Medical Policies toward Indigenous Medicine in Colonial Korea and India

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Abstract
Both the British and Japan emphasized the superiority of Western medicine to indigenous in their colonies, India and Korea respectively, partly relying on the practice of indigenous medicine due to the lack of "qualified doctors." The British and Japan, however, differed in acting medical law on indigenous practitioners and affected the sociopolitical space where the revivalist movements for indigenous medicine resulted from indigenous medical practitioners in India and the Japanese colonial government in Korea. It is worth noting that the two imperial powers politicized Western and indigenous medicine in similar fashion to legitimize their rules over the colonies.

Keywords: indigenous medicine, imperialism, colonialism, medical policy, Western medicine, indigenous practitioner, doctor, revivalist movement

Introduction

As Peter Duus poignantly notes, it is tempting to assert that Japanese imperialism was unique.[1] In particular, Korean historians working on a colonial period that "is both too painful and too saturated with resistance mythologies"[2] are vulnerable to this narrative. The arguments claimed by a North Korean historian that the colonial rule in Korea was a "unique terrorism," and that Japan reinforced the Korean ruling base by performing "unique and barbarous policies" are indicative of this tendency.[3]

Japanese ruling policy was, in a sense, unique among modern imperialism in that Japan pursued an assimilation policy that did not permit Koreans to elect representatives to serve in the Japanese imperial parliament. However, I feel that whether Japanese imperialism was unique or not is less urgent a task than accumulating research findings on Japanese imperialism. In this regard, a comparative study would be useful not only in delineating the nature of Japanese colonialism but also in investigating the features of imperialism in the modern period. Accordingly, a comparative study with British colonial policies could prove to be productive. While Britain utilized local leaders to act as agents between the colonized and their colonizers, and tolerated the indigenous cultures or social identities of its colonies,

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1) Duus (1995, 437).
2) Cumings (1997, 139).
3) Gwahakwon Yeoksa Yeonguso (1988, 124).

Japan dispatched its own officials to govern its colonies and attempted to assimilate the colonized population as Japanese by repressing the colonies' particular customs and cultures. Thus, the ruling policy of Britain could be epitomized as tolerance in contrast to that of Japanese intervention.

I focus on indigenous medicine in colonial Korea and India in this comparison as Korea and India constituted the core part of the Japanese and British empires respectively, and because indigenous medicine was exemplary in its utility in constituting a native cultural identity that could be wielded in resistance against imperialism. An analysis of the ruling policy toward indigenous medicine will supplement the various studies on imperialism as well as the history of colonial medicine.

There have been a few scholars who have conducted comparative studies between Japanese and British imperialism,[4] though the studies have little to do with medicine. According to them, Britain, as opposed to Japan, gave the local people a larger political space in which a national movement, by expanding its influence among the local people, was able to gain concessions from Britain. This difference helps explain the different fates of indigenous medicine in Korea and India. Working from the existing scholarship, I would like to concentrate my attention on identifying the similarities and differences in medical policies regarding indigenous medicine in colonial Korea and India.

Similarities

Emphasis on the Superiority of Western Medicine

The first similarity the British and Japanese shared in terms of medicine was the continuous emphasis on the superiority of Western medicine. In the course of expanding empire, Western medicine was utilized as a sophisticated tool that justified the intrusion into and the ruling of foreign countries.

Developments in anatomy and physiology led Europeans to view the body in fundamentally different ways from Asian practitioners. The new science of pathological anatomy altered the conception of disease, viewing disease as localized in a particular organ or tissue. As a result, Western medicine attached great importance to clinical observations, and a prominent element in these was the use of postmortems.[5] The development of bacteriology in particular ushered Western medicine into an age of "curative confidence."[6]

By the first half of the nineteenth century, few European practitioners considered the Indian medical system as a totality. The assertion made by the Viceroy of India demonstrates European confidence in Western medicine. In 1899, Lord Curzon claimed that Western medicine alone justified British rule and was the most cosmopolitan of all sciences.[7]

The Japanese also had confidence in the superiority of Western medicine.[8] Dojinkai,

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[4]) For comparative studies on British and Japanese colonialism, see Kibata (1992), Bak J. (2000), and Bak S. (2001). Lewis H. Gann wrote on Western and Japanese colonialism, however, his works do not include a direct comparison between Britain and Japan. Gann (1984, 1996).

[5]) Harrison (2001, 50-67); Arnold(1993, 53).

[6]) Arnold (1988, 12).

[7]) Arnold (1994, 346).

