechanism to maintain public hygiene, white supremacy, and protect their states from the so-called potential yellow peril.

Despite their different objectives, the enterprises of these states were all driven by an idea that did not exist before the twentieth century: the sovereign right and obligation of a state to bring all healthcare providers within its territory under a single scheme of law and order.

In hindsight, the endeavor to institute a mandatory medical licensing system, to verify the qualifications of migrant doctors and to ensure that the foreign doctors spoke the national language fluently, seems to be a natural and neutral development of the modern medical profession. However, when a modern state and a national medical society started to launch these new medical institutions and regulations, there were actually many socio-political concerns behind these seemingly neutral issues. In many cases, the accusations and attacks on migrant physicians, from their moralities and qualifications to their language abilities, were in fact driven by racist or nationalist motivations, camouflaged under the guise of professionalism. Nation states promulgate many new medical regulations in the name of modernization; however, their real concern is to insist on their sovereignty and the right to monopolize power over medical care. The study of medical migration is a perfect touchstone to explore and examine the national and racial politics behind the professionalization of modern medicine.

Chapter Four

Advancing with the Empire:

The Geo-Social Mobility of Taiwanese Doctors under Japanese Imperialism

In 1940, Jian Qing-jie, a Taiwanese dentist practicing in Japan, wrote a letter to the Japanese Foreign Affairs Ministry to inquiring about his overseas employment opportunities. [1] After graduating from a Japanese medical school, Jian practiced in suburban Tokyo and was thinking about opening his own clinic. Although he preferred to live either in Japan or Taiwan, he was discouraged by the high cost of living and saturated job markets there. He had also considered Manchuria and other parts of Japanese-occupied China, but did not like the long, cold winters there. Jian eventually set eyes on Thailand, partly because of the warm climate, and partly because he had heard that the Thai government was welcoming foreign medical doctors. He also believed his emigration would contribute to the expansion of the Japanese empire, which was seeking to extend its control over Southeast Asia. As a holder of Japanese medical degree and license, Jian was sure he was qualified to practice in Japan and also Japan's overseas colonies, including informal territories such as Manchuria, but what about in a foreign country like Thailand? Would his qualification be recognized by the local government? Did he have to take some additional exams in order to get a license? Jian sought answers to these from the Japanese Ministry of Foreign Affairs.

This chapter examines medical migration in colonial context. Specifically, it elaborates how Taiwanese colonial subjects of Japan moved across the imperium with the hope of improving their inferior civic status and pursue upward social mobility through the medical

[1] JACAR（Japan Center for Asian Historical Records）Ref.B04012694400

profession. In previous chapters, I have discussed how Japanese doctors used migration as a means to enhance their career opportunities. To some extent, this chapter is the Taiwanese version of the story, as it demonstrates similar efforts by Taiwanese physicians. However, there is one crucial difference between the two cases. For Japanese medical migrants, the primary "motivating force" was the increasingly intense competition due to the professionalization and commercialization of medicine. For Taiwanese migrant doctors, the main "motivating force" was not the economic factor, but rather an aspiration to get rid of the discriminations imposed by Japanese colonial government to block their access to higher education and career advancement. It was precisely these restrictions that built and maintained the hierarchy between colonizers and the colonized and were the foundation stones of the colonial rule.

Hence, from this point of view, a Taiwanese doctor's attempt at overseas movement was not only an individual's career choice, but potentially a challenge to the imperial order and colonial rule. Theoretically, the upward social mobility of colonial subjects would blur the differentiation between colonizers and the colonized thus undermining the whole hierarchical system. For the colonizers, the challenge primarily came from native doctors. As the most educated intellectuals among the indigenous people, they were the ones most likely to blend into Japanese society, thus posing a challenge to the discriminative colonial order.

This study is inspired by Benedict Anderson's discussion of the constrained geo-social mobility of colonial intellectuals, which he termed as the "cramped pilgrimage" of indigenous elite. Anderson has argued that the career prospects of colonial intellectuals were confined to their respective colonies. It was generally impossible for the colonized to get ahead outside their home territories. "[J]ust as in the British Empire, Japanified Koreans, Taiwanese or Burmese had their passages to the metropole absolutely barred. They might speak and read Japanese perfectly, but

they would never preside over prefectures in Honshū, or even be posted outside their zones of origin."[2]

This study does indeed show that the career passages of colonial intellectuals were institutionally stifled. The objective of this study, in part, is to explore how while Japan attempted to cramp the career pilgrimage of native physicians through the design of the medical licensing system, nonetheless, more and more Taiwanese moved abroad for purposes of education and employment, especially during the last decades of Japanese rule (1895-45). As the letter of Jian Qing-jie vividly reveals, Taiwanese medical personnel were very imperially conscious. They were informed and alert to the new opportunities in other Japanese territories and eager to spread their wings abroad. Obviously, although Japan and its colonial government in Taiwan set up various institutional obstacles to block them, at least for some of Taiwanese elite, these hindrances were not insurmountable. How did Japan limit and constrain the overseas opportunities of its colonial subjects? What circumstances gave rise of the outflow of Taiwanese medical personnel? If, as Anderson argued, the "cramped pilgrimage" was an important means to produce the otherness of the colonized, how did the overseas activities of Taiwanese doctors impact the imperial order of Japan? Thus, a study of the migration of Taiwanese doctors is also simultaneously a study of the formation of the Japanese empire.

Building Colonial Subjecthood in the Medical Profession

Medical migration provides a lens to explore Japan's empire-building since the mobility of physicians (area within which they could legally practice) was subject to state regulation, a fact

[2] Benedict Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism* (London and New York: Verso, 1991), 99.

that reveals the state's close relationship with, or control over, the medical doctors. In the first chapter, I discussed how the Meiji Japan's modern state-building created a homogenous national medical profession. By establishing a compulsory licensing system, the state government monopolized the power to supervise the training and licensing of doctors. As state-licensed professionals, they were entitled to practice anywhere within the state territory. In short, the newly formed medical profession was sanctioned by the state and its jurisdiction overlapped with its territories.

With the expansion of modern Japan from a nation state to an empire, the Japanese medical profession was also imperializing. And similar to the Japanese empire-building, the imperial formation of the Japanese medical profession too involved not only the governance of new territories but also the incorporation of indigenous peoples. When Japan occupied Taiwan as its first colony in 1895 by defeating China, the imperial power suffered severely due to the poor conditions of sanitation in the newly acquired territory. Many Japanese soldiers, officials, and civilians were exposed to and perished from epidemics as there were very few "reliable" doctors – i.e., physicians trained in Western bio- medicine that had been accepted as the standard in Japan – in the island. The native practitioners were healers trained in traditional Chinese herbal medicine, whose services were untrustworthy in the view of colonizers. A few foreign missionary doctors and their Taiwanese disciples practiced modern medicine, but they were all too few to meet the demand. This shortage of medical resources not only hindered the progress of Japanese colonization but was a challenge to Japan's intention of transforming the island into a showpiece model colony. At a period when all major world powers were colonial empires, the capacity to possess and rule a colony was considered a necessary mark of a civilized state, a status Japan aspired to.

To transform Taiwan into a safe and healthy territory was thus an urgent priority for the Japanese empire, and the realization of the goal depended heavily on the existence of a body of well-trained doctors. To ensure the quality of healthcare providers, the Governor-General promulgated the Regulation on Medical Practice in Taiwan in May 1896, within a month of the establishment of civil administration. This was the first time in the history of Taiwan that the qualifications of medical doctors were brought under government regulation and surveillance. According to the law, only those holding licenses granted by the Home Ministry (of Japan) or the Bureau of Civilian Affairs (of Taiwan) were permitted to practice medicine in the island. Those in violation were fined or imprisoned.[3] In the following year, the Governor-General established a medical training center in Taipei in order to train native people as practitioners of cosmopolitan medicine, which in 1899 was upgraded into a formal medical school. Taipei Medical School[4] was the only medical school in Taiwan for nearly four decades. As a chartered institution of the Governor-General, its graduates were automatically licensed by the colonial government and therefore qualified to commence practice anywhere in the island.

The founding of Taipei Medical School brought in its wake a lot of controversies. When the Governor-General of Taiwan submitted the bill to establish a medical school, it was widely criticized as an overambitious and impractical plan. Some criticized the timing of the decision stating that it was an inopportune time to begin since the indigenous people had not been fully

[3] "Taiwan igyō kisoku", *TSKR*， V00061¥ A013(1896).

