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Contours of (Heteronomous) Modernization?

A comment on papers presented at a symposium,
Transaction in Medicine & Heteronomous Modernization: Germany, Korea, Taiwan and Japan
September 20, 2008, at University of Tokyo

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It is a pleasure and honour to comment on four papers in the Part I of this symposium. All of them are so interesting and I have learned so much from each paper. The richness, depth, and diversity of the papers make it impossible for me to comment on each paper one by one, discuss various aspects of history of medicine dealt with by them and still present a talk which is coherent. Instead, I will select three areas of history of medicine in modern Japan, about which I know just something, and try to discuss issues related with the theme of this symposium, which is "heteronomous modernization". I think the "heteronomous modernization" is an interesting, useful, and potentially powerful concept. It enables us to avoid the rigid framework of nation-state, to overcome the dichotomy of the centre and periphery, and to delineate a new topography of modernization and perhaps globalization. On the other hand, I am not sure whether we know enough about the modernization of Japanese medicine itself. Recent historical works suggest that the more one studies the modernization of Japanese medicine, the more one finds important continuities with the medicine of the pre-modern or Tokugawa period. The pace of modernization differed tremendously from one aspect of medicine discipline to another. The contours of modernization of Japanese medicine in the late nineteenth- and early twentieth-century seem to have been enormously complex, and I am not aware of any major works which deliniated the contours based on recent historical scholarship. Neither am I going to present any useful model for us to discuss modernization of Japanese medicine. Below I will present somewhat disconnected talk about three topics, namely licensing and traning of the medical profession,

psychiatric provision, and public health. They are selected to show the complexity of the modernization of Japanese medicine. I will conclude my talk by coming back to the concept of heteronomous modernization and explore its possibilities, as well as suggesting some areas of future collaboration between German and Japanese historians of medicine.

1. Professional training and licensing

Medical education and licensing of practitioners was the area where one can identify the modernization of Japanese medicine with Westernization. One should, however, distinguish the new elite of medicine from the grass-roots practitioners. Any discussion of modernization and Westernization of Japanese medicine should consider Isei, which was the foundational manifesto on medical matters published by the new Meiji government in 1874, just seven years after the overthrow of the Tokugawa Shogunate. Among many other things, Isei pronounced two major things: medicine would become one of the responsibilities of the state, and the state would adopt Western medicine instead of medicine of Chinese origin, which was to be called Kanpō medicine.

The Westernization of medical teaching and research based on universities went rather smoothly, starting from the medical school of the University of Tokyo founded in 1869. The University of Tokyo then went on to dominate medical education in Japan, by installing its graduates in other prestigious medical schools. These institutions were the home to many discoveries made by Japanese medical scientists. By the late nineteenth- and early twentieth century, Japanese medical scientific communities were capable of fostering world-class research projects by themselves.

In contrast, the modernization of medical practice lagged behind, with compromises and half-measures abounding. The government attempted to install a medical licensing system based on the formal education of western medicine and the examination system to ensure competence measured by the new standard of Western medicine. Since the system included only western medicine in the subjects of examination, it met substantial opposition from practitioners of Kanpō medicine. As is well known, leading Kanpō practitioners, many of whom had connections with former provincial medical schools which taught both Kanpo and Westerner medicines, put fierce

opposition against the Meiji government's policy of the total westernization of medical licensing. In the end, their attempt failed when in 1894 the bill for the amendment of the Medical Licensing Act was rejected by the parliament. The victory of the government-led westernization of medical practice was only partial, however. In 1874, there were about 28,000 medical practitioners, of whom only about 5,200 had learned, or claimed to have learned, Western medicine. More than 80% of medical practitioners had been trained, if they had been trained at all, in Kanpō medicine. A significant minority were barely literate, due to the almost total lack of regulation of medical practice during the Edo period. The government had to bow to this reality and put the quantity before the quality of medical provision. The resulting system thus had a huge loophole: those who had already practiced medicine were not required to stand the examination. This exemption of practitioners from licensing requirements was first adopted in 1875, and retained in subsequent pieces of legislation. This led to a situation that although newly granted medical licenses were based on western medicine, the majority of practitioners long remained Kanpō doctors. Even in 1900, more than half of the 40,000 medical practitioners received their license without any examination or attendance at modernized medical schools. In the late nineteenth and early twentieth century, medical profession in Japan, if one is able to call this bunch of people a profession, was made up of people with highly heterogeneous training and background. One needs to take this heterogenuity into consideration, when one talks about medical modernization in the context of the wider society.

2. Psychiatric Provision

While medical education and licensing system represented, at least on the surface, a complete or even agressive Westernization, laws regulating psychiatric provision presents a reverse picture, in which the state started a new game to consolidate an old pratice. The newly consolidated practice was putting a lunatic to a cage usually set up next to his or her own house. The result is an almost surreal picture of mental patients confined in a cage strictly based on the law and public policy.