[8]) Japan placed confidence in Western civilization as well as medicine. More specifically, Japan's faith in Western medicine stemmed from a definite belief in the primacy of Western civilization. Japan claimed that the seizure of Korea would give Koreans a chance to accept the Western civilization Japan had assimilated before other Asian countries did. Japan assumed as its obligation the duty of cultivating "backwards" Korea by way of transmitting Western civilization, in particular, medicine. About the Japanese yearning for Western civilization, see Bak J. (2000, 274-275).

a medical association that supported the incursion of Japan into Korea until its annexation in 1910, displays such confidence. Dojinkai claimed that people from the West were superior to those from the East because Western knowledge including science was more advanced than Eastern knowledge. To Dojinkai, medical science was a leader of civilization or, in most cases, the symbol of Western civilization itself.[9]

The need for using Western medicine was more urgent in Japan than in Britain. Japan considered medicine, meaning of course Western medicine, an indispensable component in establishing a modern nation, because Western medicine was better not only for treating patients, but for supporting courts of law, military action, and in particular, sanitary administration, which was considered an essential element to make people healthy and strong. For Meiji leaders whose principal aim was modernization, Western medicine was considered to be exactly what they needed to attain the goal of a civilized Japan.[10]

It is not surprising that the Meiji government would set up a new medical system on the basis of Western medicine. The partiality of the Meiji government towards Western medicine was clearly manifested when the regulations on medical examination and licensing were enforced. As the subjects of examinations consisted only of Western medicine, for instance, anatomy, physiology, pathology, surgery, internal medicine, etc., it was no longer possible for indigenous medical practitioners to became official "medical doctors." Although indigenous medical practitioners put a great deal of effort in receiving official recognition for their medicinal knowledge, the dismissal of their petition to the Imperial Diet that an examination for indigenous medical practitioners be established on the same par as for Western doctors resulted in the extinction of the revivalist movement.[11]

At the same time, the Meiji government actively encouraged Western medicine, founding public medical schools and sending graduates to Western countries like Germany. As a result, the development of Western medicine, especially as worked out by Japanese bacteriologists such as Kitazato Sibasaburo and Siga Kiyosi, led Japan to have more trust in Western medicine, which was then claimed as Japanese medicine. Western medicine as it progressed in Japan was seen as crossing boundaries of specific localities. Japanese medicine was thus raised to the status of a universal medicine worth emulating. "The medicine developed by the Japanese is neither Western medicine nor Eastern. It is universal, accomplished by following the law of nature."[12]

In consequence, confidence in Western medicine entailed the degradation of the value of indigenous medicine. Britain and Japan in particular ignored the value of indigenous medicine to justify their rule, underscoring the backwardness of the colonies.

The British interestingly enough held an initial interest in indigenous medicine. For instance, by the end of the seventeenth century, European medical practitioners made extensive use of Indian indigenous medical knowledge, using local medicinal plants and consulting practitioners of the Indian system of medicine. The epistemological similarities between Europe and Indian medicine, and the same humoral conception of the human body, facilitated the learning of Indian indigenous medical knowledge and practices.[13]

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9) *Dojin* 1 (1906): 1; *Dojinka nijunensi* (Twenty Years' History of Dojinkai) (1924): 24-25.

10) Park Yunjae (2005, 51); Interestingly enough, advocates for Western medicine in both Britain and Japan used a similar metaphor, that is, arms. A professor of a medical college in India remarked, "The financing of Unani and Ayurvedic institutes by the government . . . is precisely on par with the same government financing archery clubs to find out the possibilities of the bow and arrow in modern warfare." In the same way, an eminent founder of private a Western medical school in Japan said that "In modern warfare, while Oriental medicine works like a bow and arrow, Western medicine works like a seven-shot revolver." Anil Kurmar (1998, 72); Kawakimitakesi (1965, 159-160).

11) Sugaya (1976, 6, 41); *Iseihyakunensi* (Hundred Years' History of Medical System), 19-20, 34.

12) *Maeil sinbo* (Daily News), November 20, 1913.

13) Harrison (1994, 39-43; 2001, 50).

This interest in indigenous medicine laid the groundwork for the establishment in 1822 of the Native Medical Institute (hereafter NMI) where both Western and Indian indigenous medicine were taught side by side in vernacular languages. However, NMI was abolished in 1835, allegedly because of the high cost of hiring professors and translation of Western medical texts, inappropriate tuition, the brief period of training and examination, absence of courses on practical anatomy, and so on.[14] In truth, though, it was a growing disbelief in Indian indigenous medicine that was behind the reversion of attitude.[15] The discontinuance of NMI symbolized the transition of British colonial policy from recognition to discrediting of the value of indigenous medicine.