[4] The exact name of the school had been changed for several times: The Subsidiary Training Center of Taipei Hospital (台北病院附屬醫學講習所;1897-99), Taiwan Governor-General Medical Academy (台灣總督府醫學校,1899-1918) Medical Special Institute of Taiwan Governor-General Medical School 台灣總督府醫學校醫學專門部（, 1918-1919）, Taiwan Governor-General Medical Special School (台灣總督府醫學專門學校, 1919-1928), Taipei Medical Special School (台北醫學專門學校; 1928-1936) ; The Subsidiary Medical Special School of Taihoku Imperial University (台北帝國大學附屬醫學專門部, 1936-1945). For readers' convenience, hereafter I will mention it as Medical School.

enlightened.[5] After all, Japan had ruled the island for only four years. All basic educational projects had just been started. The only modern educational institutions that had been established for the Taiwanese at the time were the "common schools" (*kō gakkō*) whose levels were only equivalent to elementary schools in Japan. Further, the number of common schools and students enrolled were very small. Moreover, since most Taiwanese could not speak Japanese, the curriculum of common schools focused on basic language learning. Training in basic sciences was very elementary and limited. Hence, the opponents insisted that even for the most "enlightened" of Taiwanese students, their Japanese language ability and preliminary knowledge were insufficient. Hence, it was problematic whether they had the requisite background to study medical science, which undoubtedly required advanced understanding of both Japanese language and modern science. There were also opponents who deprecated as the capability of the faculty and quality of the curriculum. The objectors claimed that teachers in the school were unqualified since they were all merely practitioners who worked at Taipei Hospital and lacked real teaching experience.[6] The design of the curriculum was also too ambitious, i.e., too difficult, given the standing of the native students.

But the severest criticisms originated from more fundamental issues: Were the indigenous people sufficiently intelligent to be educated? Was it a good idea to provide colonial subjects with opportunities for higher education? What underlay these questions was a blunt assertion that the Taiwanese were not only inferior, but also a potential threat to the Japanese empire. As Yamaguchi Hidetaka, the first president of Taipei Medical School, frankly admitted at the

[5] Tsurumi Yūsuke, *Seiden Gotō Shinpei*, vol.3 (Tokyo: Fujiwara Shoten, 2005), 439. The Medical Special School of Taiwan Governor-General

[6] Yamaguchi Hidetaka,"Taiwan zong du fu yi xue xiao cheng li zhi you lai yi ji jiang lai zhi qi wang," trans. Han Liang-chun in *Taiwan shi liao yan jiu* 8 (August, 1996), 52.

opening ceremony, many Japanese spoke out against the school because they believed that the knowledge of medical science was just too advanced for the natives. Consequently, all the effort would be in vain. Furthermore, to enlighten indigenous people might lead them to rebel against the colonial masters. This had already occurred in the Philippines, Cuba, and India.[7] Therefore, providing advanced education to Taiwanese would be hazardous to the security of the empire.

The establishment of the Taipei Medical School would have been cancelled or postponed for decades but for the firm patronage of the Governor-General. As a matter of fact, Japan's first colonial medical school project was not inaugurated in Taiwan, but instead in Okinawa. At the time, its primary advocate was Yamaguchi Hidetaka, who coincidentally had served in the Okinawa government before coming to Taiwan. At that time his proposal was considered extremely radical and unwelcome and Yamaguchi himself was regarded as a trouble maker by his colleagues.[8] The proposal ended in the forced resignation of Yamaguchi. This unpleasant experience however did not quench his ambition. After accepting the directorship of Taipei Hospital, Yamaguchi soon decided to propose the project to the colonial government of Taiwan. This time he succeeded, primarily because he had a powerful supporter: Gotō Shinpei, the head of civilian affairs at the Governor-General and arguably the most important colonial engineer of the Japanese empire. A doctor by training, Gotō advocated the great value of medicine as a tool both for civilizing the colonial subjects and for legitimizing the colonial regime. One of his most famous and influential proposals was to let physicians serve as sowers of civilization and pioneers of imperial expansion, similar to the role the missionaries had played in Western

[7] Ibid.

[8] Ōtsuru Masamitsu, "Aru meiji no senkusya: Yamaguchi hidetaka" in Guo li Taiwan da xue i xue yuan fu she i yuan edit, *Tai da I yuan bai nian huai jou* (Taipei: Guo li Taiwan da xue i xue yuan fu she i yuan, 1995), 5

colonial empires.[9] Both Gotō and Yamaguchi proclaimed that it was Japan's destiny to spread and patronize modernization in East Asia, and the dissemination of medical education in colonies was the first step in this endeavor because it cultivated the necessary talents required to achieve the long-term goal.[10] Accordingly, they condemned the opponents to the Taipei Medical School as being shortsighted, narrow-minded, who failed to understand the real spirit of the Japanese empire.

Promoted by Gotō and Yamaguchi, the Taipei Medical School was built in 1899. It was the only higher educational institution in Taiwan until the founding of the Taihoku Imperial University in 1928.[11] Taiwanese warmly welcomed the school as it provided access to higher learning and in Chinese culture education was traditionally valued as an avenue for social mobility. Wu has argued that the Governor-General utilized the desire of Taiwanese for higher education in order to channel native elite into fields useful for Japan's colonial projects, of which medicine was the primary example.[12] By restricting the content of higher education to the field of medical science, the colonized were also discouraged from seeking a career in more "dangerous" fields such as law and politics. This tactic proved to be very successful. Becoming a physician was the most desirable profession for the Taiwanese throughout the period of Japanese colonial occupation. As the most educated people in native society, Taiwanese doctors were not merely healthcare providers but also active in public life.[13] They played a leading role in a great variety of social reforms, cultural activities, and political movements. In many senses, doctors represented top

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[9] Fan Yanqiu, *Yi bing, Yi xue yu zhi min xian dai xing : Ri zhi Taiwan yi xue shi* (Taipei: Dao Xian, 2005), 71.

[10] Yamaguchi Hidetaka,"Taiwan zong du fu yi xue xiao cheng li zhi you lai yi ji jiang lai zhi qi wang," 52.

[11] Wu Wen-xing, *Riju shiqi Taiwan de shehui lindao jieceng*(Taipei: Wu nian, 2008), 87.

[12] Ibid., 83-84.

[13] For a thorough discussion of the political and social participation of doctors in colonial Taiwan, see Ming-cheng M. Lo, *Doctors within Borders: Profession, Ethnicity, and Modernity in Colonial Taiwan* (Berkeley and Los Angeles, California: University of California Press, 2002).

stratum of colonial Taiwanese society. To become a doctor thus was also to climb up the ladder of success.

As Tsurumi has pointed out, medicine functioned as a "main safety valve" by means of which colonial subjects could legitimately seek upward mobility.[14] The scale and scope of social mobility, however, were under careful control. Although Taipei Medical School represented Japanese colonial schooling at its highest level, the education offered by the school was not really as advanced in comparison with its Japanese counterpart. For example, to enter a medical school in Japan, a student had to at least finish junior high school education.[15] In contrast, Taipei Medical School only required its prospective students to have six years' primary education.[16] Furthermore, although the school's curriculum was modeled after its Japanese counterpart, it was not completely carried out in reality. For instance, although forensic medicine, hygiene, and psychiatry were all listed in the curriculum, as of 1914, none of these subjects were taught at the school, and until the 1920s the school did not provide any foreign language courses (English or German).[17] Moreover, according to the regulations of the Japanese Ministry of Education, the faculty of a medical school should include at least three teachers who had bachelor's degrees in medicine (i.e., those who had graduated from medical departments of imperial universities rather than lower-ranking medical colleges).[18] But when the school was founded in 1899, there were only two members in the faculty fulfilling this requirement and they were both administrators, not teachers. It was only as late as 1903, that there were at last three

[14] Patricia Tsurumi, *Japanese Colonial Education in Taiwan, 1895-1945* (Cambridge: Harvard University Press, 1977), 77.

[15] Sugaya Akira, *Nihon iryō seidoshi* (Tokyo : Hara Shobō, 1976), 58-59.

[16] Patricia Tsurumi, *Japanese Colonial Education in Taiwan, 1895-1945*, 25.

[17] Lin Jichong, *Taida yixueyuan bainien shi* (Taipei: Jingmin, 1997), 60-66.