Historical works have revealed that lunatics in small northern

villages during Tokugawa period (1603-1867) were put in sashiko, or a makeshift cage set up next to their own house. In Edo, recourse was mainly taken to the prisons and poor houses for keeping vagrants and the sick poor, as well as putting the patient in the cage at his or her own house. After the Soma case which involved an illegal confinement of a former Daimyo and attracted huge attention in 1885, a call for a new legislation quickly gained momentum. In 1898 a governmental committee was appointed to study psychiatric laws in Western countries, particularly those of England. These concerns culminated in the Mental Patients' Custody Act in 1900.

This first piece of national legislation regulating the confinement of the insane both aimed at the prevention of wrongful confinement and the secure custody of lunatics. For the former purpose, the Act took a straightforward but fresh approach, by newly criminalizing unjust or improper confinement, and set heavy fines and penalties against those who detained a sane person or improperly confined an insane person, and against those doctors who issued an improper certificate of lunacy. In contrast, the second aim of custody was achieved not so much by creating something new as by codifing the old practice. In essence, the Act demanded that if one wanted to have a lunatic confined, one should do so by appointing a "custodian". The custodian was allowed to confine the lunatic, only with the permission of the authority of the local government of city, town, or village. To get a permission the place of confinement should should meet special requirements for the safe custody of the patients. If the custodian wanted to confine the patient at his or her own house, he should do so first by seeking permission from the local administrative head and making a petition which included a detailed plan of the place and cage. These are the pictures of patients confined in their private homes taken in the early twentieth century. It should be emphasized that they were not illegally confined: their families were law-abiding citizens who had made formal petitions and received a sanction from the public authority. Despite the intention of modernisation and the protection of human rights surrounding this piece of legislation, a core part of the Mental Patients' Custody Act was a national and legal confirmation of a long-standing local semi-customary practice.

Not surprisingly, the Act was deeply unpopular to those doctors who liked to frame themselves as progressive modernizers: for them, home

confinement was a glaring piece of barbarity sanctioned by the state, and their criticism of home custody as a remnant of the barbaric past was certainly one of the important background of the Mental Hospitals Act in 1919, which aimed at the expansion of hospital-based public provision for mental patients. In a less evident but perhaps more important way, it was unpopular among people. Although the number of the cases of home custody slowly grew, the number of hospitalized patients grew much more rapidly. (Figure 2 above). During 1905 to 1940, home custody cases only doubled, while the hospitalised patients ten times. Especially important was the period of the most sharp decline in the custody rate, which took place from about 1911 to 1920. This suggests that, proportionally speaking, home-custody was a means of confinement which was becoming increasing unpopular, even before the passing of the Mental Hospitals Act. Facilities of psychiatric hospital had started to expand without the assistance of the Mental Hospitals Act and was gradually replacing the home as the locus of care and confinement of the insane.

I cannot go into detail but would like to add that this was due to the vigor of the private sector in the psychiatric provision. Privately owned psychiatric hospitals were more numerous and took care of more patients. In 1918, there existed only one public asylum, which was in Tokyo and housed about 450 patients; in the same year there already existed 57 private psychiatric hospitals, with total capacity for about 4,000 patients. Despite the growth of public hospitals through the Mental Hospitals Act, privately owned psychiatric hospitals continued to dominate the scene: in 1940 there were seven public psychiatric hospitals and 160 private hospitals. Indeed, the strength of private sector became more prominent in Tokyo. In 1906, about one-third of 600 patients hospitalized in Tokyo were sent to the private hospitals. In 1918, on the eve of the Mental Hospitals Act, the rate increased to about one-half. In 1940, more than 80% of 6,000 hospitalized patients in Tokyo were taken care of by privately owned hospitals.

3. Public Health

My third topic is that of public health, espeically the preventive measures against epidemics of infectious diseases. This is, like the area of medical

education, the area in which the historians have emphasized the innovative role of the state and the Western medicine, particularly bacteriology, in the making of modernity. Nagayo Sensai, the director of the Office of Hygiene at the Home Ministry, famously had the moment of epiphany when he recognized that in Western countries the state was responsible for the protection of the health of the people; Japan had not had such an office and needed it in order to become a modernized state; moreover, there was not a word for the concept of hygiene and he had to coin a new word – eisei -- from a Chinese classic. This episode beautifully represents a certain aspect of the modernization of Japanese medicine, namely radical discontinuity with the Tokugawa period.