Unlike the British, the Japanese discredited Korean indigenous medicine from the beginning of their intrusion into Korea. It was Japan's opinion that indigenous practitioners treated patients without considerable clinical experience, after superficially reading a couple of introductions to medicine. It was also claimed that they often caused the premature deaths of their patients due to their lack of knowledge of diseases and *materia medica*. The colonial government in Korea concluded that indigenous practitioners were not qualified to be awarded licenses to practice medicine.[16] An official who was responsible for sanitation went so far as to say that "some Korean indigenous practitioners have less medical knowledge than lay people."[17]

In reality, even before the colonization process began in 1905, indigenous medicine had continuously been the target of criticism among Koreans. Critics suggested that indigenous medicine adopt the advantageous characteristics of Western medicine, for instance, long-term and organized education, an objective examination and evaluation system, official issuing of licenses, etc. They claimed that if practitioners learned the appropriate knowledge and acquired the practical skills of indigenous medicine, they could provide satisfactory treatments to patients. This meant that it was not indigenous medicine per se, but practitioners who were to blame.[18]

However, Japan held a different attitude toward indigenous medicine. It criticized not only the practitioners but also indigenous medicine itself, claiming that it was merely the accumulation of thousands of years' first-hand experiences. According to colonial Japan, the essential theory of indigenous medicine, for example, the Five Phases and *yinyang* theories of correspondence, were mere doctrinarism.[19] If the theory of indigenous medicine was useless, there was no good reason why it should continue to exist. It was precisely this view that Japan held regarding indigenous medicine in Korea.

The Utilization of Indigenous Medicine

Even though both Britain and Japan passed harsh judgment against indigenous medicine, they could not help but bring indigenous practitioners into service because there were not enough "qualified doctors" to satisfy the medical needs in both colonies. Neither allocated an

[14]) Kurmar (1998, 22); Bala (1991, 46).

[15]) Arnold (1986, 137). Even when Britain and Japan displayed a positive attitude toward indigenous medicine, it was not towards the "process" but rather the substance. They recognized only the importance of indigenous drugs and emphasized their use. Kumar (1997, 176).

[16]) *Maeil sinbo*, November 20, 1910.

[17]) *Chosento manshu* (Korea and Manchuria) 189 (1923): 32.

[18]) Park Yunjae (2005, 99-109); A doctor in India published a description of Ayurvedic medicine in which he attributed the decline of Ayurvedic medicine to indigenous practitioners. His identification of Ayurvedic medicine as "a lost culture that was more open, scientific, and more profoundly 'Indian' than inherited" rendered innovation desirable. Charles Leslie (1973, 223-224).

[19]) Ogusimasaharu (1921, 278).

education budget large enough to establish adequate Western style medical schools, and in consequence, Western medicine was not able to monopolize the medical system in colonies, especially in the rural areas where the majority of the population lived.

In 1824 in Calcutta, India, the colonial government founded the first British medical school in which the teaching was presented in the local vernacular language. Establishment of medical colleges continued in Madras, Bombay, and other cities. However in 1916, some 90 years after the first medical college was founded in India, there were only 5 medical colleges and 14 schools. The total numbers of students in each institution were 2,311 and 2,453 respectively, far below the standard to meet the medical need in India.[20] As the colonial government worried about the expense and risks of a political backlash, its commitment to the spread of Western medical ideas and practices were half-hearted.[21]

The lack of medical education institutions was not merely the result of the great shortage of educational facilities, such as teaching staff, but more importantly due to the colonial government's fear of the financial involvement. For instance, the colonial government turned down a proposal for founding a medical school, although a Raja showed his intent to donate enough funds to establish a medical school in the local area, insisting that the total funding of outlay and maintenance of the institution be placed on the natives, either through subscription or provincial revenues.[22]

When the Japanese colonial government degraded the traditional practitioner into "disqualified doctor," in Korea, there were only two Western style medical schools that produced about 50 graduates per annum. In 1923 two medical institutes providing a short course of medical knowledge were added to this number. Even when these institutes started to give lectures, they did not receive any financial support from the central government, being subsidized by the provincial government.[23]

As Japan did not have the sufficient budget to establish medical schools in Korea, it sought an alternative to increase the number of Western style practitioners. This was the medical examination, its law was promulgated in 1914. This law prescribed that applicants in Korea, unlike Japan, did not have to graduate from medical school, providing applicants without a regular medical education more opportunity to practice.[24] Moreover, for the purpose of increasing the number of successful applicants, the colonial government revised the law several times. For instance, applicants were able to take three examinations one by one, and if an applicant passed one of examinations, he did not have to take the same examination again, permanently holding the validity of certificate of the examination that he passed.[25]

Nevertheless, the number of Western style practitioners was still not enough to reach the majority of the population. The colonial government had no choice but to employ indigenous practitioners. In Punjub, India, *hakims* were taught anatomy and surgery as a short course of instruction in order to extend medicine to rural areas. The University of Punjab offered courses for *hakims* and *vaids* until 1907.[26]

In particular, when an epidemic broke out, it was inevitable for the colonial government to make use of the available indigenous practitioners, fearing that the failure to prevent epidemics would incur massive social unrest.[27] The colonial government in Korea emphasized that indigenous practitioners should learn about epidemic diseases and medical

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20) Jaggi (2000, 57).
21) Arnold (1993, 288).
22) Kurmar (1998, 50-51).
23) Kee Changduk (1995, 263-266, 287-289).
24) *Maeil sinbo*, August, 14, 1914.
25) Park (2005, 312).
26) Hume (1977, 214-231); Harrison (2001, 76).
27) Kurmar (1998, 72).