[18] Sugaya Akira, *Nihon iryō seidoshi*, 58.

professors with bachelor degrees listed as faculty at the school, but one of them was soon transferred to another place.[19] In short, although Taipei Medical School was chartered by the Taiwan Governor-General, the level of its prospective students, curriculum, and teaching faculties were lower than what was required by law for medical schools in Japan.

To be fair, the lower academic standing of Taipei Medical School might not have been an intentional arrangement, but a result of the situation in Taiwan, which as a newly seized territory was still in short supply of qualified instructors. Nevertheless, the gap between the colonial medical school and its metropole peers gave Japanese authorities a convenient excuse to grant its graduates an inferior qualification, which impeded the prospects of Taiwanese doctors. In an official document sent to colonial government in Taiwan, the Cabinet Legislation Bureau of the Japanese Imperial Government informed the Governor-General that because of the deficient qualifications of Taiwanese practitioners, they should be designated only as contract workers (*shokutaku*) or assistants (*koin*).[20] Throughout the colonial period, Taiwanese were almost exclusively placed in low-ranking positions in public hospitals and state-headed health projects under the leadership of Japanese physicians, and with only one exception, none of the colonized was appointed as a professor at the medical school. With limited prospects of promotion to a higher position in the colonial health services, most Taiwanese doctors went into the private sector and became self-employed practitioners. In view of this, the courses not taught at the medical school—forensic medicine, hygiene, and psychiatry— provide a profound clue, for their absence; as each of the subjects excluded could have empowered the colonized with the ability to leverage political power.

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[19] See the faculty lists in 1899 and 1903 in Lin Jichong, *Taida yixueyuan bainien shi*, 60-66.

[20] "I inn kan sei no ken", *TSKR*，11:3:9 (1912).

The inferior qualifications of Taiwanese doctors not only impeded their chances of promotion at home but also stifled their overseas career opportunities. As mentioned earlier, because Taipei Medical School was a chartered school of the Taiwan Governor-General, graduates of the school would receive medical licenses that were valid in Taiwan. However, since the school did not match the standard of the domestic medical schools, its alumni were not acknowledged by the Japanese Imperial Government, and hence unable to get certificate to practice medicine in Japan. This was in sharp contrast to the Japan-trained doctors, whose qualifications to work overseas were legally ensured in the Regulation on Medical Practice in Taiwan. Taiwan was later to become a model for Japan's other colonies. After the acquisition of Korea and Manchuria, the local colonial governments also gave priority to the improvement of public hygiene and regarded the founding of medical schools and cultivating native physicians as an important means of colonial rule. As in the case of Taipei Medical School, the graduates from these schools too were licensed to practice only in their respective colonies, and not elsewhere in the imperium.

Consequently, the once homogenous Japanese national medical profession was spilt into two strata. Physicians trained in Japan, who held degrees and licenses sanctioned by the Imperial Government, were qualified to practice anywhere in the Japanese empire, while physicians trained in colonies, the recipients of more limited medical education and credentials granted by the Governor-Generals, were restricted to practice only within the territories where they were certified. While this stratification might appear neutral and professional, they were in fact ethnically discriminative. Until the 1920s, all colonial medical schools accepted only native students, so in practice, with few exceptions, the second-tiered physicians were exclusively colonial subjects. This tiered structure also reveals the divergent expectations of the empire from

its physicians. While Japanese doctors were expected to be versatile professors who could serve in any of the territories in need of medical personnel, indigenous doctors were cultivated to become healthcare providers in their own native society. In short, they were destined to be colonial elite, not imperial elite.

The chasm between the Japanese licensing system and its sub-systems in Taiwan might be regarded as the institutionalization of the "cramped pilgrimage," to borrow Anderson's term, for it exemplifies how Japan restricted the geo-social mobility of colonial intellectuals through institutional design. In doing so, the empire was able to systematically create, justify, and operate the inferiority of the colonized. As Stoler, Cooper, and many other scholars in Colonial Studies have reminded us, "the otherness of colonized person was neither inherent nor stable; his or her difference had to be defined and maintained."[21] In this case, the otherness of colonial subjects was defined and maintained in the name of medical professionalism. On the other hand, because the restriction of Taiwanese physicians' geo-social mobility was claimed to be a result of the lower standard of medical training in Taiwan rather than their ethnicity, the institutional obstacle opened a space that allowed the colonized to evade it with a smart stratagem; that is, to study abroad.

Studying Abroad in the Imperium

Despite the not-quite-satisfactory academic standing of Taipei Medical School and all the restrictions on its graduates' career opportunities, it was still a dream school for Taiwanese youth, primarily because medicine was the only field in which higher education available to them.

[21] Frederick Cooper and AnnLaura Stoler edited, *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley: University of California Press, 1997), 7.

Before the establishment of the Taihoku Imperial University in 1927, Taipei Medical School was the only institution of higher education in Taiwan, and was also highly selective. In the first twenty years of the school, the number of applicants increased more than six fold, from 46 in 1900 to 618 in 1918, while the number of enrolled students remained relatively stable, about thirty to fifty each year.[22] Hence, except in the first few years, the entrance examination of the medical school had always been competitive —the average acceptance rate was maintained in the 8% to 10% range.[23] The statistics clearly reveal a keen interest of Taiwanese youth in medical education and the control of the colonial government over their opportunities to access social mobility through higher learning.

It was in this context that medical schools in Japan came to the attention of Taiwanese students. Because the Governor-General admitted the validity of Japanese licenses and diplomas, according to the Regulation on Medical Practice in Taiwan, Japan-trained physicians were qualified to practice in Taiwan. Going to Japan thus became an attractive alternative for those who wanted to become doctors but could not make it at home.

Taiwanese studying abroad in Japan could be traced back to 1895, the same year that marks the beginning of Japanese colonization, and it experiences a rapid growth in the late 1910s and the years following. This grows into such a massive wave by the last decade of Japanese rule, that the Governor-General had lost count of the number of Taiwanese studying in the home islands.[24] Initially, most Taiwanese students in Japan were elementary and high

[22] Wu Wen-xing, *Riju shiqi Taiwan de shehui lindao jieceng*, 93-94.

[23] Lin Jichong, *Taida yixueyuan bainien shi*, 89.

[24] Patricia Tsurumi, *Japanese Colonial Education in Taiwan, 1895-1945*, 127. Scholars estimate there were more than 60,000 Taiwanese graduates from Japanese colleges and universities. See Wu Wen-xing, *Riju shiqi Taiwan de shehui lindao jieceng*, 112.

school students, but over the years college (and graduate) students become the majority. [25] This change in the composition of the student body suggests the desire for higher education and its inaccessibility at home were important motivations that drove the flow of Taiwanese youth to metropole schools.

Not surprisingly, medicine was by far the most popular subject. According to Wu Wen-xing's survey, more than two-fifths of Taiwanese students in Japan studied medicine, and the ratio climbed further to about one-half after the 1930s.[26] The number of graduate students was even more striking. During the entire colonial period of the 116 Taiwanese who got Japanese doctorates, except for one Doctor of Laws, they were all Doctors of Medical Science.[27] Scholars believe that in the last decades of Japanese rule perhaps more Taiwanese doctors were trained in Japan than in Taiwan.[28] But unfortunately, in the absence of complete data, it is hard to tell how many Taiwanese studied medicine abroad during the colonial era. What can be ascertained is that as late as in the 1950s, a decade after the end of Japanese rule, Japanese-trained doctors still constituted one third of all the physicians in Taiwan.[29]

What triggered Taiwan's rush to study-abroad was the expansion of higher education in Japan. Because the First World War temporarily cut off the export of European goods to Asia, Japanese commerce and industry boomed in the late 1910s and early 20s. The economic boom created an urgent need for highly educated workers in modern sectors and hence a demand for greater access to colleges and universities. At the same time, by the end of the Meiji era primary education in Japan had been well established. The duration of compulsory schooling had been

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[25] Wu Wen-xing, *Riju shiqi Taiwan de shehui lindao jieceng*, 105.

[26] Ibid, 107.

[27] Ibid, 109.

[28] Jin Jungwon, "Fangyan diguo sijierdong: zai chaoxian xue i de Taiwan ren," *Taiwan Shi Yan Jiu* 19:1 (2012): 90.