Nagayo's recollection supports the historiography of the modernization of Japanese public health as a rupture from the past so beautifully that we are in danger of losing sight of other aspects, some of which showed remarkable continuity. I will talk about just one episode which is pertinent in the context of this paper, namely the dietary regimen for the prevention of cholera. Since the Tokugawa period, doctors in Japan, whether educated in Dutch medicine or Chinese-Japanese medicine, emphasized the importance of food in the etiology of cholera. During the second visitation of cholera in 1858, Pompe van Meerdervolt, a Dutch doctor who taught medicine to Japanese students in Nagasaki at that time, advised people to avoid food which is hard to digest: fruit, fish, shellfish would stay in the stomach too long a time and would be one of the causes of cholera. The dietary regimen and the avoidance of certain foods were followed by people in Edo. A chronicle noted large fluctuations of the prices of various food items during the cholera epidemic of 1858, due to the changing pattern of people's consumption. "Vendors of fish became very small in number, because fish would turn out to be fatal to those who had eaten it. Fishermen and fishmongers suffered heavy loss of their living. So did restaurants and bistros. Especially sardines were thought to be poisonous, and few people bought them even when they were fresh. On the other hand, prices of eggs and vegetables rose."

When cholera came back in the 1880s, the Meiji government introduced a whole new measures against the epidemics of cholera: disinfection, cleaning the place of abode, avoidance of the crowd, quarantine and separation of patients to hospitals. These measures were alien to

traditional medical concept and some were deeply unpopular. The practice of dietary regimen showed, however, a remarkable continuity. During the cholera epidemics of the 1870s and 80s, similar instances of the fluctuation of food prices according to the rules of dietary regimen were abundantly observed. Sudden shifts in demand and prices of particular food were regularly reported in the press. In the outbreak of 1886, Yomiuri Shinbun conducted a survey of the changes of the prices of various food items in Tokyo. In June the newspaper found that the sales of fishmongers slumped and sushi bars and soba-noodle bars suffered heavy losses. On the 26th of June the newspaper published an article which listed the ups and downs of the sales and prices of various food items. Items which recorded good sales and high prices were eggs, poultry, beef, dried bonito, grilled eels, vegetables, pickled raddish, milk, starch gruel, dry confectionaries, and choice sakes. The food items whose sales slumped included; raw fish, salted fish, tempura, sushi, and tōfu. Sales of shellfish suffered the heaviest slump. Many, if not all, of these foods were listed in the precepts of dietary regimen for the prevention of cholera.

Dietary regimen was not just practised by populace. Progressive modernizers preached to people to avoid certain foods. Indeed, doctors trained in Germany joined the chorus in the dietary etiology of cholera: Mori Ogai combined the bacteriological theory with the traditional etiology of cholera when he wrote that certain food would harm the stomach and made people more prone to cholera. Japanese doctors endorsed the traditional dietary etiology partly because laboratory experiments demonstrated the survival of comma bacillus differed greatly due to the acidity of the environment. Perhaps more importantly, they preached the harm of certain food because they believed the control of one's desire was the linchpin of public health. The logic was that restraining one's desire for food and keeping one healthy was an integral part of the public virtue or hygienic citizenship of the prevention of infectious diseases. Ogata Masanori, the professor of hygiene at the University of Tokyo succinctly summed up in his popular lecture on cholera: "those who indulge in immoderate eating and drinking are manufacturers of cholera." Doctors were particularly concerned that the rule of economy might pose a threat to public health. When a certain food was deemed harmful and its price went down, some were likely to risk their health and buy the food because of the lowered price.

Yamane Masatsugu, a graduate of the University of Tokyo and a chief medical officer of the Tokyo Metropolitan Police, wrote in 1902 that those who buy and eat tuna in the time of cholera because of its low price posed threat to public health.

4 Conclusion

I have above shown that the process of modernization of medicine in Japan showed enormous complexity. The path of modernization showed considerable difference accodring to which area of medicine we are talking about. In the area of medical education and licensing, the Japanese state took the most straightfoward approach to modernize its medicine. It selected Germany, a country which had had very little interaction with Japan, as a model, because Germany was being recognized by doctors in Europe and North America as the most advanced country in terms of academic medicine. Despite its success in academic medicine, the state had to bow to the reality and ended up licensing an enormous number of doctors trained in chinese medicine. In the first legislation for psychiatric provision, the government took a very different strategy. In its attempt to regulate the treatment of lunacy and to protect human rights, it showed an atavistic move and consolidated an old practice of confining the patient in a cage. The momentum towards psychiatric hospital, arguably a hallmark of modernity in Western countries, did not come from the state but initially from private institutions and then confirmed by the state in the Mental Hospitals Act in 1919. Finally, in public health measures for the prevention of cholera, the state endorsed both imported measures such as disinfection, quarantine, and separation hospital and indigenous measures such as dietary regimen. Even after the confirmation of the bacteriological causation of cholera, Japanese doctors put perhaps disproportionate emphasis on the control of one’s desire for food in order to foster a sense of hygienic citizenship.