law so that they could report any case of epidemics as early as possible. When indigenous practitioners took regular lectures on Western medicine organized by the colonial government, the first subject they had to take was epidemic disease, to be more specific, disinfectant, sanitation, and local diseases.[28]

Though the persistent utilization of indigenous medicine was mainly due to the inadequate supply of "qualified doctors", indigenous medicine had several advantages over Western medicine, the low cost of treatment being one of the best advantages for patients. A report committed to investigate the situation of indigenous medicine stated that the average cost per patient per day in the Western medical dispensary was about four times more than in the Ayurvedic one.[29] In Korea, the cheaper cost of indigenous medicine, owing to the easier availability of medicinal plants and less use of medical machines in treating patients, was stressed as an advantage in the consumption of Eastern medicine.[30]

However, behind the widespread use of indigenous medicine in the colonies was a firm belief among the colonized of its remedial value fostered by the acknowledgement of the difference between particular "soils". According to indigenous medicine, this "soil" consisted of environmental conditions, socio-cultural factors, etc.[31] In other words, Western and indigenous systems originated and developed in different environmental and cultural conditions. In this context, the indigenous system was claimed to be in harmony with the nature of the inhabitants of that particular country.[32] This is why while Western medicine was superior in surgery, indigenous medicine, owing to the acknowledgement of the relations between patient, disease and environment, displayed distinct effects on internal and chronic diseases.[33] If the links between a particular medical system and nature and society is more important than the question of which system is better equipped and developed, it follows that it becomes natural for the native population to use indigenous medicine, which recognizes local and physical differences, on principle in prescribing medications and treating patients.

The reasons as laid out above allowed indigenous medicine to survive despite the unfavorable circumstances created by the colonial government. A colonial officer at the Indian Medical Service described the medical policy they had to enforce, "For many years to come, they [indigenous practitioners] will constitute the medical attendants of by far the largest portion of the Indian community."[34] Japanese colonial government suffered a similar quandary. In consequence, "while there were not enough facilities to meet the medical need, it was not a good policy to exclude indigenous practitioners from treating patients."[35]

Differences

The Purpose of Medical Law

Though both colonial Korea and India had laws on practitioners that were promulgated in the

[28]) *Chosen sotokuhu siseinempo* (The Annual Report of Japanese Government-General) (1915): 311; Siraisi (1918, 49-50).
[29]) Panikkar (1995, 152).
[30]) Jo (1997, 199).
[31]) Lambert (1997, 199); Nair (2001, 228).
[32]) Panikkar (1995, 163); Jaggi (1980, 34).
[33]) *Hwangseong sinmun* (Hwangseong Newspaper) May 5, 1899; Yi (1977, 296).
[34]) Jeffery (1988, 53).
[35]) *Chosen sotokuhu siseinempo* (1913): 215. Two sets of statistics accurately demonstrate the similar situation faced in the rural areas of both colonies. Just before liberation from the British, a committee appointed to inquire into the situation of Indian indigenous medicine concluded, "Indian medicine at present serves more than 80% of the population in rural area." In 1944, a year before Korea was liberated, about 60% of death certificates in a province were issued by indigenous practitioners. Jaggi (1980, 33); *Chosen 6* (1944, 68).

1910s, the fact that regulations on indigenous practitioners in Korea were enforced only three years after its annexation (whereas in India they came about 180 years after the beginning of British conquest of Bengal) suggests a difference in colonial rule between Japan and Britain. This difference was in accord with the colonial policies of the two empires, that is, intervention and tolerance respectively.

It was limited budgets and bureaucrats that virtually forced the British government to adopt an indirect ruling policy. The British Parliament was loath to pass a bill that allowed the government to collect taxes from its people to spend on ruling the colonies. 1848 saw only 23 personnel attached to the Ministry of Colony in Britain. By 1907, there were only 125. The poorly organized recruiting system for colonial personnel hindered the establishment of a centralized administrative system in the colonies. Furthermore, nearly none of the colonial officials had enough training experience or knowledge to effectively rule the colonies, and they wanted to work as “gentlemen” rather than colonial officials.[36]

Japan was able to carry out a more interventionist policy on the basis of military force. To suppress Korean resistance to Japanese rule in Korea between 1907 and 1911, the Japanese increased their initial force of a division and a half to two permanent army divisions consisting of about 16,000 men, assisted by 13,000 military and regular policemen. The British establishment in Nigeria in 1914, on the other hand, comprised just under 4,000 men. However, it was bureaucratic power that enabled Japan to virtually infiltrate Korean society. In 1937 the French ruled a population of 17 million Vietnamese with 2,920 administrative personnel. The Japanese ruled about 21 million Koreans in the same year with some 246,000 Japanese in public and professional positions. And yet resistance leaders in Vietnam noted the large French presence in Vietnam, in contrast to British rule in India.[37]

In 1913, the colonial government in Korea promulgated a series of medical registration laws affecting indigenous practitioners as well as doctors, public doctors, and dentists.[38] The main thrust was that these laws officially recognized the predominance of Western medicine. Medical law prescribed that only a Western style practitioner was able to have the title of “doctor.” Indigenous practitioners were reduced to the lower status of *uisaeng* or medical student.[39] In contrast to medical law in the precolonial period, which recognized indigenous practitioners as official medical doctors, this was a big change in the management of the medical system in Korea.