[29] Bian Fengkui, *Ri zhi shi qi Taiwan liu xue Riben yi shi zhi tan tao* (Taipei: Bo yang wen hua, 2011), 447

extended from four to six years and the attendance and graduation rates had reached as high as 98 percent and 80 percent respectively.[30] The increase in the number of elementary school graduates drove the competition for high schools and eventually led to the rapid expansion of higher education in the Taishō and early Shōwa era. The enrollment in institutions of higher education grew more than threefold, from 14,062 in 1915 to 62,525 in 1935.[31] In the same two-decade period, the ratio of college and university graduates to the total population also rose from 1.1 percent to 3.2 percent, a near three-fold expansion.

The expansion of higher education caused the resurgence in medical education. Because medicine was considered an essential tool for the Meiji government's modernization projects, Japan experienced a sudden boom in medical education in the 1870s. At the peak of this trend, there were 48 medical schools in Japan, but most of them were short-lived, partly because they could not fulfill the newly placed state requirement on medical education and partly because the maintenance of public medical schools caused enormous financial burden on the municipalities. By 1912, on the eve of the Taishō period, the number of medical schools had dropped sharply to 14, but rose again in the following years, to 27 in 1928.[32] The change in private medical education was even sharper. At the zenith of the Meiji medical education boom, 25 of the 48 medical schools in Japan were private institutions; only two of them survived to the Taishō era. The number of private medical schools increased again to 10 by 1928. That is, eight of the thirteen new medical schools founded in the 1910s and 20s were private institutions.[33]

The proliferation of Japanese medical education enlarged the opportunities for

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[30] Amano Ikuo, *Kyōiku to senbatsi no shakashi* (Tokyo: Tsukuma Shobō, 2006), 245-246.

[31] Ibid, 247.

[32] Kōseishō, *Isei hachujūnenshi* (Tokyo: Insatsukyoku, 1955), 825.

[33] Ibid.

Taiwanese to become physicians. Because there were far more medical schools in Japan than in Taiwan, it was relatively easier for a prospective Taiwanese student to get admission in the metropole. This was particularly true in the case of private institutions, since they were often less well-established and prestigious. For instance, in 1920, the acceptance rate of Japanese public and private medical colleges (not including the medical department of universities) were 19 and 21 percent, while the enrollment rate of Taipei Medical School was as low as 10 percent.[34] Moreover, since there was only one medical school in Taiwan, the entrance examination of Taipei Medical School was a single-shot test for medical applicants. If failed, they had no option but to give up or try again the following year. But in Japan, applicants could apply to as many medical schools as they wanted to (and most of them did), so even if they failed in some entrance examinations, they might still be able to get accepted by some other medical institution. In other words, by studying abroad in Japan Taiwanese youth could not only have more opportunities to enter but also less competitive ones.

Not surprisingly, most students studying abroad were male, but there were female students too. Because Taipei Medical School accepted only male students, all Taiwanese female doctors were trained overseas, especially in Japan. Three of the newly founded medical colleges in Japan were women's schools and they trained more than 100 Taiwanese women physicians.[35]

Although studying abroad offered a wider and easier avenue to become a doctor for the

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[34] Amano Ikuo, *Kyōiku to senbatsi no shakashi*, 235; Lin Jichong, *Taida yixueyuan bainien shi*, 88.

[35] According to Fu Daiwie, there were 101 Taiwanese graduates from the three women's medical schools in Japan. The exact number should be higher, since Fu's survey is based on a medical directory of Taiwan and therefore excludes people who did not return and practice in the island. Fu Daiwie, *Yaxiya de xin shen ti : xing bie, yi liao yu jin dai Taiwan* (Taipei: Qun xue chu ban you xian gong si, 2005), 378.

Taiwanese, only people from wealthy families could afford the expense. The primary destination of Taiwanese students in Japan was Tokyo, which was home to nine medical schools. Except the medical college of Tokyo Imperial University, all the other institutions were private, including two schools that had most Taiwanese students: Tokyo Medical Special School and Nihon Medical Special School.[36] This implied that in addition to the higher cost of private schools, the students also had to be able to afford the notoriously expensive living costs in the imperial capital. How expensive was studying medicine in Tokyo? According to a survey of household economy conducted by Taiwan Governor-General in the 1930s, nearly a half of Taiwanese families had a monthly income of 70 to 100 yen.[37] At the same time, the expense for four-years at Tokyo Medical Special School was 3,200 yen, which was quite reasonable as compared to other metropole medical schools.[38] Nonetheless, it was a fortune for most Taiwanese families that had to invest 3 to 4 year's income in order to support a child to complete a degree from the institution. Nihon Medical Special School was even more expensive since it was a five-year school and hence the students had to pay one more year's tuition and fees. In contrast, the four-year training at Taipei Medical School cost only about 2,700 yen.[39]

While Taiwanese medical students were heading to medical schools in Japan, Japanese medical students were also moving to medical schools in the colonies. Initially, all medical schools in Taiwan, Korea or Manchuria were built to train native physicians, and they exclusively accepted indigenous people. But with Japan's adoption of more inclusive colonial policies in the 1920s, the schools also opened their doors to the Japanese. This new principle of inclusivism, to a

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[36] Wu Wen-xing, *Riju shiqi Taiwan de shehui lindao jieceng*, 109

[37] Taiwan Sōtoku Kanbō Kikakubu, *Kakei chōsa hōkoku* (Taipei: Taiwan Sōtoku Kanbō Kikakubu, 1940). A reprint of the report can be found in *Kyū shokuminchi kakei chōsashū*, vol. 1(Tokyo: Seishisha, 2000), 3.

[38] Ōbunsha henshūbu, *Zenkoku jyōkyū gakkō taikan* (Tokyo: Ōbunsha, 1938), 609.

[39] Ibid, 617.

large extent, was a response to the political upheavals that occurred both within and beyond the Japanese empire. During the First World War the Allies declared self-determination as an important objective for the postwar world order. This principle was restated at the Paris Peace Conference in 1919 and resulted in the fragmentation of the Austro-Hungarian and Ottoman empires. In colonial Taiwan and Korea, the idea of self-determination as a right of nations stimulated intellectuals to launch demonstrations and petitions against the social, political, and economic inequalities under Japanese rule, and these movements soon gained wide support from indigenous society. Apprehensive that the flourishing of nationalist sentiments might encourage demands for national independence, Japan decided to widen and deepen the assimilation of its colonial subjects under the slogan "Impartiality without Discrimination" (*isshi dōjin*), which promised full equality of opportunities for Japanese and native peoples.

In the field of education, the equality of opportunity translated into mixed education of Japanese and the colonized, but only in middle schools and above. Although Taiwan Governor-General (as well as its Korean counterpart) believed coeducation would promote integration and mutual understanding between Taiwanese and Japanese, they were also concerned that the policy might eventually result in the assimilation of young Japanese by their Taiwanese classmates, since native students would be the overwhelming majority in classrooms and on campuses, especially in elementary schools.[40] To prevent such an unpleasant situation, the colonial government decided to maintain racial segregation in primary education, on the excuse that the Japanese language ability of Taiwanese children was not as proficient as their native-speaker peers.

[40] Chen Pei-feng, *Tong hua no tong chuang yi meng: ri zhi shi qi Taiwan de yu yan zheng ce, jin dai hua yu ren tong* (Taipei: Mai tian chu ban, 2006), 284-285.

Taipei Medical School became co-educational after 1918, and number of its students were from the metropole, especially nearby areas such as Kyūshū and Okinawa. About one third of the Japanese students and alumni of the institution were from the two regions, according to a 1933 record.[41] What made studying abroad in Taiwan appealing to metropole youth? Less expense was undoubtedly a powerful incentive. The tuition of Taipei Medical School was almost the cheapest among the Japanese medical colleges and universities in the colonies, only higher than Keijō Medical Special School (in Seoul), another colonial medical school, and much lower than all metropole medical schools.[42] Moreover, because Japanese medical colleges and universities were heavily concentrated in the Honshū island, especially in Tokyo,[43] for students from Okinawa, Kyūshū or Shikoku regions studying medicine in Taiwan was an economical choice since it was geographically adjacent and had lower living cost. On the other hand, the applicants to Taipei Medical School seldom came from the regions east of central Japan, simply because Taiwan was too distant for them.[44]

The higher acceptance rate for Japanese students was another incentive that motivated metropole youth to apply to Taipei Medical School. Although ostensibly coeducation was to give Taiwanese an equal opportunity to access middle and higher education, what it did in practice was the opposite. Since the entire entrance examination of Taipei Medical School was conducted in Japanese, Japanese native speakers naturally had greater advantage than Taiwanese examinees. Rough statistics show the average acceptance rate for Taiwanese students was 6 or 7:1, compared

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[41] A survey of the native places of Taipei Medical School students can be found in *Taiwan sōtokufu taihoku igaku senmon gakkō ichiran* (Taipei:Taiwan sōtokufu taihoku igaku senmon gakkō, 1933), 124-127. For medical students from Okinawa, see Matsuda Hiroko, "Kindai Okinawa no iryo to Taiwan: Okinawa ken shusshin sha no shokumin chi igakkō he no shingaku," *Imin kenkyū* 9 (2013): 97-122.