The 1913 medical law specified that, in order to work as *uisaeng*, the applicant had to be at least 20 years old and have over two years of clinical experience.[40] This meant that the colonial government no longer wanted to issue medical licenses to new indigenous practitioners, because the law only acknowledged those practitioners currently practicing at that point. However, the lack of practitioners could not meet the medical needs of the colony, and the reluctance of the colonial government to allocate a budget sufficient to produce enough “doctors” put an end to the original plan. The colonial government reluctantly had to permit the production of indigenous practitioners, by adding a clause that conferred a 5-year-license to applicants who had over three years of clinical experience. This interim measure continued to be valid until the end of colonial rule, and in consequence, *uisaeng*

[36]) Bak J. (2000, 213-217).
[37]) Gann (1984, 509-510); Cumings (2002, 11-12).
[38]) Japan planned to enact a medical law just after annexation, however, the practitioner’s complicated sphere of activities in Korea delayed the promulgation of the medical law. *Maeil sinbo*, September 22, 1911. Considering that the main purpose of the medical law was to draw a line clearly demarcating indigenous practitioners from “qualified doctors,” that is Western style practitioners, it is reasonable to conclude that the complicated working forms of indigenous practitioners delayed Japan’s legislative capacity in this regard. *Chosen sotokuhu siseinempo* (1913): 210.
[39]) *Chosen sotokuhu kampo* (The Government-General’s Official Gazette), November 15, 1913.
[40]) *Chosen sotokuhu kampo* (The Government-General’s Official Gazette), November 15, 1913.

continued to play a main role especially in rural areas such as agricultural or fishing villages.[41]

While colonial Korea had medical laws covering a generous portion of the medical system in the early colonial period, it was towards the end of British rule in the 1910s that India began to have medical laws. Moreover, what differed from the Korean case is that the Indian law only concerned Western style practitioners. Western medical practitioners had campaigned for a medical registration law since the 1860s in order to refrain practitioners holding degrees and diplomas from unrecognized medical institutions from disguising themselves as qualified medical practitioners. But their efforts were unsuccessful in achieving their goal, due to the reluctance of the colonial government to tread on the sensibilities of its colonized population.[42] However, by the1910s, the activities to improve indigenous medicine by synthesizing it with Western medicine was gaining popularity, and as a result, the colonial government could no longer avoid the increasing pressure from Western practitioners who complained about the "hodgepodge exposure" to Western medicine without regard to standards of training or qualifications.[43]

The medical registration laws were passed in all the provinces between 1912 and 1919 and decisively threatened the position of Indian indigenous medical practitioners. Prior to these laws, no preferential distinction officially existed between practitioners of Western and indigenous systems of medicine. However, these new laws explicitly stated that their intent was to distinguish between qualified and unqualified Western medical practitioners.[44]

For instance, these laws allowed only registered practitioners of Western medicine to enter government medical services and work for government institutions. Considering that most of the colleges, hospitals, dispensaries, and public health and sanitary programs were administered by the central government, these laws dealt a devastating blow to indigenous practitioners.[45] The discrimination against indigenous medical practitioners was clear in a court of law. The enforcement of laws meant that death certificates could be issued only by Western medical doctors and that only the evidence of these same doctors was admissible in a court of law. More importantly, this meant that the colonial government gave Western doctors the power not only to prove the existence of diseases but also to declare a defendant's innocence or guilt in a court of law. It is obvious then that the medical law was enacted for the benefit of Western practitioners. An advocate of *Unani* (Greco-Arabic medicine) bitterly criticized the law, calling it "a legal method aimed at removing the Eastern systems of medicine from the face of the earth."[46]

About 30 years later, the colonial government in India passed laws specifically regarding indigenous medicine. As India already had a law over Western medicine that the British considered to be official, the colonial government did not feel the urge to pass a resolution on indigenous medicine. Until then, indigenous practitioners practiced medicine without the official recognition of the government.

However in 1938, the government of Bombay legislated regulation on the qualification of indigenous medicine and established a registry for this purpose. Concretely, the State Board of Indian Systems of Medicine was formed to register practitioners, regulate the curriculum of schools for indigenous medicine, and set examinations all in the same year.[47] Although this 1938 law was enacted to encourage the study and spread of indigenous medicine, and although, after the law was promulgated, *vaids* and *hakims* in India "formally"

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[41]) Park (2005, 314-322).
[42]) Panikkar (1995, 149); Harrison (2001, 75).
[43]) Kumar (1997, 176-83).
[44]) Steintal (1984, 60).
[45]) Steintal (1984, 52).
[46]) Quaiser (2001, 342-343).
[47]) Steintal (1984, 64); Leslie (1975, 413).

enjoyed the same rights as their Western doctor counterparts,[48] the fact that indigenous medicine failed to gain recognition in the Medical Council in Britain meant that this separate registry put an end to the long-term endeavor to improve the status of indigenous practitioner. The only way to improve the status of indigenous practitioners was for them to gain the same position as Western practitioners and be recognized by the British council. As a result, even after India's liberation, indigenous medical educators, in order to attract better students, continued to appeal for the same career prospects in government health services and the same legal privileges as Western practitioners.[49]

A more significant difference between colonial Korea and India was the ramifications of the medical law. The law in Korea authorized officials, especially the sanitary police, to exclude unqualified practitioners. From the beginning of colonial rule, the Japanese police worried about the disorderly situation in which unqualified practitioners, in particular indigenous doctors, could rashly treat patients and write prescriptions, due to the lack of proper medical law that would impose strict regulations.[50] The law in India, on the other hand, merely protected the registered practitioner, but did not prohibit unqualified healers from practicing in the field of indigenous medicine. The law in India was enacted to encourage indigenous medicine, not to limit the activities of practitioners. In consequence, Indian law gave traditional practitioners more opportunities to receive medical licenses than Korean practitioners who later had to pass an examination to be licensed. Indian indigenous practitioners were registered only on the basis of experience or apprenticeship, which meant that their status could be threatened by amendment of law allowing new practitioners to be registered on the basis of experience.[51]

In India, there had been pressure for stricter registrations, as clinical experience was the only condition for licensing, but that experience varied widely among the provinces. A clear delineation between qualified and unqualified practitioners was a primary task for the Indian government to achieve. However, even after the 1970 Central Government Act, some states were registering on the basis of experience only, while others insisted on the acquisition of a registrable qualification. Among the number of institutionally qualified and not institutionally qualified registered practitioners in the Indian system of medicine, 149,457 and 216,217 respectively suggest that the "registration boards took a relatively lenient view of claims to qualifications."[52]

This kind of disturbance did not take place in liberated Korea. Korea did not have trouble with authorizing unqualified practitioners, because, after the promulgation of medical laws in 1913, practitioners were well regulated by the colonial government. After the liberation of Korea, in the course of reorganizing the medical system, despite the fact that a few members of the National Assembly were skeptical of the value of indigenous medicine,[53] an important problem to solve was whether to grant indigenous practitioners, who had been discriminated against, the same status as Western style doctors.

The time lag between colonization and the enacting of medical laws on indigenous medicine reflected the contrasting attitudes of the two imperial powers held towards indigenous medicine or society. Japan attempted to intervene in colonial society from the outset, whereas the British did not. It was the provincial government, not the central

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[48]) Jeffery (1979, 320).

[49]) Leslie (1973, 235); Furthermore, unlike Korea, the registration law in India did not embrace all regions of the subcontinent. As this law was only enforced in one city, Bombay, the need still remained to set standards for indigenous practitioners

[50]) *Keimuiho* 警務彙報 (Bulletin on Police) 22 (1912): 21, 30; (1912): 35.

[51]) Jefferey (1982, 1836).

[52]) Jefferey (1982, 1839).

[53]) Records of National Assembly of Korea (1951), 25th and 30th plenary sessions, 11-25, pp. 22-4; 11-30, pp. 16-17.

government, that promulgated a medical law on indigenous medicine in order to encourage the study of Indian systems of medicine. This dissimilarity in colonial policy between Britain and Japan produced different local government policies, resulting in contrasting conditions for indigenous medicine.

Sociopolitical Condition for Revivalist Movements

As previously stated, in terms of medicine, Britain and Japan held contrasting policies toward their colonies, that is, tolerance and intervention. The Indian colonial government feared that intervention would incur social unrest, and was reluctant to interfere in Indian society with sanitary reforms. In 1898 when plague invaded India, a sanitary commissioner to the Government of India acknowledged that "what is medically desirable may be practically impossible, and politically dangerous."[54] Japan intervened in colonial societies to the extent that military forces were sometimes used to prevent the spread of epidemic diseases. The anti-plague activities in 1911 were one such an example. As Korea and Manchuria shared a border, the outbreak of plague in Manchuria terrified the Japanese colonial government. To prevent Manchurians from crossing the frozen river, the colonial government called on not only the police but also the army to guard the borders, as mobilizing residents alone was not enough. The activities resembled a "military campaign."[55]

The different medical policies in the colonies produced dissimilar sociopolitical spaces for revivalist movements of indigenous medicine. As the Japanese colonial government did not provide any space for indigenous medicine to escalate from its low status, the revivalist movement in Korea began on Japan's initiative. On the other hand, it was the Indian nationalist movement that catalyzed the revivalist movement in indigenous medicine.