[42] For the cost of Japanese medical schools, see Ōbunsha henshūbu, Zenkoku jyōkyū gakkō taikan, 609-643.

[43] 21 of the 26 metropole medical schools were located in the Honshū island; nine of them were in Tokyo.

[44] Ōbunsha henshūbu, Zenkoku jyōkyū gakkō taikan, 615.

to 2 or 3:1 for Japanese students.[45] A professor at the school also noticed that most of the Japanese students in Taipei Medical School were those who had failed to get into medical schools in Japan— many of them had re-taken the entrance examinations over several years.[46] This observation indirectly proved that for Japanese students, it was easier to get into Taipei Medical School than any other medical school in Japan. On the other hand, in order to be accepted, Taiwanese applicants had to perform far better than their Japanese competitors. The view of some scholars that the colonial government or the board of Taipei Medical School probably limited the number of Taiwanese students enrolled is quite possible. As noted above, Taiwan Governor-General's Office was concerned that if Taiwanese students dominated the campus in numbers, Japanese students might become indigenized. However, no direct evidence has been found to support such an argument and probably there is no hard black and white evidence. Further, under the slogan "Impartiality without Discrimination," it is inconceivable that any administrative rule limiting the number of Taiwanese student would be openly set by any Japanese colonial authorities. More likely, the limitation would have been carried out in a more subtle and inconspicuous manner under the guise of some legitimate excuses. [47]Oral tradition has it that some Taiwanese suspected the Governor-General or school administrators favored Japanese applicants in the entrance examinations by giving Taiwanese applicants lower grades in the sections such as composition, oral interview or physical examination (where grading was likely to be arbitrary).[48] Although these testimonies do not involve the Taipei Medical School, a

[45] Lin Jichong, *Taida yixueyuan bainien shi*, 92.

[46] Ibid, 89

[47] Shozawa Jun, "wo de fang tan ji jing yan: ri zhi shi dai Taiwan ren de zi wo su zao si," *Kou shu li shi* 6 (1995): 242.

[48] Shozawa Jun, "Kikitori chōsa: gaichi no shingaku taiken," *Gunma Daigaku Kyōiku Gakubu kiyō Jinbun shakai kagaku hen* 44-45 (1995-96): 155-156; 161-163.

similar situation could also have occurred at the school.

Print Media and the Circulation of Information

Hence, the outflow of Taiwanese to Japanese medical schools was not an isolated phenomenon, but part of a larger studying-abroad fever that impacted youths across the empire. A cultural infrastructure that stimulated and supported the movement was the flourishing industry of publishing guidebooks for students seeking higher education. This specific genre first appeared in the Meiji era, with the abolishing of the status system and created the possibility of social mobility and projected the self-made man as the veritable cult icon among young people. As school education became the new principle avenue for self-advancement, Japanese youth needed reliable sources that could provide specific and current information about educational opportunities and requirements. To fulfil the market niche, numerous periodicals appeared in the late 1880s which aimed to provide youth guidance in how to advance in society, specifically through education.[49]

While the journals were suited for all students, they were particularly useful for provincial youth who aspired to pursue higher education in Tokyo. As the national hub of higher education, Tokyo was the home to numerous colleges, universities and preparatory schools; though not all of them were well established and accredited. For most students, especially those from the provinces, to discern the real standing of a school was not an easy task, since their impressions about the institution were based on newspaper advertisements, which tended to give

[49] Earl H. Kinmonth, *The Self-Made Man in Meiji Thought: from Samurai to Salary Man* (Berkeley and Los Angeles, California: University of California Press, 1981), 120-123.

an over-glowing description.[50] In this context, the guidebooks became popular because they supplied the data that helped readers to choose the school they wanted to get admitted to: location, tuitions, academic atmosphere, years required for graduation, scholarships, placement, legal status and the consequent privilege (such as postponement of military service). After making their choice, readers also found information and advice that was useful for entrance examination preparation, such as subjects to be studied, dates of examinations, enrollment rate, as well as sample questions and notes on various subjects, especially in science and mathematics.

With the expansion of higher education in the Taishō and early Shōwa era, the publication of youth-oriented periodicals became more lucrative and thrived. Like their Meiji forerunners, the Taishō and Shōwa guidebooks also offered information for school selection and advice for examination preparation, but some significant changes had occurred. First, in the beginning, schools introduced by the guidebooks in Meiji era were mostly concentrated in Tokyo. Then schools in other urban areas such as Kyōto and Ōsaka started to be included in late Meiji period. From the Taishō period on, schools in Japanese colonies also began to appear frequently. Second, although reader's response columns had already appeared in those Meiji guidebooks, the flow of information was basically one-sided, i.e., most information was gathered, processed and summarized to the readers by editors and column writers (usually anonymous). However, in Taishō and Shōwa period, the readers of guidebooks were no longer passive information receivers, but also played the roles of information givers and advisers. They often introduced the schools they were currently enrolled in and frequently shared their experiences of preparing and taking exams, in many cases on the invitation of the editorial department. As a result, by

[50] Ibid, 125-126; Sugawara Akiyoshi, "Meiji ki ni okeru manabi to shingaku annai sho" in Sugawara Akiyoshi edited, *Juken shingaku gakkō* (Tokyo: Gakubunsha, 2008), 191-198.

reading those guidebooks, readers not only built connections with column writers and editors, but also had some interactions with other readers.

The pinnacle of this trend was the *Examinee's Biweekly* (*Juken junpō*), the most popular guidebook-periodical in the 1930s and 40s. Initially, the journal was a newsletter for subscribers of the correspondence courses of Ōbunsha, a publisher that offered mock examination questions for college-bound students and provided corrections and comments on their answers.[51] Probably because of this member-only orientation, *Examinee's Biweekly* greatly emphasized the interaction with its readers, and they were good at it. This characteristic was particularly obvious when compared to its major competitor, *Examinations and Students* (*Juken to gakusei*). Although *Examinations and Students* also accepted articles contributed by readers (who were very often people who had successfully entered prestigious imperial universities), most accounts in the journal were written by professors, who were invited to introduce their own schools, offer advice for academic and examination preparation, or design and answer sample questions.[52] In fact, information and suggestions from the authorities were a major selling point of *Examinations and Students*.

In contrast, *Examinee's Biweekly* was more eager to incorporate the voices of readers, in many different and creative ways. For example, other than the commonly seen reader's response column, *Examinee's Biweekly* also had a marketplace page for selling and buying used textbooks and other exam preparation material at bargain price. Moreover, Ōbunsha held round table discussions from time to time, inviting those who successfully entered college or

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[51] Terasaki Masao and Asamuma Nio, "Keisetsu jidai: senj*ū* *sengo no* kōtō kyōiku shigan sha ni motarasareta kyōiku jōhō" in Sugawara Akiyoshi edited, *Juken shingaku gakkō*, 82.

[52] Funaki Yoshio and Sugawara Akiyoshi, "Juken to gakusei 1981 nen -30 nen no kōtō kyōiku juken jōhō" in Sugawara Akiyoshi edited, *Juken shingaku gakkō*, 51-60.

university after taking Ōbunsha's correspondence courses to share their experiences of how to prepare and take exams as well as introduce their current schools to other readers. Some of them were even commissioned by Ōbunsha as on-campus correspondence for *Examinee's Biweekly* in order to gather information and to write reports. Actually, most of the *Examinee's Biweekly's* reviews of schools and universities were written through this kind of correspondences, only a small part of them were by the editorial department or school faculties. In doing so, the *Examinee's Biweekly* was able to foster connection, communication, and sense of community with and among the readers, and hence gained advantage over *Examinations and Students* and other similar journals.