Before a full-scale revivalist movement arose in 1920s' India, there were various attempts to encourage indigenous medicine. The princely elites, the theoretically autonomous rulers of India, were important patrons of indigenous medicine. They valued medicine intrinsically as well as for its symbolic value.[56] Some states' governments sanctioned a system of medical grants to practitioners and offered instruction in indigenous medicine through the traditional disciple system or indigenous medical colleges.[57] However, the critical factor for the revivalist movement was the transference of political power, albeit limited. Indigenous medicine, owing to the lack of a political base, was denied a chance to compete with Western medicine on an equal footing following British rule.[58]

It was the 1919 reform that transferred the jurisdiction of some subjects like public health, education, agriculture, etc, from the central government to the provinces, thus escalating the movement to revitalize indigenous medicine in each local government. Reform of the local system provided limited political space, though, which the Indian nationalist movement made efficient use of to strengthen its political power.[59] The strength of the nationalist movement put pressure on the provincial government to respond to demands to encourage, or at least to inquire into, the efficacy of indigenous medicine.

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[54]) Arnold (1993, 232).
[55]) Park (2000, 778-780).
[56]) Metcalf (1985, 8).
[57]) Nair (2001, 226-227); Brass (1972, 345).
[58]) Panikkar (1995, 157). After liberation from British rule, political forces continued to play decisive roles in the formulation of medical policies on Indian systems of medicine. Paul R. Brass concludes that the revivalist movement "has tended from the beginning to be strongly oriented toward politics" (Brass, 1972, 368).
[59]) Kibata (1992, 278). Britain was going to hold onto key powers in the areas of finance and defense, however, the India Act of 1935 brought all the provincial governments under the control of elected Indian ministers (Bose and Jalal, 2004, 125).

After the 1919 reform, several provincial governments, following the recommendations of several committees appointed to investigate indigenous systems, opened colleges of indigenous medicine.[60] Nationalist politicians also started to implement policies supporting indigenous medicine, since the Indian National Congress, discovering that the revivalist movement could be used as cultural symbols in the nationalist struggle, had begun to pass resolutions in its support for indigenous medicine.[61]

The British allowed the introduction of indigenous medicine in some major medical colleges under the pressure of movements that advocated for “oriental learning.” However, the colonial government was unwilling to spend any funds to promote indigenous systems of medicine or to open well-organized schools or colleges.[62] The power of the nationalist movement was not enough to persuade the government to establish a medical college where indigenous medicine could be taught, but it did convince the government to concede to financing the maintenance of established medical colleges.[63]

However, in order to expand its activities, the revivalist movement made active use of the sociopolitical space allowed by the laws of local government. As a result, the Ministries of Health in several states instituted Boards of Indigenous Medicine responsible for running government dispensaries, registering practitioners, and regulating school curricula. When India became an independent nation, it had approximately 50 hospitals and 57 colleges of indigenous medicine,[64] while Korea had only a few indigenous institutes.

Korea, on the other hand, was not able to enjoy the same autonomous rights as India. Although, the “cultural policy” in the 1920s witnessed the formation of autonomous organizations in each province, they were just advisory organs, not legislative ones. Their advisory capacity was limited to the budget and taxation. The 1930 Reform transformed the advisory organs into legislative ones, but the areas in which provincial organizations were able to deal were almost the same as that in the 1920s.[65] As Japan worried that the development of autonomy in local areas could possibly lead to independence, Korea did not have the benefit of responsible government as enjoyed by Indians.[66]

Due to the lack of political autonomy in local areas, it was less the indigenous medical practitioners or nationalist movement in Korea and more the Japanese colonial government that created a sociopolitical space for indigenous medicine to attempt a revival. The first area in which Japan displayed interest in Eastern medicine was the use of medicinal herbs. As early as the 1930s, the colonial government encouraged the cultivation of traditional medical plants in order to increase the income of farmers in rural areas, and to bring herbs from Korea to Japan, which had previously had to import herbs from China.[67] The need for plants cultivated in Korea increased after the outbreak of the Sino-Japanese war in 1937. The colonial government provided lectures to farmers on the cultivation of herbs in provincial halls to increase the harvesting of medical plants. Making pharmacopoeia of indigenous medicine, for the purpose of standardizing the quality of plants, symbolized a change in Japan’s policy toward indigenous medicine.[68] In other words, Japan began to