Colonial Students and Schools frequently appeared on guidebook-periodicals. For instance, the 1939 January issue of *Examinee's Biweekly* published the minutes of a round table discussion by the Ōbunsha members at Tokyo Medical Special School in order to explore "the real image of the school and inform examinees how to prepare for the coming entrance examination of the school." Among the fourteen student members at that meeting, as can be inferred from their surnames and the high schools they graduated from, there were evidently two Taiwanese students who came from the colony. It was also mentioned in the discussion that one of the traits of the Tokyo Medical Special School was that there were many students from Taiwan—about twenty Taiwanese students a year (the annual enrollment number was around 140 to 150). Therefore, Taiwanese students were especially encouraged to apply the Tokyo Medical Special School by the attendees at that meeting. In the same issue, there was also an article on Keijō Pharmaceutical Special School of (in Seoul). Its author was anonymous, but according to the article he was a student from the metropole who had got accepted by the college the previous year. He explained that his school was a good choice for college-bound

students in the Japanese home islands, because its graduates would have plenty of job opportunities. Compared to the increasingly competitive job market in Japan, Korea, Machuria, and China proper were still virgin lands full of opportunities for a newly licensed pharmacist. According to that article, Keijō Pharmaceutical Special School had three hundred students at that time, approximately seven-tenth of them were from the Japanese home islands, three-tenth from Korea and Taiwan.

The frequent references to students and schools of the colonies suggested the target market of the examinee-oriented guidebooks/journals covered the entire Japanese imperium, and their readers/customers included both Japanese and Japan's colonial subjects. Due to their great influence and popularity, these periodicals were also a good channel for colleges and universities to advertise in. For example, the president of the newly founded Daegu Medical Special College in Korea (established in 1933) submitted a public letter to *Examinee's Biweekly* in 1936 entitled "Message for Applicants to Our School: Those Who Want to Spread Their Wings in Manchuria and Korea, Come Here!" As a new school, Daegu Medical Special School was not as renowned as its peer schools, especially for people outside the Korean Peninsula. An introductory article in popular journals could enhance the awareness of the college among students, thereby bringing in more and better applicants. His efforts prove to be very successful. In the following years, the number of applicants to the school reached a new historical record; quite a few of them were from other Japanese territories.[53] Two months after the publication of the president's public letter, a reader who called himself "a Taiwanese fan of Daegu Medical Special School" claimed he would apply to that school the following year in the reader's response of the *Examinee's Biweekly*. The following month, another reader under the alias of

[53] Jin Jungwon, ""Fangyan diguo sijierdong: zai chaoxian xue i de Taiwan ren," 117.

"Daegu Medical Special School Mania" wrote a letter to rally for the previous reader. Another month later, some other reader responded that since there are many medical schools in Korea, those who plan to go to Daegu to attend the entrance exam should, in the meantime, apply for other schools in order to increase the chance of acceptance.[54] A Taiwanese physician recalled that he applied for both Keijō Medical Special School and Pyongyang Medical Special School, and when he went to Korea to take the entrance examinations he ran into many other Taiwanese applicants in the examination halls. He got accepted and chose to go to the medical college at Keijō (today Seoul), and the decision was supported by his family as well as relatives. When he returned to Taiwan after graduation, he was often acclaimed as a talented doctor educated at a prestigious medical school.[55]

The Dual Border-Crossing of Taiwanese in Manchuria

On the eve of the collapse of the empire, there were 63 medical schools in the Japanese imperium and more than forty of them were located in colonies: two in Taiwan, eight in Korea, one in Sakhalin, fifteen in Manchuria, eleven in (Japan-occupied) China, and six in Southeast Asia.[56] All of them accepted both Japanese and native students. This means that every year several hundreds or thousands of youth travelled to other territories of the empire seeking admission to their dream school. Throughout the colonial period Japan was the most popular study-abroad destination for Taiwanese medical students, but there were also quite a few among them who decided to attend the schools in China, Korea, Southeast Asia, and most importantly,

[54] Ibid.

[55] Ibid.

[56] Kōseishō, *Isei hachujūnenshi* (Tokyo: Insatsukyoku, 1955), 825; Izumi Takateru, *Gaichi no igakkō* (Osaka: Medikarurebyu sha, 2009).

Manchuria.[57]

Although the purpose of Taiwanese intellectuals' migration was to circumvent the restriction on their social mobility imposed by Japanese colonial government, it was the institutions and culture of the empire as a whole that made their movement possible. Had either the Taiwan Governor-General refused to recognize the credentials issued by the metropole, or without the detailed information and advice given by the guidebooks on schools outside the island, it is doubtful if Taiwanese students and medical personnel would still have been so eager to move abroad. In this section, I will demonstrate how the social mobility of Taiwanese physicians in Manchuria benefited from the imperial institutions, culture, and network.

Compared to their Korean and Japanese counterparts, Taiwanese migrants in Manchuria were much smaller in number and more homogenous in social class. According to a partial survey done by Xu Xueji, in the late 1930s there were more than seven hundred Taiwanese living in Manchuria and most of them were highly educated middle class: government officials, high school and college teachers, technicians, college students, and most important of all, physicians.[58] Medical doctors and students together constituted nearly one fifth of this group of people. Indeed, the association between Taiwanese and physicians was so strong in the minds of local people that they sometimes called Taiwan "the island that produces doctors."[59]

As early as the 1910s, some Taiwanese medical personnel had embarked on a career in Manchuria, and they had moved there with their former Japanese teachers in Taiwan. After the

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[57] Xu Xueji, ""Rizhi shiqi Taiwan ren de haiwai huodong: zai manzhou de Taiwan ren ishi," *Taiwan Shi Yan Jiu* 11:2 (2004): 1-75; Jin Jungwon, ""Fangyan diguo sijierdong: zai chaoxian xue i de Taiwan ren," *Taiwan Shi Yan Jiu* 19:1 (2012): 84-160; Zheng Lihang, "Rizhi siqi zai zhongguo de Taiwan ishi (1895-1945)," Master's thesis, National Chengchi University, 2012.

[58] Xu Xueji, ""Rizhi shiqi Taiwan ren de haiwai huodong: zai manzhou de Taiwan ren ishi," 3.

[59] Xu Xueji, *Ri zhi shi qui zai "Manzhou" de Taiwan ren* (Taipei: Zhong yang yan jiu yuan jin dai shi yan jiu suo, 2002), 121.

Russo-Japanese War (1904-05), Japan obtained the Kuantung Leased Territory as its concession. To reconstruct the newly acquired land, some Japanese bureaucrats were transferred from Taiwan to Manchuria to assist in the local colonial projects. Among the relocated officials was Gotō Shinpei and several medical professors and sanitary officers. As mentioned earlier, as a colonial engineer Gotō insisted on the great value of medicine in civilizing the colonial subjects and legitimizing the colonial regime. The belief formed the core of Gotō's colonial policy in Taiwan, and he was now aiming to transplant the Taiwanese experience in Manchuria. Consequently, after assuming the presidency of South Manchuria Railway Company (hereafter SMRC), Gotō decided to build hospitals along the railway lines, and a medical school (The South Manchuria Medical Academy, which was later renamed Manchu Medical University) was founded by the company in Mukden. Some of the first employees of the newly established institutions were Gotō's ex-colleagues in Taiwan. One of them was Omi Kaoru, the director of SMRC Hospital in Dalain. Before moving to Manchuria, Omi was a surgery professor in Taipei Medical School and he brought some of his favorite students with him to the new position. One of them was Meng Teng-chen, who later established one of the largest private hospitals in Dalian.[60]

Manchuria was not a popular destination among overseas Taiwanese doctors in the 1910s. Most of them preferred to practice in South China, given its geographical, linguistic and cultural affinity to their home island. South China, Fujian Province in particular, remained a hub of overseas Taiwanese physicians until the 1940s,[61] but the number of Taiwanese doctors in Northeast China grew continuously and considerably. After the 1930s Manchuria

[60] Lin Jichong, *Taida yixueyuan bainien shi*, 35.

[61] Liu Shi-yung and Liu Ts'ui-jung, *Oral History of Dr. David Landsborough IV* (Taipei: Institute of Taiwan History Academia Sinia, 2007), 103 and 113.

had become a new major settlement of Taiwanese medical migrants, and they showed a strong inclination to permanently settle down. They brought in friends and relatives, and most Taiwanese graduates from medical schools in Manchuria chose to practice there.[62] What made Manchuria so appealing to the Taiwanese?

Although it could be over-emphasized, some clues indicate that Taiwanese medical professionals' career was less hindered in Manchuria. Unlike the situation in Taiwan, here they were allowed to fill relatively higher administrative positions despite the strong quasi-governmental status of their workplace. For example, before Meng Teng-chen opened his own hospital, he was promoted as the president of a branch hospital of SMRC. Xie Qiu-tao's case might be somewhat atypical, for he chose to be a sanitary administrator instead of providing medical treatment, which was more profitable. He was appointed as the first leader of the Public Health Board of Manchukuo.[63] None of these promotions could have been achieved by the Taiwanese in Taiwan.

There are also materials suggesting that Manchuria was a relatively non-discriminating environment for Taiwanese, or at least that was how they felt. While the Taiwanese Governor-General and the Japanese government that patronized industries in Taiwan hesitated to employ Taiwanese as executives, the quasi-official companies in Manchuria such as SMRC were more willing to hire Taiwanese employees regardless of their ethnic status.[64] As a Taiwanese put it, "although Manchuria was also ruled by Japan,

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[62] Zheng Lihang, "Rizhi siqi zai zhongguo de Taiwan ishi (1895-1945)," 72.

[63] Du Cong-ming, *Hui yi lu zhi Taiwan shou wei yi xue bo shi : Du Congming* (Taipei : Long wen chu ban she gu fen you xian gong si, 2001), 118-119.

[64] Xu Boyan zhu, *Xu Bing, Xu Boyan hui xiang lu* (Taipei Shi : Zhong yang yan jiu yuan jin dai shi yan jiu suo, 1996), 289-291; also see Yang Zang-yue, "Yang Zang-yue xian sheng fang wen ji lu" in *Ri zhi shi qi zai "Manzhou" de Taiwan ren*, 440.

everything was ruled by laws there. As long as a person has the capacity, he can enter any governmental institution and school he wants."[65] Many other Taiwanese also mention that their opportunities for promotion were far better than at home or in Japan and their treatment was basically equal to the Japanese.[66] In fact, some Taiwanese doctors asserted that a major reason prompting them to go to Manchuria was to avoid the discriminative colonial institutions in Taiwan. For instance, Jian Ren-nan went to Manchuria because he participated in the petition demanding the setting up of a legislative assembly in Taiwan (so that Taiwanese could exercise the franchise) and consequently became a target of the Governor-General's oppression. Consequently, he chose to leave the island and joined the SMRC hospital in Dalian.[67]

The turning point in Jian Ren-nan's life is ironic if not self-contradictory: he was forced to leave his hometown because of his challenge to Japan's colonial rule in Taiwan, but later decided to become an agent of Japan in controlling Manchuria. However, Jian was not the only one who shared a similar fate. Xie Chun-mu, another participant in the petition, spent several months traveling in Japan, China, and Manchuria trying to evade the Governor-General. After visiting many places, he decided that Manchuria was the best place for a Taiwanese to succeed in the world, since all his friends (many of them were medical doctors) had prospered and successfully accumulated considerable wealth. He contended that of all the overseas Taiwanese, it was the immigrants in Manchuria who were the first to stand out and be counted as somebody in the local

[65] Liu Jian-zhi, "Liu Jian-zhi xian sheng fang wen ji lu" in *Ri zhi shi qi zai "Manzhou" de Taiwan ren,* 14.

[66] Chen Tin-ching, "Chen Tin-ching xian sheng fu ren fang wen ji lu" in *Ri zhi shi qi zai "Manzhou" de Taiwan ren,* 298.

[67] Guo Wei, "Dalian di qu jian guo qian de Taiwan ren ji qi zu zhi," *Dailian wen shi zi liao* 6 (Dec. 1989), 71.

society.[68]

In all these narratives, the success of Taiwanese (medical) migrants in Manchuria were claimed to be due solely to their own capacity; Manchuria was only a stage that provided fair opportunities. This belief, however, was only a partial truth, if not wishful thinking. The relatively "non-discriminating" atmosphere the Taiwanese enjoyed in Manchuria was in fact largely derived from their being Japanese colonial subjects, as well as their Chinese ethnicity. The former allowed them to enjoy all the favorable institutional advantages designed for Japanese colonizers, while the latter allowed them to benefit from the unique "ethnic concord" politics in Manchukuo, a protectorate of Japan.

Unlike Taiwan or Korea, Manchukuo was not a formal territory of Japan. While the empire tightly controlled the real power, it also made great efforts to project the image of Manchukuo as an independent sovereignty. That is to say, despite the real situation on the ground, in theory the Japanese were not and ought not to be in a privileged position in Manchukuo. In order to guarantee an "impartial" treatment between Japanese (or *Nikkei*) and Chinese (who were referred as Manchurians or *Mankei*) in all national examinations, from college entrance examination to civil service examinations, the two groups were always evaluated and enrolled separately.

In the following discussion, I will show how Taiwanese medical students played their in-between status to get accepted by the medical colleges in Manchukuo. The school most Taiwanese were admitted to was the four-year ancillary college of the Manchu Medical University in Mukden founded by SMRC. Although the program was less respectable than the regular seven-year program of the university, its graduates could also get a physician's license to practice and hence could begin earning sooner. However, there was one problem: although the

[68] Xie Chun-mu, *Taiwan jin wa saku miru* (Taipei: Taiwan min bao sha, 1930), 132-33.

university was open to both Japanese and Chinese, the ancillary college was reserved exclusively for *Mankei* students in order to protect the local people's opportunities to receive medical training, since they were less fluent in Japanese, which was the language of instruction at the school.[69]

Hence, to enter that college the Taiwanese had to first establish themselves as Manchurian. And by what means were they to prove that they were *Mankei*? According to the reminiscences of the alumni of the school and the regulations in other universities, it appears that the applicants' basic information material and the guarantees from their sponsors played an important role here. To prove they were who they claimed to be, the applicants had to provide a copy of their household register in order to prove that they did in fact live at the address written on the application form. Further, the applicants needed a guarantor to accept responsibility that all the information written on the form was true, and an applicant's guarantor had to be either the father or elder brother, or someone who could be in the place of the father or elder brother and take responsibility.[70] Generally speaking, the guarantor of a student was usually one of his or her older relatives, but sometimes could be a friend of the family. For example, when Yu Xi-qian entered Xin-Jing Medical University, his guarantor was Kishi Nobusuke, his father's boss who later became a minister and then prime minister in Japanese government.[71]

Since the schools relied on the material submitted by the Taiwanese students to determine which group they belonged to, their ethnic status was quite flexible. For example, Liu Jian-zhi, a student from Taiwan, registered as a Manchurian by using the address of one of his relatives'

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[69] Takenaka Ken'ichi, *Manshū" ni okeru kyōiku no kisoteki kinkyū*, vol.3 (Tokyo: Kashiwa Shobō, 2000),196.

[70] "Jian kuo da xue zhang cheng" in Wu Qiang edit, *Dongbei lun xian shi si nian jiao yu shi liao* (Changchun shi: Jilin jiao yu chu ban she, 1989), 618-619.

[71] Yu Xi-qian, "Yu Xi-qian xian sheng fang wen ji lu" in *Ri zhi shi qi zai "Manzhou" de Taiwan ren*, 30

homes in Mukden, and his guarantor was his uncle-in-law's brother, who was also a Taiwanese immigrant. Liu's wife, Xie Jiu-zi, too was a Taiwanese. She was registered as a Chinese from Guangdong Province of South China, which could have been her ancestral home before moving to Taiwan. As a matter of fact, Xie had finished her middle school education in Manchuria because her father, a physician, ran a hospital there. In any case, both of them were recognized as Manchurian by the Manchu Medical University and they successfully graduated from the ancillary medical college. The experiences of Liu and his wife were not unusual. In 1941, three Taiwanese students were enrolled by Xin-Jing Medical University, but their formal statuses in the school records were all different. The first student, Yeh Ming-gang, was recommended by Hualiang Middle School in Taiwan and hence, he undoubtedly entered the university as a *Nikkei* from Taiwan. Another student was from Japan, who had already changed his name into a Japanese-style name, was registered as a Japanese student from the metropolis (thus also a *Nikkei*). The third was enrolled in the school as a Manchurian (*Mankei*), because his elder brother served in the Manchukuo government. And all of them graduated successfully. Obviously, the universities in Manchuria adopted a very lax attitude toward the national self-identification of Taiwanese applicants and students.