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[60]) Bala (1991, 91); Jaggi (1980, 18, 27).
[61]) Jeffery (1988, 53). However, the Congress paid little attention to indigenous medicine in the beginning. The practitioners of Western medicine demanded Indianization of the Indian Medical Service and creation of more openings for them, an issue that was figured in every session of the Congress from 1893 to 1907 (Kurmar, 1998, 71).
[62]) Kurmar (1998, 72-75); Budget allocations for the indigenous system of medicine never exceeded 13% of the total health budget and usually remained far below this figure. Steintal (1984, 65); Hume (1977, 225).
[63]) Bala (1991, 55).
[64]) Leslie (1974, 98-99).
[65]) Yun (2001, 33-39); Son (1992, 235-259).
[66]) Kang (1980, 299-305).
[67]) *Donga ilbo*, March 14, 1933.
[68]) Shin (2003, 118-119).

recognize, although in limited fashion, the value of Eastern medicine, denying its original "mission" to bring modern values to Korea, values which could not coexist peacefully with "backward" Eastern medicine.

As the war expanded to the Pacific, the colonial government went so far as to found a training school producing indigenous practitioners, although it furnished only a school building and one administrator. The school began in April 1937 and about 300 practitioners graduated over five years.[69] Although some have asserted that this school was founded thanks to a petition spearheaded by the leaders of *uisaeng* for the recognition of indigenous medicine, it would be fair to say that the shortage of medical practitioners and the lack of medical plants were the main motives behind the colonial government's granting of the establishment of an Eastern medical school.[70] However, it is worth noting that the appeal took advantage of a political era when "oriental" values were considered a contribution to the establishment of the Greater East Asian Co-Prosperity Sphere and thus emphasized by imperial Japan in its attempt to expand the war against "Western" enemies.[71] Considering that Japan adamantly refused to establish a Korean Assembly or to tolerate Korean cultural peculiarities,[72] Japan could not have been open-minded enough to consider "Korean" traditional medicine as an essential component of cultural identity. Against this backdrop, a revivalist movement in Korea, in contrast with that in India, had difficulty progressing into a full-scale nationalist movement.

Conclusion

After investigating the situations in which Korean and Indian indigenous medicine fought to survive under colonial rule, I have laid out two major similarities and differences. The first similarity the British and Japan shared was an emphasis on the superiority of Western medicine. Confidence in Western medicine necessitated the degradation of the value of indigenous medicine, which not only justified colonial rule but also underscored the backwardness of their colonies.

The second similarity was the continued practice of indigenous medicine. This was due to the fact there were insufficient numbers of "qualified doctors" to meet the medical needs in each colony to the satisfaction of the colonial governments. However, indigenous medicine had also several advantages over Western medicine, such as low cost of treatment and more importantly a firm belief in its remedial value among the colonized population.

The first dissimilarity between colonial Korea and India was the time lag between the legislation of indigenous registration laws and the onset of colonization. Japan promulgated a medical law on indigenous practitioners in Korea just three years after the annexation; however, India, owing to the reluctance of colonial government to risk a political backlash, enacted such a law on the provincial level, about 30 years after the passing of a law on Western medicine. Furthermore, the way medical law acted on unqualified practitioners differed. While the law in Korea authorized officials to exclude unqualified doctors, the law in India protected only those practitioners who were registered. It did not prohibit the practice of unqualified healers in the field of indigenous medicine.

The second contrast was the dissimilar sociopolitical space that emerged to foster the

69) Kim (1984, 506).

70) Shin (2003, 123). The indigenous practitioners in Gyeonggi-do province promised to send graduates to villages without doctors in order to persuade a Japanese official who was sympathetic to Eastern medicine to support their cause. Yi (1977, 299).

71) In 1939 Korean indigenous doctors established an association in an effort to revive indigenous medicine, supporting the medical policy of the Japanese colonial government. The association used "Oriental" as its name.

72) Kang (1980, 347).

revivalist movement. While a series of local government laws in India enlarged the space for indigenous medicine to expand its activity, and instigated the Indian nationalist movement to accelerate the revivalist movement, colonial Korea enjoyed fewer political rights than India. Thus, it was less the indigenous medical practitioners or nationalist movement in Korea than the Japanese colonial government in Korea that ignited the revivalist movement for Korean indigenous medicine.

Indigenous medicine in colonial Korea and India had to survive under different ruling policies, namely, intervention and tolerance, an observation made by previous studies on Japanese and British imperialism. In the case of colonial Korea, due to the harsh medical policy against indigenous medicine, the medical milieu was much more bitter for indigenous practitioners in Korea, thus distinguishing Japan from other Western imperial countries and, after liberation, produced different medico-social conditions in which indigenous medicine reorganized its system. However, it is worth noting that Britain and Japan politicized Western and indigenous medicine in a similar fashion to legitimize their rules over the colonies. Considering that both Britain and Japan emphasized the superiority of Western medicine even while utilizing indigenous medicine until the end of their colonial rules, there is little doubt that the colonizer used medicine as political rhetoric rather than as a medical apparatus to meet the medical needs in the colonies that had different environmental conditions and socio-cultural circumstances.

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