It should be noted that Japanese was the common language used in all institutions of higher education in Manchukuo, and hence Japanese was a required subject in the entrance exams of all the schools, including the ancillary medical college of Manchu Medical University. Also, because all the examination papers, from the entrance exams to the mid-term exams, were set in Japanese, examinees' grades were significantly influenced by their felicity in Japanese. Hence, by registering as a *Mankei* these Taiwanese students not only had an advantage in the entrance exams, but also in the course of their studies, since as imperial subjects who received Japanese

education from elementary school onwards, their Japanese was certainly much better than that of a real *Mankei*. Consequently, it was easier for them to get admission, pass exams, and graduate.

Of course, it goes without saying that the only reason why Japanese was so important in Manchukuo was because of Japan's colonial rule there. It was hard to imagine that the schools were not aware of the tricks these Taiwanese students played, since some of the Taiwanese students changed their status from *Mankei* into *Nikkei* soon after entering the school or during their period of study.[72] Ethnic or nationality status was just something they could manipulate in order to get the best advantage at any particular moment. And perhaps for the same reason the administrators of the Manchukuo higher educational institutions –most of them were Japanese –were willing to overlook these activities. After all, whether the Taiwanese youths entered the schools either as *Mankei* or *Nikkei*, it appears that because of their cultural background and linguistic ability, they in general, were naturally closer to the *Nikkei* students outside the classrooms.

[72] Yu Xi-qian, "Yu Xi-qian xian sheng fang wen ji lu," 31. Liu Jian-zhi, "Liu Jian-zhi xian sheng fang wen ji lu,"15.

Conclusion

When Philipp Franz von Siebold and William Willis came to Japan in the nineteenth century, their presence was troublesome in the view of the Tokugawa shogunate, which had adopted a policy of national seclusion. For this reason, European doctors were required to stay in the treaty ports and were not permitted to enter the rest of the country. They were also expected to treat only foreigners, not the native people (but they did not always follow that requirement). The obstacles Siebold, Willis, and other Western physicians encountered in Tokugawa and early Meiji Japan were because they were foreigners, not because they were doctors trained outside the country. No Japanese authorities requested information about their educational background or attempted to test their professional expertise. Neither were they mandated to obtain a Japanese physician license. This is in great contrast to what contemporary medical migrants confronted in Japan and, indeed, most countries in the world. Today, any foreign-trained personnel who seek to commence medical practice in Japan are commanded to submit their foreign credentials for the evaluation by the Japanese government, pass the licensing examination conducted in the Japanese language, and register with the Japanese Home Ministry. It makes no difference whether a candidate is a foreigner or an overseas-trained Japanese.

This research examines the transformation of the international migration of medical doctors from a *laissez faire* free movement to a flow under the governance of modern states. Ultimately, this is a medical history of the building of modern Japan in a globalizing world. How did Japan draw and consolidate the boundaries of its state and empire to control the influx of people? In what ways did the demarcation help legitimize the sovereignty of Japan in the international society comprised by modern states? This study seeks to answer these questions

through a discussion of the problems surrounding the qualifications of foreign doctors in Japan and the destinations of overseas Japanese physicians.

When a medical licensing system was legislated by the Meiji government in the 1870s, it functioned as a declaration of the medical opening of Japan. Western (now read as modern) medicine was adopted as the only officially recognized knowledge system in Japanese medical institutes and institutions, and licentiates of other countries were qualified to practice (Western) medicine in Japan. Essentially, the establishment of the licensing system manifested the desire of the Meiji state to modernize the country and make Japan more homogenous with the West. In doing so, Japan sought to join the international society led by Western countries and be accepted as an equal partner. The qualifications of foreign doctors were not considered a problem, partly because they had extraterritoriality and were therefore exempt from Japanese laws and partly because, at that time, creating the image of an open Japan was a more urgent issue for the Japanese government than border control.

However, priorities changed after the turn of the twentieth century. With the rise of Japan as a major imperial power, the presence and practice of foreign doctors in the territory came to be viewed as a potential threat undermining the sovereignty of Japan. As such, it was believed that these foreign residents should be brought under the governance of the Japanese government. In domestic and international politics, regulation of foreign doctors was also used as a method to demonstrate Japan's status as a sovereign independent country, or taken as a hint to check the equality of Japan with other modern states. Japan was not the only country that sought to impose more rigid control over the immigration of doctors through the design of a licensing system in the early twentieth century. China, America, Australia, and many places in the world were operating in a similar manner. However, the exact process varied from country to country. China,

for example, did not seek to license foreign doctors until the late 1920s. The relatively late development made China a land of opportunity for Japanese practitioners, who were struggling within Japan's increasingly competitive medical market following the professionalization of medicine. Even after the 1920s, the Nationalist Government still could not effectively exercise its licensing power over Japanese doctors in China. The inability to protect the medical boundaries of the country impeded the Chinese government's ability to establish an exclusive authority and thus obstructed the construction of China's modern state.

The establishment of a medical licensing system in Japan not only helped control the inflow of foreign physicians. It also assured control of the mobility of Japanese doctors within the boundaries. Under the licensing system, all Japanese doctors had to be trained in Western medicine and their professional expertise had to be authenticated by the central government in the form of granting diplomas and licenses. Only then, as state-sanctioned professionals, were they permitted to commence medical practice in any part of Japan. However, with the Japan's expansion from a nation-state to a colonial empire, the homogenous national medical profession was spilt into two strata in order to create a hierarchy in the medical society between native Japanese and Japan's colonial subjects. Taiwanese and Koreans received a deficient education in colonial medical schools. This gave Japanese authorities a convenient excuse to grant them inferior credentials. As a result, their qualifications were valid only at home, which institutionally obstructed their overseas career opportunities. By contrast, the qualifications of Japanese doctors were recognized all over the imperium. In short, while Japanese doctors were prepared to become imperial elites and could be active in any territory of the empire, Taiwanese and Korean physicians were expected to be colonial elite and active only in their respective regions.

Nevertheless, research on overseas Taiwanese doctors suggests that in the last decades of

Japanese rule, especially in the 1930s and 40s, Taiwanese physicians also actively moved within the empire for purposes of education and employment; they used emigration as a strategy to circumvent the discrimination that restricted their chances for upward social mobility at home. There were several reasons that made the geo-social mobility of Taiwanese doctors in the Japanese empire possible. The gaps between the Japanese medical licensing system and its sub-systems in the colonies created a loophole that allowed the colonized to maximize their career opportunities. The expansion of higher education in Japan increased the chances of Taiwanese to get accepted by metropole's medical schools. A thriving print media facilitated the circulation of information within the imperium and consequently stimulated the desire to move abroad.

Overseas activities of Taiwanese doctors revealed another more inclusive layer of Japan's imperial formation in the sphere of the medical profession: the emergence of an imperial culture and network shared by medical personnel in different territories of the empire, regardless their ethnicity. "Domestic" medical migration in the Japanese imperium continued even after the collapse of the empire. From the 1950s to the 70s, a substantial number of Taiwanese and Korean practitioners were "imported" to remote areas of Japan to provide medical service in doctorless villages. Most of them received medical education during the colonial period and therefore spoke fluent Japanese and, more importantly, had a Japanese physician's license.[1]

The consolidation of medical borders in Japan and overseas countries receiving Japanese doctors might be considered as a backlash against the migration of medical personnel, a retreat into protectionism, nationalism, and racism impelled by the insecurities and change brought by

[1] Konno Takumi, "Sengo nihon no gaikokujin ishi tōnyū: ishi fusoku to kyū shokuminchi shusshin ishi," PhD dissertation, Nagoya University, 2002.

interaction. As a matter of fact, however, it also set up an institutional ground for the burgeoning contemporary international movement of healthcare workers. The new requirements created to restrict the immigration of foreign doctors in the early twentieth century— for example, the evaluation of their foreign credentials, the possession of local medical licenses, and fluency in the national language of the receiving country—later became common global requirements for foreign-trained medical personnel in the second half of the twentieth century. In this sense, a study of physicians on the move a century ago is a study of the early history of the global migration of medical professionals today, and is therefore also a story of contemporary globalization.

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